Chasing Paddy:

And finding

Hope in a hostile place.

An Autoethnographic exploration of my practice and experiences as a lecturer in Mental Health Nursing.

Margaret Prendergast.

Submitted in fulfilment of the requirements of the

Doctorate in Higher and Adult Education.

Department of Adult and Community Education, Maynooth University, Co. Kildare. Ireland.

October 2023.

Supervisor: Dr Camilla Fitzsimons

Head of Department: Dr Mary Ryan.

Acknowledgements

I wish to thank all the staff of the Department of Adult Education at Maynooth University. I have learnt so much from you all on this Doctoral journey. I want to say a particular thanks to; Bernie, Fergal, Michael, and Patricia for sharing your knowledge and time so willingly. Thanks to Dave for your insightful feedback as second reader and interest in my work and thank you also to Dr. Jerry O Neill for your time, patience, and expertise. Sincere thanks to my supervisor, Dr. Camilla Fitzsimons for your guidance, vision, high standards and for keeping me and this work both intact.

I also want to thank Dr Christina Larkin, Dr. Maura Fitzsimons, Dr. Justin Kerr, and colleagues at ATU Mayo, for facilitating me to complete this work and to Olive and staff who went above and beyond the call of their library duty. Thanks also to the staff development team at ATU without whom this would not have been possible.

To my fellow Doctoral comrades, thank you for the support, the laughs, the messages, and your all-round goodness.

The biggest thanks of all goes to all my loved ones, both human and canine who had to endure my poor company, my unavailability and general crankiness, especially over the past twelve months.

Thank you.

A special acknowledgement

For Robert, Una, Victoria, Hattie, Jan, Miss V and especially Paddy.

I am so grateful to have met you all.

Abstract

Chasing Paddy and finding Hope in a hostile place is a story about the role of a mental health nursing lecturer in Ireland. It is an autoethnographic exploration of current practice and the daily dramas and dilemmas of working within the hostilities of higher education in Ireland.

This research surfaces the challenges and difficulties encountered by many mental health educators as their practice has changed enormously over the past number of years and continues to be shaped by changes in nursing and education policy. Such policy changes have negatively impacted the occupational and professional positioning of the role locally and internationally. In Ireland there is an absence of research in this area and this thesis is an attempt to shine a light on the way in which educator practice is being shaped by the impact of neoliberalism within the mental health and higher education sectors.

This work is structured over the five years it took me to complete this doctoral programme and starts at year 1, at the beginning of term and follows this course throughout. The start of the academic year anchors this research and presents an opportunity to unpack some of the complexities of mental health nurse educator practice.

Adopting an autoethnographic approach, in which the researcher becomes the researched, this work presents a series of stories about people who have impacted my educator practice and help to shine a spotlight on issues of professional identity, the nature of mental health work, occupational positioning and the multiple influences on current pedagogical practice.

The role of a mental health educator involves the educational preparation of students to become registered mental health nurses and so this research transcends mental health, nursing, and education. Navigating these areas involves is a complex and messy task and the addition of carefully crafted characters aid this process enormously. These characters are composites, drawn from a sociological imagination and are situated at various points which transcends almost forty years of nursing practice. The central character is Paddy who helps craft an intertwined, layered story of self and others which provides the main backdrop for this story.

Underpinned a social constructionist lens this work explores the lives of the characters in the research and interprets lived lives emotively and critically.
Autoethnography is the research approach which guides the researcher through sensitive, soulful, and searching questions allowing for author vulnerability, self-expression, critical reflexivity, and scholarly creativity.

Such creativity allows this work to be presented in a nontraditional way. The importance of author positioning which is central to autoethnography is represented in the non-conventional, performative, and sometimes fragmented means of writing seen throughout this research. This fragmentation is often

evident in the back-and-forth nature of the work, moving from present to past, to present, to future, to present and never settling. The use of various tenses helps to draw the reader into experiences but not confine them to a particular era, signifying the ongoing, messy, evolving, and infinite nature of this work. This facilitates expressions of uncertainty, questioning and ambiguity which is incorporated in many diverse and interpretative ways of knowing. The performative nature of the study invites the reader to follow a story with many different elements each attending to different sensibilities.

An important feature in this study is the representation of voice, that of the author and that of others which sometimes appears in differing guises in this work. The use of capital letters, commas, inverted commas, singular inverted commas instead of the traditional double, short punchy dialogue, pauses, white spaces, incomplete sentences, neologisms added to the purposeful disruption to narrative flow and aesthetic nicety. Carving out a place for the characters to represent their own textual narrative necessitated a departure from the artificiality of conventional academic writing with the use of imperfect dialogue, unsavory language, and words which are common parlance within mental health. Reader sensitivity underpins this research throughout as the reader can interpret their own meaning from the stories therein.

This study is an important one because it draws attention to mental health nurse education in Ireland. Much of the referenced work about this area of concern emanates from the UK and Australia and the study attempts to locate the problem and its particular situation within an Irish context.

It is insider research, which is a departure from traditional forms of enquiry in mental health nursing and one where the author is fully present and accountable standing behind each word written. It has helped me to understand my practice, its limitations, and possibilities both from an educator and activist perspective.

Prologue

Paddy is sitting on his bed quietly thinking on a warm July day. He is staring at the floor. Thoughts of a nice walk in the garden brings a smile to his worn and aged face. It has been six weeks since his admission to the ward and this time, things do not seem *so bad*. Not too bad at all, or maybe it's just a case of getting used to how things are. Sometimes hospital routines are helpful he thinks, like fish on a Friday and knowing when it is time to go to bed and time to get up again.

That big blue sky seems very inviting, he thinks as he cautiously moves towards the window.

Footsteps!

someone approaching, firm and fast.

It's not two o clock already, *is it?*

A voice calls his name out LOUD, and his heart begins to sink into a black hole.

No, Not again, no, no. no!!!

Which one is it now? he says to himself.

Maybe it's *that* student, the really annoying first year one, who is *always* on his case.

A smoke might help. A few pulls at least.

Louder and louder the student voice gets. 'Paddy, Paddy!'

'Where are you, Paddy?'

'Paddy!'

He bids his bed a temporary goodbye and quickly decides it is time to hide.

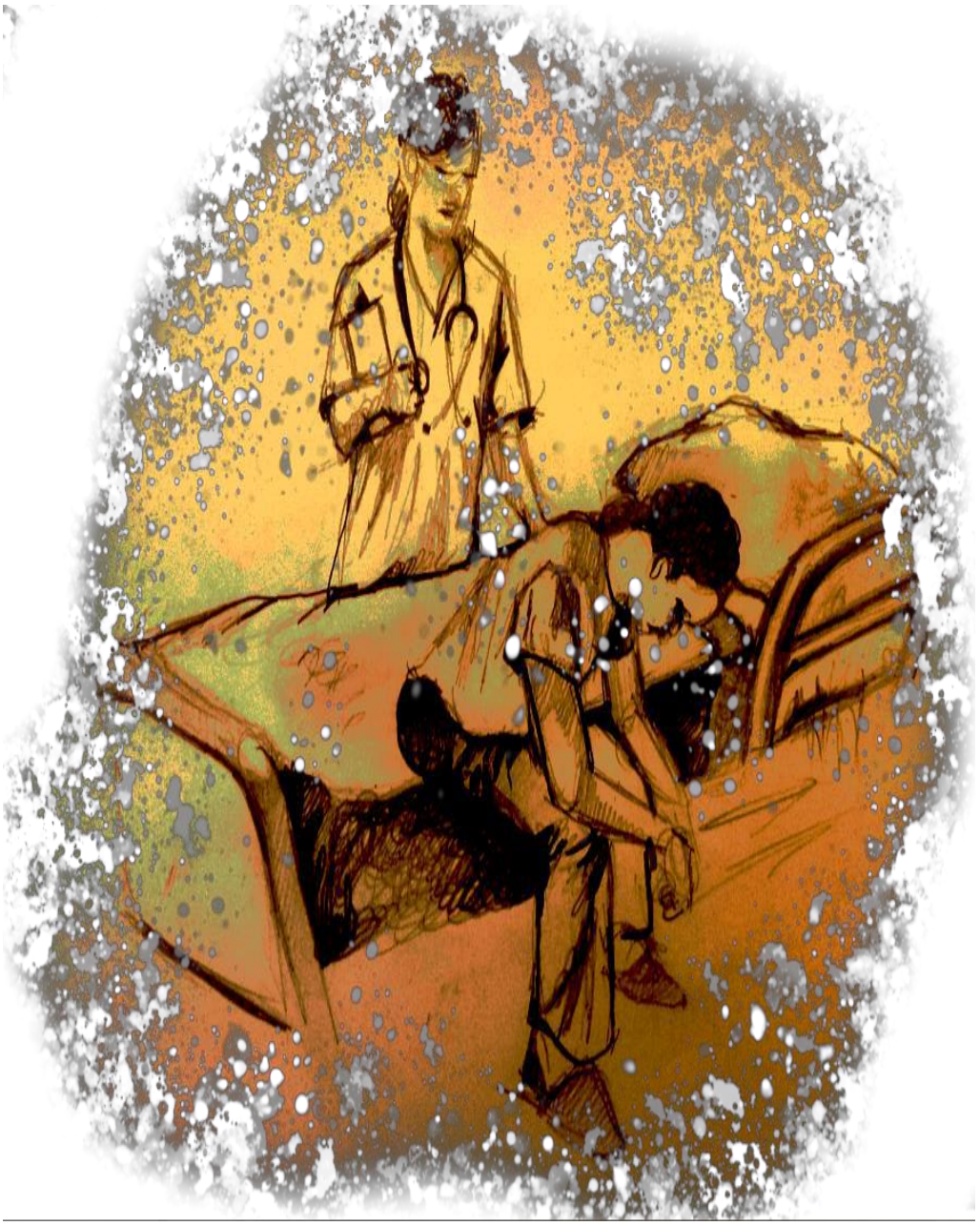

Table of Contents

Year 1

New Beginnings

It is 8.30 am on September the 2nd 2018, the academic New Year.

It is Monday.

There is a sense of all things new and fresh as I park my car in the car park at the back of the sprawling higher education institution where I work. First day back. 'Get a parking permit! I remind myself. Adding it to the growing mental list of errands that comes with the start of the new term. I check myself in the car mirror and fix my skirt, change my shoes from flats to heels, fix my unruly hair, adjust my long blue beady necklace, and compose myself. All should feel good in the world today. It is a beautiful warm September morning, and I can see colleagues, whom I have not seen since the summer break, moving about in the distance. Has it really been three months? Three months of leave from the hectic environment of undergraduate nurse education, I think wistfully. Colleagues are ambling slowly towards the University backdoor entrance smiling and chatting, some carrying large lunch boxes again, in keeping with the start of something new and prevenient. They must be delighted to be back; I think as I watch their smiles slowly infect each other's faces.

My ease is suddenly interrupted when I remember I had agreed to meet the new lecturer by the big door at the front of the health science building.

'Damn it,' I muttered, 'I'm supposed to meet the new person *Robert*, I think he was called at 8.30 am.' I need to hurry. Pausing for a moment, I ask myself 'why ever did I agree to take on *a new lecturer* mentor role and especially to someone who hasn't taught at *higher level* before?'. A first proper job!

I had previously accepted the role of mentor before the summer recess and was now beginning to regret my offer. 'You have enough work on already for term one Margaret', the voice inside my head claimed, 'and you have work outstanding from last year'. Recalling feelings of exhaustion and stress from the preceding June I started to feel anxiety, the anticipatory, pernicious kind. *Septembers* are always busy in undergraduate nurse education and seem to be getting busier every year. It feels much easier to *say yes* to such requests in June, as the long-awaited Summer recess eases any feelings of work overload. This is true for me, anyway.

As I leave the car park behind me and head through the foyer towards the front door, I see an outline of a tall man looking down at his wristwatch. I quicken pace, my heels clattering on the old, tiled floors. A mist of familiarity descends around me and a voice, the voice which has by now become my critical companion, tuned into my current predicament. 'You're late and already feeling shaky' she says. 'It's your own fault for agreeing to mentor this new lecturer and take on this additional role'.

But I did not want any additional tasks.

Not today. Not this term. Not again.

In truth, I was not looking forward to this academic year because I feel somewhat disconnected from pretty much everything and had done so for some time. The teaching, the assessing, the planning, the marking, the endless meetings, the mentoring. I had previously enjoyed some aspects of my role but had not felt any joy for some time. In fact, I now feel the opposite. Dread on most days. Maybe it is just *me* that feels this way and wonder if the *smiling faces,* I saw in the car park earlier feel like I do. If they do, they do not seem to show it. Not like me. The gnawing feeling of unease and anxiety, which I had previously felt, had returned into and onto me.

As I walk into the building, I fall deeper into thought and heard *Her.*

That critical inner voice, whom I shall call 'V'[1], whispers again, 'this year might be different Margaret, you need to be more positive in approaching your mental health nursing educator work, do better this year, be more optimistic, more hopeful and you will have a better year. It's the beginning Margaret, the beginning of a new start'.

The Academic New Year often brings *new beginnings* for both staff and students and as such my travails were only minor by comparison to others and, as V clearly asserted, I had brought some of the stress upon myself with no one to blame but me. But taking on new tasks meant more stress and …

……what *was* I thinking? Taking on new responsibilities AND starting a Doctorate in Higher and Adult Education at the same time, I begin to ask myself! Honestly, where was I going to get the time to do it all? A Doctorate? A full-time job and mentor a new Assistant lecturer (AL) in mental health nursing, who had very limited teaching experience.

Madness, I think. And it was all my own fault because I *had* agreed to it.

[1] V is an internal voice- a critical friend who resides in my mind as a way of bringing many different perspectives to the story (Noonan, 2020, p.418)

I decide there and then on that September Monday morning that that I need to have better boundaries, to be more assertive, stop agreeing to the ever-increasing demands of my employer and just to do *better* at everything. The Academic New Year was the perfect time to start such personal development work. And besides, the AL already had a PhD. I did not.

'Jeepers!', I thought to myself, 'PhDs starting as ALs, on yearly contracts – that's tough', but that level of precarity seems to be the way of things these days[2]. I remember my first day as a lecturer and the first day nerves, all those years ago and decide that my priority for today was to make *his* first day memorable and help *him* to settle into the world of Higher Ed. a bit better than I did.

I could work on my own feelings about my role and practice when I had the time.

I meet Robert and apologise profusely for being late, shaking his hand firmly. I welcome him to '*the mental',* a routine unsavory joke, in reference to where he was now located and would be teaching in the future. He is a tall, smartly dressed young man in a well-tailored suit and seems pleased to see me. This was Robert's first proper teaching job.

'Our day starts with class at 9am', I advise him, thinking, crikey, we need to make up time – it's *five to already*. Time seems to fly extra-fast in September.

We are both timetabled to teach the new first year nursing undergrads from nine until one pm, a healthy four-hour stint. I offer to bring my young charge along with me to settle him in with the new arrivals and show him how it's done, or at least how I do it. My anxiety begins to ease slowly.

Our paths cross with a group of new nursing students who are being led like obedient sheep by a student ambassador along the corridor and up the stairs to the classroom. They look fresh and crisp, ready for the first class of their very first day in undergraduate psychiatric nurse education.

We walk along the narrow corridor, and I watch as Robert chats with me, smiling and nodding confidently in stark contrast to my own *New Beginnings as a lecturer* in 2007. I was

[2] Precarity in Higher Education in Ireland has been described as a socio-economic condition related to pay, conditions and contractual structures (or lack of) which has serious consequences on the quality of lives of workers (O'Neill and Fitzsimons, 2020, p.16)

terrified on my first day having left clinical practice to work in higher education. Terrified of *not knowing*, not understanding my role fully and moving into a very different culture.

Septembers are always busy within higher education and the buzz of the academic New Year, while exciting, is also stressful for new staff. I can relate to Penn et al (2008)'s description of feelings of uncertainty, isolation, and anxiety, which is not unlike the 'beginning days of practice' (p.13). Learning how systems worked (timetables, class schedules, exam boards) meant that when I started, I was often overwhelmed with new information which at times felt 'a par with drowning' (Anderson, 2009, p.105). Back then, the multiplicity of roles, the endless tasks, the assimilation into faculty life and the need to take on additional responsibilities was often problematic for me (Gazza, 2006, p.220). Nursing is a relatively new academic profession but is still considered a *lesser* profession (Logan et al, 2016, p.595) when compared to more established ones such as medicine or law.[3]

I wonder how Robert will cope.

But before we head upstairs to the classroom, there is the matter of student handouts. I love handouts. Piles of class notes which are stuffed with information to summarize my knowledge. It's my gift to students, particularly first years. It is also my accessory (or maybe even a crutch).

Armed with fresh paper, the clipped evidence shows that I am a lecturer as I routinely hand them my wisdom, my knowledge, and my experience.

'Bear with me for a minute, I just need to run off a few copies, won't take long, about thirty or so will do it.'

I usher Robert into the tiny old photocopying room, which admittedly is too small to accommodate the new industrial sized photocopier it now holds. Its foreboding presence consumes the entire room. It is bigger and grander than its elder cousin and I cautiously bid it a warm welcome to the new academic term.

'Thank God, they finally ordered a new one', I say in earnest gratitude. A colleague smiles and beams at her stack of photocopies savouring the smell of freshly baked paper, as she heads off

[3] Following a series of recommendations (Dept of Health, 1995; Commission on Nursing,1998) the introduction in 2002 of a four-year degree became the standard entry point to the NMBI nursing register. This heralded a significant change for both students of nursing and for those nurses who transitioned to the Higher Education Institutes to teach and support them.

Higher Education Institutes (HEI) have delivered undergraduate nurse education programmes (BSc (Hons) Nursing Degree) in both general, psychiatric, learning disability and midwifery

in time for her New Year class. She, too, shares my love of handouts and advises me to *take it easy* and not to use staples, *just in case*.

We must all mind the new-born.

I load it with a bale of crisp white paper and slam the copier door shut. She starts off like a steam train chugging fresh copies, replete with staples and a round hole punch. Robert mentions that where he had studied previously, 'they never photocopied anything' because of 'the sustainability policy'. My mind begins to wonder what teaching might look like without photocopies as I listen to him share the marvels of emerging green educational technologies in higher education.

As expected, a paper jams the photocopier.

The pragmatist in me says 'this is not a problem'. I will solve this problem.

No problem.

None at all.

All I need to do now is to open the door and yank the offending piece of paper out of this mountainous machine. Although we are new friends, she knows the drill. Bit by bit. I have done this so many times with her sister models that she and I are, by now, old friends. For eleven years we dance the photocopying dance where she belligerently refuses to do as she is told and chews and tears valuable pieces of paper with valuable words on them. But she always comes good. And so, on this September morning, there is no reason to think otherwise.

I lean into the copier machine and put my arm as far as it will extend to grab the last piece which, of course, is wedged at the very back. I can see the stubborn little tuft of whiteness with streaked black smudges on its outer face. It is badly stuck, so I decide on careful retreat to withdraw my arm slowly.

As I move my arm out with experienced ease, to my horror, I lose my balance and fall down onto my right knee! Ouch! God that was painful. My poor -old knee felt that.

My whole body falls onto the cement floor with neither grace nor safety. I could feel Roberts' eyes glare into the back of my head probably wondering what on earth I was doing. I rescue myself back onto my feet and as I do, I fall over once again! My arms flailing about in histrionic

panic, causing my full double length neck blue beads to get caught in one of the spokes in the copier. I try desperately to yank the chain out with all my might but to no avail.

The beads drop in rain like fashion into the body of the copier bouncing and bouncing and bouncing like raindrops on a puddle and landing wherever they could. Catastrophically, there are BLUE beads everywhere!

Everywhere! Mainly inside the copier.

'Did that really happen?'

'Oh shit!', I shout.

Realising that I had just used the most inappropriate, unprofessional language and embarrassed myself, I quickly grab the rest of the copies and cut a hasty retreat out of the photocopying room, glancing around quickly in case I was seen leaving the crime scene. Robert follows like a bewildered but trusted collie.

'Shouldn't we…?', he asks.

'No, we shouldn't,' I retort agitatedly.

'We should,' says V.

'But she won't….'

I pull the photocopying room door shut behind me and decide that I need to be elsewhere. Anywhere. Preferably where others are not. *That* door would remain shut until the next person discovers the injured photocopier, door ajar and those beads, those blue beads inside and everywhere.

'Breathe, you idiot, breathe, just breathe.'

'Move and breathe, keep walking, it will be ok.'

I can feel the cold sweat on my back, my heart is racing uncontrollably, and I feel strangely dizzy.

'It's just a bit of dissociation, that's all, normal after a shock,' says V.

I walk quickly towards Pinel, a large classroom on the second floor, hoping to be liberated from my distress in the company of the great liberator of the mentally entangled. Unconsciously wondering what Phillippe, the father of moral psychiatry,[4] might think of my amoral act.

As we climb the three flights of stairs within the former asylum building, Robert asks, if I was '*all right'* and I laugh it off, despite guilt and shame creeping up on me like a cold wet mist. That SHAME feels as if it is all around me- in the air, on the floor, the walls, the lightbulb, the windowsill. I feel awful. I damaged the *new* photocopier.

The clouds shield the morning sun, and the world seems as if it had stopped. Panic.

It is now it was 9.05 am and there was no time to plan our joint teaching session with the first years properly.

Disaster.

Disaster.

Only a teacher knows what a disaster this really is. No time for warm relaxed welcomes from lecturers and, disappointingly, no handouts. It feels like a transparent sham. Parker Palmer's (1998) words offer me both comfort and discouragement in equal measure:

> "The entanglements I experience in the classroom are often no more or less than the convolutions of my inner life." (p.3).

Perhaps that is true, but I do not have time to think about that now.

When we reach the top of the stairs, I see the classroom directly ahead of us. I look in the window and the room seems full. The bright sun is shining down on the new novice students of psychiatric nursing. I am expecting a group of about twenty-eight first years, as I begin to count the heads as they all sit anxiously waiting for me to arrive. The enormity of the first class of the year and the fact that this was the group's first experience of a professional nursing undergraduate programme always excites me and I begin to feel very tense. I should feel a bit more relaxed,

[4] Philippe Pinel (1745–1826) is often said to be the father of modern clinical psychiatry. He is most famous for being a committed pioneer and advocate of humanitarian methods in the treatment of the mentally ill, and for the development of a mode of psychological therapy known as moral treatment (Charland, 2018, p.245)

even bored, by now, given the number of first years I have welcomed students since 2007, but instead I felt inadequate and embarrassed.

My shoulders ache and I feel a horrible headache lurk in my skull, remonstrating with myself that I should be better organised and just *better* in general. I feel like I am letting everyone down this morning, especially Robert.

Realising that I need to compose myself and buy myself some box breathing time, I lean against the wall and ask Rob to tell me about what teaching experience he had. He spoke enthusiastically about his recent Doctorate and his thesis on simulated teaching strategy in psychiatric nursing. I promise myself that I would read that knowing deep down that I probably wouldn't. I don't have much knowledge of educational technologies and probably should, I think to myself wistfully.

'It might serve you well to read it', V says sharply, 'then you may not find yourself in such a mess'.

'When I want your advice, I will ask for it', I reply with a firm tone, albeit in my head.

As I lean against the corridor wall, I inhale deeply to mindfully connect myself to my reality and think about the teaching task which lays ahead of me.

I begin to feel more and more tense, and my neck begins to hurt. My fingers do not seem to work anymore.

Box breathing. Box breathing.

5

4

3

2

1

Inhale and Exhale.

Pursed lips.

‘Notice the ground, your shoes, your hands, the walls, your lovely new skirt’, my wise self says to me in a calm reassuring tone, recalling *radical acceptance* and *distress tolerance* techniques from Deep Breathing Techniques (DBT).

Breathe Margaret, breathe. (Mehan and Morris, 2018, p.235).

Awareness and acceptance.

Just remember, awareness and acceptance.

ACCEPTS ACCEPTS…God I wish, I could remember what that stood for...

But …

(Intrusive thought)

‘Forget those bloody beads!’

I scan my mind and body in the hope that both were now becoming reacquainted. The body can be a source of comfort, a source of worry, it can be everything. It has the answers, I think. Just move with your body. Everything feels distinctly hostile now.

'Just move and breathe and everything is actually fine…honestly fine...'

Everything has gone wrong this morning. None of the tasks were completed.

My body seems to have left me. It is elsewhere. Running away because it could not cope. My head felt empty and light and not connected to any part of me. Arms and legs seem to move in different directions across the room looking for their comrades. I can see my fingers dancing around in my peripheral vision and then fall onto the floor.

Breathe …….

Keep breathing.

Just work through this task Margaret.

The first years.

I locate the *first day* folder from memory and withdraw a warmup/*getting to know you* exercise. I know that a welcome exercise might settle me as much as the new students.

'Robin, can you please lead out on the warm-up exercise when we go in?'

'Sorry?', he replied.

'Just start off the session by introducing yourself, where you are from and what makes your heart sing.
A well-worn harmless, formula.'

'No problem, Margaret.'

We walk into the classroom. It was 9.25 !

Immediately my heart sinks. The chairs are not arranged as I had previously requested - in a circle of sorts so everyone is equally visible to each other, an essential for any group work. Instead, they were scattered across the room.

V now decides she wants to add to my woes.

'Has your time here not taught you that if you want something done properly, just do it yourself Margaret?', she asks sharply. 'Why didn't you come in early to check that the chairs were organized as you wanted them? Why did you ask someone else to do that for you? Is that not the role of a lecturer? To prepare the room properly or have you become complacent?'

'Have you forgotten the basics? The learning environment?'

'Enough V !'

I walk around the room in an effort to burn off energy and to silence my inner critic.

In keeping with my social constructionist lens (at least for this morning's session) I follow the lead of Akpan et al (2020, p.50) in assuming that knowledge develops because of social interaction and shared experience and is not just as an individual or isolated experience. The need for a learning space which honoured collaboration and relationship building is important to me.

I always feel that is important that the space in which I facilitate group work, looks inviting especially for the first class of the year. But is classroom layout my job ?'

'It is *not my* job to...put the chairs in a circle.'

'It *is your* job to….put the chairs in to a circle.'

'If not, then what is your job, Margaret?'

I ask the students to stand up and to help me organise the chairs into a large circle. Some students take the lead from others in helping to shape the room. Soon the large circle envelopes the group providing rounded structure and security. Sitting comfortably, the familiar brings me some comfort.

I explain to Robin that, since this is his first time doing a warmup session, it is important to try and remember every student's name. He nods agreeably. We sit down in the newly

rearranged circle, and he starts the welcome session with a warm natural ease. Confidently, he put his laptop bag to the side and introduces himself.

'I am Robert, I am originally from Dublin, so no jokes about the football ,and this is my first day too'. Some of the new students laugh at his football joke. He is warm and welcoming and shares a joke about having *first day* nerves with the new group.

I wonder if he is referring to me or to him.

Note to self: order his office pass key and remember his name is Robert, not Robin.

I watch intently as each participant introduces themselves nervously and share demographic information about their lives. *What makes one's heart sing* never fails to deliver as an exercise, and it offers a window into what brings joy into the world of these nursing newbies. Students speak of their love of football, their travels, their families, their favourite pets and the odd one looks to others for reassurance and repeats what has already been said. It seems to lift the energy and break down some of the first day barriers. That exercise is now complete, so it is now time for the morning tea break. One student, who was from the local area, seems to know the building and volunteers to show the others where the canteen is. And, so, off they trail for morning break.

Robert and I watch them as they slowly and nervously chatting to each other as we follow suit.

Down the three flights of stairs along the freezing cold corridor with the high ceilings and the tall green plastic plants. I observe a crowd gather outside the photocopying room. It seem like a big crowd. A perceptual disturbance, perhaps. A momentary hallucination but, none the less, the word is out….

One person is busily erecting a huge sign:

New Photocopier broken. Reported. ….

Emails will be sent. Colleagues were sure to be annoyed. Some very annoyed. Septembers are busy. Lecturers are busy. Disappointed students with no handouts. Nothing to cling on to, to feed their appetite for knowledge, no takeaway summaries.

My fault.

Beads would be analyzed forensically; I am sure of it.

Guilt sets over me like a smothering wave, but not as awful as the creeping cold anxiety that comes with the possibility of being outed as *the offender*. September is the start of the new term, when days are still bright and sunny and newly energized academics take receipt of long-awaited equipment *whatchamacallit*s that make first teaching term, almost bearable. New copiers were important. I should own up.

I could hear V repeating a few words of Emily Dickinson (1830- 1886) in my head,

Tell all the Truth but tell it slant…..

Tell all the Truth but tell it slant …

I need to tell the Truth. Not as Dickinson suggested but the whole truth. Even if the enormity of it, as big as the new photocopier itself, blinded me.

I would have to own up.

But just not today.

After tea break and the students seem to be more relaxed, I show them the Blue Book, the *Requirements and Standards for Psychiatric Nursing in Ireland* (NMBI, 2016) and hold it up in front of them so that they can easily see the key operating framework which underpins the course they are now registered. I emphasize its significance and how their undergraduate nursing programme constantly defers to that document.

It is a sort of ceremonial anchoring exercise, a ritual which had been handed down to me years ago. A way of drawing the group together in common purpose. Recalling my very first Monday as a lecturer, I watched a colleague (now retired) pay homage to the significance of the *Blue Book* and explain to students that this (psychiatric nursing) was a highly regulated profession underpinned by standards and requirements which they were required to meet as learners over the course of their four-year undergraduate programme. My retired colleague's explanation was very officious and impressive, and I decided that when my *first day* came, I could do no worse than to plagiarize his excellent performance.

Later that morning, Robert led the next session by himself. The focus of this session is on teasing out the student's perceptions of what a psychiatric nurse is and what psychiatric and mental health nursing might mean to them. It is also about getting to know what prompted them to apply for the course since applications were dwindling annually (Happell et al, 2014, p.50). This BSc.(Hons) in Psychiatric Nursing course does not enjoy the problems of oversubscription like the General Nursing course does.

Many incumbents cite, as they do annually, wanting to '*help people with mental health problems* and to *learn more about the way the brain worked'*. Robert collates the feedback with enthusiasm and ease, I observe him carefully as he writes and speaks at the same time, a skill which took me years to acquire. He seems to have much more confidence than I did on my first day and shows no signs of anxiety or *first day* nerves.

I decide that he might be a good lecturer and possibly a great one in time. His energy matched only by good humour and enthusiasm, his body moving around the room with ease. I wonder if he really needed a mentor, or perhaps, if I was the best person to do that given my apathy and sense of disconnection with my professional practice.

He seems energetic and hopeful while I seem to feel neither.

I begin to reflect on the disaster that was today. Arriving late. The photocopier and my expletives. Those blasted beads. My unprofessionalism - and I am supposed to be his mentor. As my body starts to connect with itself, I relax into my chair and start to do a quick grounding exercise – planting my feet firmly onto the green carpet below. My mind starts to wander, and I start to think about the first teaching session of the year.

'I like this classroom', I think quietly to myself. *Pinel* is a nice room. The physical environment, solid, reliable, and strangely welcoming. I could describe the room as tired but reliable and available, 'a bit like me', I think, wryly. Year in and year out it shows up when it is needed, a bit like me. I have facilitated lots of teaching sessions in this room and the familiarity of those old white walls, eases my teaching self into each day of the teaching week. This room provides me security and stability where I can perform my roles as a lecturer of mental health nursing, whatever that is these days.

The enormity of being in an old mental hospital never fails to invoke a peculiar feeling in me. A feeling of ease and unease. The idea that I am now teaching psychiatric nursing in a room that was formerly a psychiatric hospital seems extraordinary. There's an inevitability about it. Now, the room offers asylum from the outside world of institutional and instituted chaos and learning seems to seep through the cracks and walls of this building since there are stories and histories present everywhere. It is as if the walls watch over the *teaching and learning* in wistful and regulated reverence. Listening to us intently, minding us, helping us to create an asylum for this group of novice undergraduates.

I imagine all kinds of people that once occupied this place. This big old institution. I wonder what it was like to walk up and down those long corridors and to live a lifetime, like many did, in this institutional space. Long term detainees or 'mental cases', with certifiable minds. Wandering up and down those corridors, queuing for their tablets outside of nurses' stations. Or maybe there were no nurses' stations back in the early nineteenth century.

Their inner worlds kept away from the outer worlds of social repression, stigma, shame, and fear. Families signing them and leaving them. Powerless and voiceless, condemned, if not by the agencies of the state or church or by their own families. Waiting and waiting in architectural paternalism. My imagination is alive thinking about the people who came before me.

Wondering…..

get out quickly!

there is nothing wrong with you.

You are not socially deviant or a P.U.M.[5]

They are wrong. Not *you*.

This is about them, not you……..

Get out now!!!!

Before the walls claim you,

Before those bricks go up around you,

brick by brick,

Stick by stick,

and then it will be too late.

The price will be too high on self, on soul, on psyche.

The bricks and mortar of care will cement your body and mind. Zombie.

For them, there is no way out. Not after, institutionalization.

But what about me?

Despite the reverence of the classroom, I felt a similar fatigue envelop me and searched within myself for energy and inspiration. Here I was again, another year, doing the same thing over and over, depositing and withdrawing knowledge from students. In and out.

Photocopying material from the learned minds of others to feed the hungry minds of others.

[5] P.U.M. refers to a Person of Unsound Mind. A Person of Unsound Mind Order enables the admission and indefinite detention of a patient with mental illness in accordance with the 1945 Mental Treatment Act (Ireland).

Performing a role and losing myself in the process. Same old routine.

Year 1

Year 2

Year 3

Year 4

and back to the start….

Year 1….

‘What’s going on?’ I think to myself.

‘What’s really going on for me in my professional practice?’

‘How am I embodying this ?’

Teaching to order, teaching something that I no longer feel passionate about. Feeling disconnected from my practice as a mental health nursing lecturer, from everything, from everyone, from smiling faces in car parks.

I want to say it out loud. To name it.

Again.

I was

I am

Feeling disconnected. From myself, from what draws me to mental health nursing education.

Doing something *I no longer enjoy*.

Did I ever? Did I ever enjoy, even love it?

Teaching *to order.* Packed syllabi.

What am I doing? Really doing?

Feeling I have lost an identity without ever knowing what identity was.

Concerned for the future of my practice- the increasing presence of the medical model in mental health nursing despite policy rhetoric.

I wonder if my colleagues in mental health nurse education experiences the same dilemmas?

Or maybe it just me who feels this way?

I sometimes feel a bit useless, a bit hopeless like I am processing students through some sort of conveyor belt putting them on at year one and taking them off again at the end of year four. They have their *New Beginnings* while I feel what I do is sometimes sterile and pointless. At least they get to care for people and make a difference, a real difference, like helping someone to have a shower or manage their anxiety or live independently. That's what I like(d) about nursing. The immediacy of it, the impact that I had on others who needed my help.
Maybe I need *New Beginnings* also?

I look around the room and Robin, sorry I mean *Robert* is engaged and alive. Teaching.

I wonder if he has the same angsts as I do, about teaching mental health nursing?

Maybe not. Because he is young and eager and wants a permanent job.

Not like me.

Too *Burnt out* for this psychiatric stand-up, every day, every year, each September Monday.

Maybe the Doctorate will enthuse me, infuse me with new knowledge and at least help me to feel gratitude for the privilege of what I do, I think to myself.

But I am also unsure about undertaking a Doctorate programme.

'Why am I even doing it ?' I think?

'You don't really need it', says V, 'It will only unsettle you even more.'

'Thanks V.'

'I feel I do need it V. I don't want to feel left out of this academic bandwagon. Besides we will no longer be an institute and the walls will come down with university status and I had better get on with it.'

I decide there and then that I was going to do the Doctorate as a *way to help me understand* some of the problems in my practice which seemed to grow larger in my headspace every day. But I have no idea of what that might look like.

I am unsure if a Doctorate would help me to understand my practice, given the personal, intimate, and emotive nature of my education dilemmas.

I start to think. And Think.

I return to feeling anxious and worry about 'being out of my depth'.
I decide to leave Robert to continue to work with the first years. The planned Doctoral programme evokes a sense of urgency about needing to read academic papers, write, buy research books, and start to talk to others who have forged the same academic path before me.

Robert is by now moving around the room with a commanding ease, as I decide to go. Now.

'Bye Robert, Bye group, see you tomorrow.' I wave before he has the chance to argue.

I must start reading. I've got a Doctorate to start.

New Beginnings

Things now felt

urgent. I decide that

I must

Start searching literature, reading, and plan my evening ahead.

Take some papers home with me to read. and find the

……course handbook for year 1. *DHAE*

I need to print this out...

and

I meet

Freire, and Foucault, Mezirow and others.

Pleased to meet you all.

Excited to study what you are saying about the world.

I run downstairs, anxiously thinking about my

upcoming reads,

Must print a copy.

Oops!

I forgot

New Photocopier broken. **Reported.**

Disconnected me.

My name is Margaret. I work as a lecturer in a Department of Nursing and Health Sciences in a Higher Education Institute (HEI) in the west of Ireland. I have held this post for a very long time; in fact, the longest I have ever held any post. My job title is lecturer in psychiatric nursing, but I also teach into other programmes in health and social care both at undergraduate and post graduate level.

The title *Psychiatric Nurse* is a bit of an outdated term although it is still used by the professional regulator in Ireland (NMBI, 2016). The term mental health nurse is more commonly used in practice and in my everyday communication with students and colleagues. My current role, as I understand it, is to prepare undergraduate students to become registered psychiatric nurses, eligible to register on the Nursing and Midwifery Board of Ireland (NMBI) and, as such, to care for persons with a range of mental health problems. Paddy, who you met in the prologue, is one such patient or service user as they are referred to today. He will feature again later, along with other characters I will introduce as you move through the text. My role largely entails supporting students to become compassionate, caring, and skilled nurses who are able to negotiate the demands of a changing and challenging mental healthcare environment (Cowman, 2001, p.10)

For fifteen years I have taught psychiatric/mental health nursing students. I enjoy getting to know students individually and sharing my rather *aged* narratives as a mental health nurse with them. However, over the past number of years I have experienced a growing sense of internal unease about my role, the nature of what I do daily, my practice environment and the broader trajectory of mental health/psychiatric nurse education.

I have seen immense changes in what I do, or more specifically in what I teach, since I started working as a lecturer in 2007. The amount of syllabus content in the BSc.(Hons) Science in Psychiatric Nursing programmes is now, simply enormous and has grown in line with the changing role of the psychiatric nurse, changes which have also greatly impacted on the role of the psychiatric nurse lecturer.

These significant changes have largely been a response to policy changes (HSE, 2006; HSE, 2020; MHC, 2018-2019) mostly brought about by the transition of psychiatric care from institutional settings (hospital based) to more integrated and recovery/community-based care.

A lot of the older psychiatric hospitals, such as the one described in my opening story, have now closed and the patients it once housed are cared for elsewhere. Mental Health Nurses (MHN) now work in different places and spaces and are expanding their range of functions, primarily in line with service developments (Cusack et al, 2017, p.93). These changes have been described as a 'protean concept' (Hemingway et al, 2016) with current approaches to preparing undergraduate nurse education tending to largely reflect 'contemporary political and economic paradigms' (p.331). It is my own sense that policy is driving practice and practice is driving changes nurse education.

Another impact of these changes is that my role has become a very busy fragmented one. I spend much of my teaching hours, teaching to order- preparing students for *add on* tasks which the role of graduate nurse(MHN) now entails. This includes copious physical health assessments, risk assessments, specific regulatory and legal training requirements and knowledge of complex psychiatric medications which now seem to occupy an ever-increasing amount of curricular content. The consequential *shaping* of my practice, and the impact this has on me as a practitioner, is largely at the heart of my dilemma. Theoretical ideas offered by Jack Mezirow help me make sense of this dilemma. In particular, Mezirow defined transformative learning as:

> an enhanced level of awareness of the context of one's beliefs and feelings, a critique of their assumptions and particularly premises, an assessment of alternative perspectives, a decision to negate an old perspective in favour of a new one or to make a synthesis of old and new, an ability to take action based upon the new perspective, and a desire to fit the new perspective into the broader context of one's life (1991, p.161).

Mezirow (1991) argued that adult learners draw on past life experiences to construct new meaning from experiences, facilitating learning, and greater self-understanding, and in the process, transforming personal paradigms. This can involve disorientating dilemmas as the learner (in this case me) critically engages with and makes sense of the world and the meanings within it. This transformative paradigm is not dissimilar to the teachings of educator Paulo Freire and his 'dialogical conscientization'. My frame of reference (Mezirow, 2008, p.44) *unhappy in my work and felling somewhat hopeless* is undoubtedly impacted by context and my journey as a learner, and journeys between positive/negative/then/now.

While this research is an introspective inward journey into my practice as an educator, I also offer it as an opportunity to critically explore my professional context and the institutional landscapes within which I operate. It is, or supposed to be, a critique of the larger world of mental health (care) told and retold. While the autoethnographic gaze may initially be evocative, self-orientated and emotional, it also evolves into critical reflection on my practice and my occupational milieu.

It is now widely acknowledged that the landscape of mental health care, of which mental health nurses make up most employees (HSE, 2012, p.4) has become a challenging place for both staff and students. The Irish mental health care system has been described in the press by the Martin Rogan, CEO of the Mental Health Commission as not being fit for purpose and out of date due to persistent under resourcing both in human and fiscal terms (McMahon and Mc Curry, 2020).

There is now an accepted crises within psychiatric/mental health nursing (McKeown and White, 2015, p.726; Nadlier-Moodie and Loucks, 2011, p.479). Commentators have pointed to poor staff morale (Totman et al, 2011, p.5), ongoing problems in recruiting into the profession (O Donnell ,2003, p.32), issues with staff retention (Durcan et al, 2017) and a lack of clarity on the role and function of an R.P.N.[6](Terry, 2020, p.416).
Moreover, psychiatric services, of which nurses make up the majority of staff, have been accused of 'uncritical fidelity to an over simplistic medical model of mental distress, neglecting socially framed alternatives' (Mc Keown and White, 2015, p.728).

This situation is not specific to Ireland. White and Brooker (2020) describe a 'continued demise of mental health nursing' in the UK and suggest that that 'mental health nursing continues to teeter on the edge of the same precipice as mental health care' (p.77). As far back as 2006, Holmes argued that the role of the mental health nurse was described as 'precariously positioned' (2006, p.410) and I wonder what that might mean for me.

[6] R.P.N. is Registered Psychiatric Nurse is the title used by the NMBI (Nursing and Midwifery Board of Ireland) to denote a nurse who is maintained on the Register of Nurses (Psychiatric Division) in accordance with the Nurses Act (2011) Ireland.

In addition, the context within which most mental health care has been described as the *poor relation* of acute general care, or 'general nursing' (Gournay, cited in White and Brooker, 2020, p.41) the strand of nursing which primarily cares for physical health problems such as diabetes or cardiac disease. Mental health care is often regarded as *lesser than* entity when compared to acute care/general nursing and does not receive the resources, attention or status it requires despite the raft of recent policy directives, as discussed earlier. The experience of *lesser than* is also reported by mental service users who report stigmatizing and discriminatory attitudes within the acute care system (Perry et al, 2020, p.11).

The sense of feeling *lesser than* often seeps into mental health nurse education, something that has historically been seen as a less attractive career option for nurses (Redknap et al, 2015, p.262). Many undergraduate nursing psychiatric and general programmes are often run side by side with shared modules, particularly in the earlier part of the programme. Undergraduate general nursing outweighs its mental health counterparts in terms of student numbers and importantly the number of general nursing lecturers employed to teach. This creates a power imbalance which can be felt in many ways. For example, many mental health nursing lecturers are teaching to full capacity in order to meet the growing demands of revised curricula[7] and there are less of them.

The impact of living within such occupational *busyness* is even more *busyness* and stress. As my encounter with Robert and the first years depicts, I was immensely frustrated with what my role had become and wanted to understand more about why I felt as disconnected and burdened down with tasks. This seemed to have happened insidiously in the absence of critical self-reflection. As the opening vignette depicted, I wondered too if the problem was just *me* rather than psychiatric nursing education itself. Feeling disconnected and *lesser than* I also worried that I was becoming smaller and smaller in the bigger hostile world of higher education which seemed to greedily demand more and more productivity and output (Singh et al, 2021, p.1).

As I begun this doctoral journey, everything in my practice and teaching environment seemed hostile and frequently irked me. Everything seemed to lose its innocence and wonder. I often dissected changes to practice as oppositional and persecutory and as a result I became stressed, annoyed, and deflated easily. The act of jamming the photocopier became yet another crisis, as

[7] The curriculum is revised because of the shift in policy emphasis on legislation, MHA (2006) increased focus on Rehabilitation and Recovery (2018), increased emphasis on physical care of service users (MHC, 2019).

was being late for class with Robert and there are many more examples throughout the thesis.

I had become immersed in an unhealthy habituated way of being in the world and felt unable to relate to it without resorting to anger or apathy or blame. I had become a problematic subset of a larger problem and yet was unable to articulately name it.

My deeply held assumptions about feeling disconnected from psychiatric nursing, concerns about the future of mental health nurse education, identity, feeling lesser than seem to preoccupy me at times. I had become enmeshed within my own dilemmas and needed to extricate myself from my own internal struggles by critically engaging with my beliefs, experiences, relationships, and my own ontological and epistemological assumptions.

I wondered if *I* felt like this, then *others* may too and maybe shining light on my pedagogical dilemmas might be a useful way of inviting the lecturing universe into a conversation about it. But my dilemmas did not seem to be a prominent issue in professional nursing literature in Ireland and that made me all the more curious about exploring it.

The purpose of this work is to grow and develop my own practice by understanding my pedagogical practice at a deeper level and my relationships both past and present within the often-hostile milieu of higher education and the landscape of psychiatric care more broadly. I am curious about seeking opportunities to teach myself or *learn my own way out of* my dilemmas as a nurse educator and to learn to enjoy the parts of the role which attracted me to it in back in 2007. To find Hope in it.

I approach the inquiry with honesty, humour and humility and draw on my past experiences which shape my career to date and to remain committed to working on myself, both as a researcher and the subject of the work. I want the text to tell a story and for readers to understand my world/s through the structure, form and voices of the work (Gannon, 2017, p.4).

This approach leads me to Autoethnography.

Autoethnography

As stated earlier, I embody a general dissatisfaction with mental health nurse education and my role within it. While the gaze of this enquiry is turned inwards towards my own practice, I recognize that I do not do so in isolation of my community of mental health education/nursing. Specifically, I am concerned about what I see an inequality/s in the way that mental healthcare and especially nurse education operates when compared to other sectors. Inequalities as stigma, discrimination, poor resourcing for mental health care, a persistent lack of funding, and the ever-increasing presence of the medical model underpin this research study.

Feeling *lesser than* and a deep sense of frustration informs both my position as a researcher and as an individual/committed to social justice within the mental health care system. Although I write from a position of learner/nurse/educator/researcher my focus primarily being therein, I have always been interested in and am committed to developing a better understanding of those who experience mental illness. From my years of nursing experience, I have found that people with mental health problems can often find it difficult to express their distress within a busy, time limited and bureaucratic care system. Such care systems which are often hospital based, often do not support alternative ways of self-expression, rather a reliance on medical taxonomy, rubrics, diagnosis, labelling and pathological affirmation.

As I am interested in ways which might help me to understand and interpret the world of *another* and the culture which seems to accommodate the pathology of mental illness in all its forms, a research approach which advances a deeper critical understanding of such complex issues is the most appropriate one. Qualitative research appeals to me as Throne (2020) describes its as 'research undertaken beyond the theoretical to intentionally engage the political discourse to advance the public good, social justice, power structures, or critical consciousness within a socially-just democratic society'(p.173).
To help me understand the world of another I came to autoethnography because of the way in which the researcher/author is fully immersed in the work and that what I experience(d) may also be felt/understood by others within the culture of mental health/nursing/education.

Autoethnography is best understood as a qualitative research methodology which seeks to describe and systematically analyse personal experience in order to understand cultural experience (Sparkes, 2000, p.21; Ellis, Adams and Bochner, 2011, p.1; Goodall, 2016, p.9). As a research method it positions the researcher as both the author and focus of the research and

according to Ellis (2009, p.13) is situated at the junction between the personal (auto) and the cultural (ethno) thereby allowing me to become a portal into this enquiry.

Autoethnography can be described in various way depending on the nature of what is being studied. Descriptors such as *analytic* which seeks to develop theoretical explanations of social phenomena or *evocative* which focuses on narrative conversations which explore and evoke emotional responses revealing the 'consciousness and subjectivity of the author through personal, reflexive, vulnerable narratives' (Bochner and Ellis, 2016, p.51) are often used. Autoethnography can also be described as *critical* with Adams (2017) describing its possibilities as 'a bridge between the individual experience and the larger sociocultural, sociohistorical, sociopolitical, and/or socioeconomic experience' (p.217). Problems related to unequal power dynamics, inequities, injustices, and other cultural and social problems can be navigated and negotiated by autoethnographic work, areas which are of great interest to me.

Smith (2005) identified what she termed as *Institutional Autoethnography* (IAE) which is based on the understanding that people's individual experiences are organized by, connected to, and shaped by larger power relations (Smith, 2005). Malachowski et al (2016) explains that this approach is often used in health/social care where 'IAE may investigate how experiences are socially constructed and how people actively coordinate and are actively coordinated in the course of their activities to produce institutional practices' (p.207). In recognizing issues of power and *relations of ruling* (an example of this might be mental health care systems, professional groups, medical hegemony) within institutions, Smith (2005) pursues a social justice position in her work adopting a *standpoint* which does 'not subordinate the knowing subject to objectified forms of knowledge of society' (p.10) therefore offering ways in which the experiences of those who are often marginalized like the service user Paddy and the various characters in this study can be heard.

This type of research can be described as *insider research* where the researcher (me) is a member of the community or culture that is being studied (Green, 2014; Beals et al, 2020) but not exclusively so, as other characters from other communities (former colleagues, service users) are also storied and analyzed throughout the work. As this autoethnography explores my experience as a mental health lecturer and the scholarly gaze is turned towards mental health nurse education, I am including others to help me to tell my story and to interpret meaning from it by reflecting on both that experience and my position/social location within it. My positionality is relative to the cultural values and norms of both me as researcher and others

(Merriam et al, 2001). Therefore, my position and locality are not understood as one dimensional or fixed but as multiple and mobile as I begin to reach an understanding of how my experiences are made possible by being a member of my cultural community during the course of this work, (Chang, 2016).

I approach this work with various identities as a professional Doctoral student, a former nursing student, a registered nurse, and a lecturer in mental health nursing, and am mindful that the boundaries between such roles can feel 'particularly porous' (Fixsen, 2017, p.44). But I also tell the stories of others, not from an insider position but that of an outsider, as I have not (to date) experienced mental health distress or diagnosis. Autoethnographies from service users (SU) or survivors of mental healthcare systems (Fixsen, 2015; Mc Mahon, 2020;Weems, 2021), help to frame a user perspective. Power/illness/identity struggles are often revealed as they (SU) may sometimes need to navigate stigmatizing and dehumanizing care environments within a mental health care system. Grant et al.(2015) is his narrative of re-storying lived user experience cites autoethnographies as a 'therapeutic, educational, existential, potentially transformational, purposive, and reflexive tool for living and moving lives forward' (p.280).

Fixsen (2023) articulates such experience in her work titled, *Fragile minds, porous selves: Shining a light on autoethnography of mental illness* and argues for the potential of autoethnography to 'contribute to broader sociological, ethnographic, and medical debates and thus impact on policy'(p.140). The epistemological and methodological congruence between autoethnography and critical pedagogy is evident as autoethnography is contextualized as a critical qualitive research set of practices (Grant, 2020a) which can disrupt and scrutinize dominant cultural narratives and question prevailing frames of thinking, dominant discourses and 'subjugated forms of knowledge which beyond traditional empirical and disciplinary boundaries'(p.280).

First-person representations framed within autoethnography allow for expression of the ways in which issues such as inequality, oppression, stigma, medical hegemony, silenced voices are represented. From my own perspective it is also a way of giving voice to what I consider is not being voiced within the nursing literature in Ireland and what I feel is of critical importance. The value of personal narrative and critical reflexivity in documenting, resisting, and transforming systems of oppression is evident in autoethnography and critical pedagogy. Both fields critically explore the complicated relationships between *self and society*; ***the personal-***

political, and the *emotional-analytical* through critical reflexivity, dialogue, and engagement with others (Adams et al., 2015, p.26).

Composites

Autoethnography is an intrinsically reflective endeavor (Holman Jones et al., 2017) in which the subjectivity of the researcher is explicit. My intention, as part of this inquiry is to disrupt traditional research approaches in which people with experience of mental illness are often *othered* (Grey, 2016) and I want (ed) to afford Paddy, Una, and others some degree of power over their stories - as subjects of their own research (Denshire, 2014) albeit as composite characters. My decision to use composite characters was purposeful and, in this context, I understand *composite* to mean those characters which are *fictional* but not quite in that they are drawn from my own repository of life experience. An example of this is the character Laz, who is a nurse- I have never known as person called Laz but I previously worked with many mental health nurses who smoked, as she did and so I felt that it was important that she was represented as a smoker. All the characters are *imagined* but may be drawn from places deep within my mind, wherever that may be.

Paddy is such a character who is created from my imagination, again I have met and cared for people *like* Paddy and who were impacted by a mental health diagnosis and so on. The characters as composites of my imagination are archetypes of a mental health system and are also drawn from my own experience as a mental health nurse educator. They are creations of creations. Carolyn Ellis in her (2004) book *The Ethnographic I- a Methodological Novel about Autoethnography* writes that 'everyone is a composite' (p.175) where characters can become humanized through interaction with others in symbolic interactionism (Blumer, 1969; Charan, 2007).

The use of composite characters to tell this story emerged as I began to critically explore the people and places which shaped my professional life. Thinking of them (Paddy, Una, Robert, Victoria) as *others* who merely *add a perspective* to my own narrative seemed inadequate as I struggled with the unchartered notion of using additional characters in an autoethnographic study. The characters in this story help me to translate my personal experience into a sociocultural one because single authored autoethnographies may 'suffer scope constraints due to the limited pool of research participants and narrow research foci of this method' (Lapadat , 2017, p.591). The highly subjective, introspective nature of autoethnographic work can often

be generally a solitary exercise, but not exclusively so. Collaborative autoethnographies are becoming increasingly common, as two or more researchers who often share a similar experience or social location decide to work together (Martinez et al, 2015,Honey et al, 2019).

Although the characters help to tell my story this was not a collaborative piece of work. The use of characters was a deliberate decision which emerged from the copious amounts of reflective journals which accompanied my doctoral journey as I began to think about who might help me to tell my story better . The use of composites within narrative research is considered 'an effective way of conveying complex ideas and projecting participants' voice' (Johnston et al, 2023, p.108) but is often not seen in autoethnographic work. Those who do (Richardson, 1997; Muncey, 2010; Piper and Sikes, 2010; Willis, 2019) do so for the purposes of data r*epresentation* to protect participant anonymity particularly in complex situations.

The subjectivity of the researcher is remains a critical component of the research. Autoethnography is more than writing, revealing and reflexivity, it feels like 'as a way of being' (Poulos, 2008, p.128). This way of *being in the world* requires me to 'live consciously, emotionally and reflexively' (Ellis, 2012, p.10) and involves constant negotiations with myself about how I understand my practice and the sociological, cultural, and historical perspectives of that.

The basis of my research is about telling stories. Life stories about myself and the many characters you will meet in this work to help illuminate some of the problems within my practice. Characters like Robert and Paddy became central to the work, voicing and showing what I often could not. Locating the self (myself) within the original frame of my research, I become the watcher and the watched. Looking at myself in mirrored auscultation. Hearing, feeling, sensing bodies of data as stories unfolded and memories are/were imagined and reimagined. Purposively writing about myself before writing about others and informing readers about my relationship to the topic early on in the research became an ethical act as I wanted the reader to know my position (*locating myself*) on issues before they were invited to read further (DuPreez, 2012, p.55). Writing as a method of enquiry 'coheres with the development of ethical selves engaged in social action and social reform' (Richardson and St Pierre, 2005, p.961) and so I was mindful that, while the focus was on the *my*self, I was in dialogue with others, speaking to the culture or the community I occupy (mental health nurse education).

Autoethnography while an enterprise in self-study is 'not isolative and relates to others as much as the self' (Edwards, 2021, p.3). In addition, words which are often used to describe genre of autoethnographic approach such as *critical, evocative, emotive* and *analytical* bring with it, its own particular way of being with and in the world and so requires varying degrees of ethical introspection.

The thesis unpacks my practice dilemmas by slowing revealing how I *read the world* (Freire, 1972). I do this through dialogue and present it back to you, the reader, as an autobiographical account of my personal and professional life both as a student, a nurse and a nurse lecturer. Liberating myself from traditional ways of problem solving encourages me to pose problems in creative and novel ways and it is my hope that this study reflects that intention. For me, autoethnography reveals(ed) itself as the most appropriate way of articulating and honouring my insider knowledge of my cultural experience as a mental health nursing lecturer (Pelias, 2019, p.22).

Becoming critically aware in the process of researching myself and my dilemma/s helps me to interpret my practice issues as a form of *crisis* (Bochner and Ellis, 2016, p.30) by framing my problems as a series of stories, inside and outside of my role as a lecturer and across different parts of my life. Although the stories are selectively chosen to light shine a light on specific experiences, they are heavily reliant on memory, and weave in and out of the thesis like a seamstress capriciously running her needle up and down my life (Woolf in Shore, 1979, p.232). This threading together of stories is my attempt to tell you, the reader who I was, who I am, and how I routinely negotiate my professional and occupational milieu.

In journalling my daily reflections about my work, I came to appreciate that *experience and memory* became the key ingredients in seeking to understand my practice as an educator and my role (self) in a busy and sometimes hostile world (culture) of Higher Education.

The retelling and interpretation of lived and living experiences are my 'stories about myself framed through the lens of culture' (Adams, Holman Jones, and Ellis, 2022, p.1) and are evocative, poignant critical, artful, and creative as a way of connecting emotively.
The stories about Paddy are particularly evocative as I reflect on my *Chasing role* and allowing me to draw on what Pelias (2019) described as my 'various selves' (p.30) as a 'learner', 'nurse', 'educator' and a 'learner-nurse-educator' or selves as *identities* which collude generatively (McCormack, 2015, p.77).

In keeping with Freirean (1972) thinking, this study 'cannot be purely intellectual but must involve action; nor cannot be it limited to mere activism but must include serious reflection for only then it will be a praxis' (p.1). The development of my educator practice is the primary intention behind this work. Holman Jones (2019) identified autoethnographic work *as activism* because 'it matters in the lives of those who experience social inequalities and injustices' (p.527). Butler (2015) prompts us to 'understand the human as a relational and social being, one whose action depends on equality' (p.88). Both authors resonated with me because at times I feel that psychiatric nursing was not equal to its general nursing cousin and that may also impact on how psychiatric may be perceived by others.

Part of the context for this is that, traditionally, mental health nursing has been inextricably linked with psychiatry in that the role was medically driven and built on diagnostic classification and labelling (Martyr, 2010, p.723). Similarly, being in a small team (mental health nursing lecturers) on the margins of much larger Higher Education space, sometimes *feels small* and it is a constant battle to be heard. Autoethnography is a way of facilitating me to *call out* issues of power and subjugation in my practice about *the inner and outer lives* (Kafar, 2021, p.59) of others in the stories, as many stories have been written by people who have 'suffered in silence for too long' (Ellis and Bochner, 1996, p.24). The stories in this thesis demonstrate my interpretation of past and present issues regarding problems with my role including 'adequacy of professional skills for psychiatric care practice, negative public attitude and concern over patients continue to impact psychiatric/ mental health nursing' (Rahmani et al, 2021, p.381).

Such interrogation of practice is an *ongoing dialogue* between myself, and world is often messy and unclear at times, as I question my understanding of ontology, epistemology, meanings, and my practice: aware that as each story unfolds it is often contingent on an appreciation of situation, context, and positionality (Holman Jones, 2019). This *insider critique* approach depends on readers 'subjectivity and emotions' (Bochner and Ellis, 1996, p.23).

As I document my work, I am conscious that not everyone in my culture (academic, disciplinary, research, student, service user) may either be interested in, or appreciate this autoethnographic approach (Wall, 2008, p.37) as it may 'be different from research traditions which are different from our own' (Sparkes, 2000, p.223) and 'such work may be met with deep suspicion and hostility within the academy' (Sparkes, 2000, p.214). Autoethnography as a research method requires a balance of the *auto* and the *ethno* to the extent that there is sufficient emphasis on one's cultural settings to enable the need to move beyond the writing of

the/myself. Reed -Danahay (1997) warns that too much emphasis on the autobiographical, may risk divorcing the life trajectory from existing social constraints.

Searching for the *nexus* of both self and culture (Pelias, 2004) can be challenging with Wolff-Michael (2009) arguing that neglecting the *ethno* in autoethnographies happens rather often (p.5) as such accounts can 'devolve into self-absorption' (p. 385). This criticism continues with Delamont (2009) suggesting that academic departments who spend public funds on self-studies such as autoethnography 'is an abrogation of the honourable trade of the scholar'(p.61). In addition, Walford (2021) disagrees with the self as a site of research stating that 'it is now time to point the cameras at others'(p.41).

Ellis et al. (2010) state that the goal of autoethnographic research should first be agreed upon before criteria to assess its authenticity can be framed.

Ethnographic narratives must *ring true* (Loh, 2013) and simultaneously produce knowledge that contributes to those within my cultural community. The goal of this work is to bring to the surface the pervasive concerns I have about my mental health nurse educator practice and to do so with epistemological and methodological commitment to subjectivity; self-reflexivity; resonance; credibility and contribution to knowledge development (LeRoux, 2017, p.10).

Such commitments to a way of working/being underpin how this autoethnographic work may be evaluated. Through reflection and working at a deeper level I explore how knowledge and knowledge creation in mental health care is often medicated through power, resistance, and agency. Mirroring the multiplicity of ways in which human beings can interact inside and outside of their own internal and social worlds, I hold space for that notion that there are also many diverse forms of research and writing which may express how individuals perceive, feel, and live in the world (Bochner & Ellis, 2016, p.440) and this is critical within the healthcare arena.

I also disclose vulnerabilities about myself in an open and brave manner (Brantmeier, 2013, p.2). My first day of the new term disclosed deep feelings of *being disconnected* and *feeling hopeless*. These feelings may sometimes be shared within friendships which often develop in an occupational setting, but they rarely make it to the pages of the academic literature. At the outset, I located myself in my dilemma to draw attention to the impact that this had on myself both emotively and bodily. The visceral effects of stress- feeling out of control, my fingers running away from my dissociated body, and the disconnection I felt

with my surroundings as if the power supply to myself was cut off, was most palpable in year 1.

The entanglement of my beads in the photocopier and the late arrival for the *New Year* class was a starting point for me, as I unpacked why I was there at that moment and at that time. I wanted to make sense of it, to find meaning but such singular events are often devoid from any multidimensional, multifaceted experience (Lasky, 2005, p.910) and this was part of the *coming to know* process, in autoethnography. Such memories, descriptions, artefacts (beads), sensations in bodies, imaginations, words, neologisms, become my autoethnographic text and academic artillery. The image of me overlooking Paddy as he is sitting on his bed is representative of both our lives at a given time as its grainy, dated, and visual imperfection shows.

On a deeper level it explores how knowledge around mental health and education is constructed and my interpretation of that.

Moving discursively across many topics including mental illness, **FEELING** small, **diagnosis hostility**, psychiatric nursing, **education**, power and *practice,* **privilege** and recovery, *identity*, interpretive **research,** *autoethnography*, reflexivity and *feeling* and thinking, **meaning** movements, *narratives*, *stigma*, and **knowledge**…….and……

Ahmed (2016) describes the autoethnographer as often:

> having a sense of things before we can make sense of things. And then perhaps you begin to put things together, different pieces, broken pieces, which reveal a social pattern. There can be joy in this process: those clicking moments, when something that had previously seemed obscure, or bizarre, begins to make sense.

This reflects the approach to this research.

Finding a way in

As a mental health nurse, I am drawn to the qualitative research paradigm because of the potential synchronicity and linkage that appears to exist between the practice of mental health nursing and qualitative research (Cutcliffe and Goward, 2000, p.590). Both are messy and seem to accommodate uncertainty and ambiguity.[8]This work starts from my biography/nurse education and journeys through some epiphany moments and life experiences which have left their mark on my life (Denzin, 2014, p.4).

Curtis and Drennan (2013) argue that our choice of research and research methodologies which we use to gain knowledge about the world depends on a large extent on what we consider to be our relationship to reality; that is to what extent do we perceive the world as it really is (p.21).

As mentioned earlier V is an important part of this research. Whether one research approach is more appropriate than another is concerned with deeper and more philosophical issues rather than methodological preference, and reflects my values, how I see the world and what I regard as knowledge or truth. These fundamental concepts underpin my whole engagement with this process and my overall commitment to it.

Reading the work of key autoethnographers offered me *a way into* topics that were both inside and outside of my professional positioning, but this is not a solitary journey. A *crisis* which often is a feature of evocative ethnographies was evidenced by my own dissatisfaction with my role as a mental health nursing lecturer and among other issues, the continued dominance of the medical model in curricular content despite the theoretical and textbook concepts such as person centred, holistic, authentic, congruence, reflective, compassion and 'being human' (Barker, 2017, p.12).

[8] In the early days of the Doctoral Research journey and writing my own biography, I was conscious about sufficiently representing my many voices, as student, learner, nurse, educator, nurse-educator and researcher. I found myself turning to what is considered *alternative* or *creative* research inquiry. This mode of enquiry was new to me and with the support of my supervisors I began to write and journal like I have never written before. Taking liberties with words was emancipating and liberating for me.

Type and Tell

The stories in this thesis are as real and as colourful as they can be. They are told through me as my fingers type and tell. I infuse a small bit of wit and humour into the often sterile and arid work of academia so, reader, I hope that you are not offended by some of the language or sentiment or indeed the literary liberty with how some of the work is presented. You will meet educators, service users, carers, and others who wander in and out of this storied landscape. While reference to real places and spaces occurs throughout this work, this thesis is fictionalized to preserve the anonymity of all the characters throughout.

V or Miss V to give her proper title, facilitates a multivocality which Mizzi (2010) suggests is a way to liberate the connection between the personal and the social world (p.3). Her main role is that of a critical constant companion, and sometimes she assumes the voice in my head/ mind busily interrupting, interfering, and drawing me back to reality with 'multivocal authority and expertise' (p.169). Sometimes I afford her a reply, particularly when she is being helpful or when I need advice. Sometimes I choose to ignore her critical intrusion.

She is fully alive, a being, a noise, a voice and maybe a figment of an imagination.

All the characters in this story have remained dormant and have been awakened by an autoethnographic searchlight. They all have a story to tell and something to say about this issue. This research is about bringing them to life.

They are the thesis……..

It is the afternoon, and I am sitting, thinking. I should be reading. Academic journals to fill my empty vessel. But I am not. I am thinking and thinking and thinking..

And Daydreaming, a bit ….

Little Voices

As alluded to and modelled already, V is a little voice which has resided inside my head and appears at various times throughout this work. This voice has taken up a lengthy residence in my thinking and feeling and body and has become naturalized to the messy uncertainty which is the nature of autoethnographic work.

I call her V (voice) and she interrupts, disrupts as an ever-present playful person in this work.

Reader, I can hear you asking….

Yes, I am listening, go ahead reader, ask that question.

‘Is she?’

‘Is she?’

‘Real’

‘Real?’

‘Who *me* ?’

‘Out of touch with reality?’

‘You mean psychotic? ‘

‘For that is what psychotic means? Doesn’t it?’

Hearing things

Seeing things

Feeling things

Inferring things

In and out of one's head – one's mind. Messy thoughts

Disordered thinking

Disordered being

Dilemmas

Crises

Insight no

Insight?

'Psychosis, is it?' I hear you ask.

'What do you understand that to be?'

'What was that? What did you say?'

'When a person is not in touch with reality, then they are psychotic, for that is the definition.'

'You mean?'

'When a person is not in touch with reality, as it is experienced by others.'

'Thank you.'

Is V psychotic?

I do not really know. She sits

on my shoulder Hopping in and

out of my head Takes words

from my thoughts Puts words

into my mouth

Puts them down on paper

My paper

My autoethnographic paper

Interferes

Says I am *hopeless*

But tells me I must have Hope

Counts my fingers

Is critical

Questions

Disrupts

Argues constantly,

Back answers

Won’t accept no.

Disturbs

Disorientates

Makes up stories

Lies and truths

Which is which ?

Won’t go away

Wakes me up

Follows me around the kitchen when I am mopping the floor.

Lies. (about mopping the floor)

Feels sad

and bad

and mad

Is inappropriate

Swears

Self-absorbed

Narcissistic or is that

Nurssistic

She is very much alive, she is real.

In her reality. In my reality. In the reality of these words. This research.

Not out of touch with reality.

For what is reality anyway?

Who's reality?

Relating to reality as constructed by her. Not socially mediated by another.

Pause to think

Ontologically speaking.

Reader,

I have been sitting in my office for two hours now. Frozen. Not from a lack of heating but because my body has decided to fix itself to the office chair in shutdown, after this morning's events. The body does not seem to want to move. My head is busy as if there are bees in it. I stare at my laptop and see yet another webinar invitation about drug surveillance in mental health. I should attend. I have so much to do today, but I should go because how else am I going keep up to date with the ever-increasing amount of *biopsychopharmacooylogyologyologyology*?

Is this a word reader ? A real one ?

Should I indent this word? That word. If I indent it, would it give it a prominence, to stand out among all the other words, as if it is a theory, or should I not indent it and include it in the same way as all the other words on the page. Then it becomes acceptable, a normative acceptable word.

I wonder if that is a *real* word. A *real* one? You know like the ones that some people who have schizophrenia can create to describe their world…neologisms. Made up words. Clever words. I begin to wonder about what is real or not. I think. And think …and think some more…and conscientize….

Thank you, reader, for listening.

I will now talk with V.

I begin to think about how I have *arrived* at the work that I do (Ahmed, 2019,p.46) and my interest in the bigger questions of life. Teaching Life. Educator Life and the meaning, identity and reality associated with just *being*. Yes just *being*!

I decide to talk to V. My words are in *italics.*

V, I've been thinking, and I want to ask you something.

Ok, Margaret.

-I want to ask you about Reality.

-Reality, or more fundamentally existence V.

…….How do we know what or who or

what exists ?

…Who and what is real?

you mean ontologically? she asks me thoughtfully

Depends.

-On what, on whom?

Perspective Margaret …. Take **existence** for example, I think it is a system of knowing and believing of what or who exists (Bullock and Tromley, 1999, p.608).

But is that enough V?

Maybe think about it as **being** in the world Margaret.

-An existence.

-Do I exist Margaret?'

Yes, you do, V.

But only in *your* mind, *your* body, your senses- because you believe I exist, Margaret.

-Your belief system allows you to acknowledge that there is the existence of multiple, socially constructed realities and that subsequent knowledge and knowing is mediated through that...

-So that your reality is laden with context. And what you know or claim to know, Margaret, exists within a pre-existing social milieu, ever interpreting and reinterpreting itself.

I understand.

Do you Margaret?

I think so V.

-So, take this chair for example, V, is it real ?

We both think so, I imagine, but others may not, or may see it not as a chair but as another object.

Give me a more relevant example V, please !

Ok, think about this Margaret.

-You teach mental health nursing, right?

You know I do !

And **mental illness** is a subject on your curriculum?

Yes!

So, Margaret, when you think of mental illness ontologically you can also think about the assumptions which are made about the nature of mental illness - whether it exists or not and how than might be perceived epistemologically.

-You believe that reality is subjective and that there are many possibilities and therefore multiple realities, just like there are many perspectives on mental illness. So no one way of knowing about mental illness is privileged over another.

But that's not true V.

What do you mean Margaret?

*Well, V, in my experience, for example, the biomedical model **is** privileged over others. It is the dominant model of mental illness and that frustrates me, despite all the policy rhetoric. It remains the most powerful way of knowing and describing and understanding mental illness.*

That is your experience, Margaret.

Yes, it is V.

So, Margaret, explain it to me? Pretend I am one of your first-year students and explain what you mean by the biomedical model.

The biomedical model argues that mental disorders are brain diseases and emphasizes pharmacological treatment to treat so called biological abnormalities. It's as if V, there is something wrong biologically with a person and they need to be fixed. A biologically focused approach to science, policy, and practice has dominated the American healthcare system for more than three decades. 'The use of psychiatric medications has sharply increased, and mental disorders have become commonly regarded as brain diseases caused by chemical imbalances that are corrected with disease-specific drugs' (Deacon, 2013, p.846).

Keep it simple Margaret, this is too technical for me, and I don't think a first year would understand it either!

Sorry, V.

-To date, no genes, biomarkers, or evidence for disease processes have been convincingly identified for functional mental health problems.

So, Margaret you are saying that this biomedical model is 'flawed and that mental health problems can be largely attributed to the causal role of social and relational adversities in our development.'(Grant, 2016, p.3).

*I guess I am, you see the pattern of 'theory making – moving from the pharmacological actions of drugs with some efficacy in treatment to biochemical notions of causation- has been common in biological psychiatry'(*Cowen and Browning, 2015, p.159*) and one which social psychiatrists like Moncrieff et al argue, 'has no evidential basis'* (2022, p.12).

-I can't help but be drawn to Moncrieff's positionality V.

So, you are saying that such drugs do not have an evidential basis, Margaret?

I am not claiming that V. I think what I am saying is that there are other ways to describe and treat mental distress other than the one which seems to be preferred- the biological one, the one which seems to be a universally accepted truth of some kind. Thomas Szasz (1960) argued that the public have been duped into believing that mental illnesses are scientifically validated bio medical diseases when in fact they are nothing of the sort. They are in fact problems of living.

-When mental illness is constructed as a biological entity in the same way as Diabetes, Asthma or Cardiac Failure, this views the body as dysfunctional or pathological in some way.

I think you have made your point Margaret.

… and, furthermore, just one more point V.

-The British Psychological Society (2013) asserted that there is a lack of empirical support for biology as a primary cause in what are currently commonly regarded as 'functional' mental health problems. Such distress is in fact not disorder. The assumption that the determinants of health (including illness) are predominantly biological, implies that patterns of health (health status as well as patterns of disease (morbidity) and mortality all have little to do with the social, economic environment in which they occur.

-It might help if I give you an example V. I remember a patient called Maria, she was financially poor and had a big debt burden. She owed money to her landlord and was about to be made homeless, I find myself siding with arguments that believe this is the likely to be the primary cause of her depression or stress, 'not a chemical imbalance in her brain' as it is sometimes claimed (Moncrief et al, 2022, p.12)…….

-The contextualization of mental illness has been an issue of concern for academics and care practitioners since the early 1970s because of the ever-increasing proliferation in contemporary mental health care of psychopharmacology as the basis of treating mental distress. Bonnie Burstow, who died earlier this year, argued that psychiatry does not account for what it means to be a human being, to think, to fall in love, to be creative and argues that psychiatry is 'an attempt to diseasify every single human experience' (Burstow, 2015, p.64)…….

…Or Moncrieff (2020) in an interview to the Psychiatric Times explains that;

> *'….assuming that drugs work by acting on the underlying biological mechanisms of mental symptoms (the disease-centred model) has obscured the fact that the drugs we use in psychiatry are psychoactive drugs-that is, drugs that change the brain in ways we do not fully understand and by doing so produce more or less subtle alterations to normal mental experiences and behaviour-what I have called the drug-centred model of drug action. Because we have ignored the fact that psychiatric drugs are psychoactive substances, we have not bothered to properly research or even describe the physical and mental physical alterations they produce and all the short and long-term consequences of these. Therefore, we are not making fully informed assessments of the benefits and harms of drug treatment, and because we assume we are rectifying an underlying abnormality, we tend to over-estimate the benefits of treatment and understate its harm. So, although I think there are some situations in which some drugs can be useful (antipsychotics in acute psychosis, benzodiazepines in acute agitation, for example), this has led, in my view, to a situation in which millions of people world-wide are taking drugs that are doing them little or no good but are causing them harm-both harm that we know about and harm that we have not properly researched yet…'*
>
> (published April 10th, 2020)

….And there's more. According to Conrad (2007, p.18*), 'medicalisation is a process in which a non-medical problem has later been deemed as a medical problem by the medical establishment. If something is defined as an illness or disease, it is usually the medical establishment who relate it to the body' This is especially relevant in mental illness as there is no evidence of a diseased body.' The Biomedical approach conceptualises mental illness via biological processes and focus on alleviating symptoms, restoring functioning and being productive' (*Deacon, 2013, p.847*). This fits in with market principles of due to its emphasis*

on standardised treatments, such as medication, for individual pathology.' (Brijnath and Antoniades, 2016, p.6*).*

-OK, Margaret, slow down a bit! - you started off by explaining the biological basis (or NOT) for most mental illness and now it sounds like you may be wander into neoliberalism? or capitalism ?

-What's this got to do with mental illness ?

Illich viewed this as Medical Imperialism.

-What? Why?

*Scull (*in Fawcett et al, 2020*) 'saw the rise in medicalisation as being related to industrialisation, urbanisation and the expansionist tendencies of medicine emanating from the Enlightenment – the 18th century movement that sought to categorize and classify the social and natural world'. (*p.2*)*

Illich?

-Sorry Margaret, but who was Illich ?

He was a philosopher, a writer, and a priest. He was, very influential in arguing that mass education and the system of modernising and medicalising life was wrong as it institutionalises and manipulated basic life……

-*….In his book Medical Nemesis Illich likened clinical care to be the result of a capital-intensive commodity production. He argued that the patient as an individual becomes a technological product and that medicine, or, to use his own words, 'constitutes a prolific bureaucratic program based on the denial of each man's need to deal with pain, sickness, and death and the proliferation of medical agents is health denying…because they produce dependence. And this dependence on professional interventions tends to impoverish the non-medical health supporting and healing aspects of the social and physical environments and tends to decrease the organic and psychological coping ability of ordinary people'* (Illich, 1975, p.77).

So, if there is no biological basis for mental illness, or one which we are not currently aware of then... is mental illness real?

-Or is it a myth ?(Szasz, 1960)

-And if it is not real, then what is this world of mental illness? And how do you work within it? What on earth do you tell your students!

This is hard to grapple with V, but this impacts on the nature of my work and the work that we as mental health nurse lecturers do.

-The medical model remains the most dominant theoretical model in general nursing, but it is limited to pathologizing mental distress and human experience in mental health nursing. Because the design, delivery and educational architecture is dominated by general nurse education programmes, this has left a legacy which remains today and is often permeated in differing and nuanced ways and the voice of the mental health nursing lecturer is often silenced.

-It is messy work but as Sara Ahmed says (2017) *'it is always good to think about how you arrive at the work that you do as there is always a story that we bring to the world and the work we do'*(p.89.)

You asked me earlier about reality Margaret, (before you got sidetracked into the biomedical model of mental illness) and the nature of reality, what you consider it to be, is critical to you understanding the world around you and your place in it….

-Knowing what you believe, what you hold as reality, what exists, is an important part of any journey of discovery. Your mind is you *and* your body….

-You are (Rolling, 2004) the living breathing, reconstituting body of yourself, the site of your research (p.877). You are your mind Margaret, a generative, creative, and reflective entity (Bandura, 2001, p.20) and there are endless possibilities about your being in the world.

-Does that make sense to you Margaret?

Yes, I think so V.

-But how does that help me to understand what's going on in my practice, in my world in the larger world?

-I mean I have lots of concern about mental health nursing education, what's happening in mental health nursing and mental health care.

Big concerns Margaret, but...

-can you be a bit more specific?

-Why are you so bothered with all the big concerns of the nurse education world ?

Because V, it impacts on my practice, and it is getting under my skin and on my skin like sweat

*(*Ahmed, 2017, p.13*) and I feel it's a struggle…*

What is?

The loaded curriculum, teaching to order, changing curriculum content to keep regulators happy, the bio medical model and how it has its hooks into psychiatric nursing, the identity of mental health nurses, the fact that there may be no mental health nurses in the future and...

-and

-there is never any time to pause and reflect on what we are doing

You mean what you are doing?

Yes !!

You seem to have a lot of concern about your place in that world, where you see yourself located …is that correct Margaret?

Yes, I can't seem to make sense of anything these days V.

I think that you need to need to get to a place where you can understand what's going on, I mean what's really going on for you and for your work .

-And your research into your practice is the best place to do that.

How can this be done?

By starting with asking yourself first and then critically exploring if what you are experiencing is understood by your culture in similar ways?

-Remember all realities are contextual. You will need to make sense of the world around you by looking at it through a social constructivist lens as you construct and co construct new knowledge about yourself and the lives of the people around you (Hutchinson and Huberman, 1994, p.29).

You mean the people I work with ?

The people who relate to you and shape your understanding about the world.

But….

Epistemological Underpinnings

But V! (I protest),

-*This thesis is about Nursing and Mental Health and Education.*

Big areas, Margaret, she replies.

*But V, my research identity is challenging because my area of interest transcends education, mental health, and nursing. And 'Nursing is a moral, communicative, and creative activity therefore my approach to research/educating future nurses rests within this space.' (*Sarvimaki, 1995, p.343).

And what about the hostilities of HE Margaret? the hierarchical structures and cultures of Higher Education ? (Brookfield, 2017, p.15).

-*Yes, it can be difficult at times.*

-*No one seems to care in higher education, sometimes it feels like there is an absence of 'ethics of care, which between what happens on the inside of the classroom and what happens on the outside'* (Noddings, 2003, p.21).

-*Yes, the outside of the classroom, impacts on the inside for sure…*

-*It is all very complex V.*

-Yes Margaret, it is but...

-This is *your* research, this is your concern, your dilemma

-You need to do the work yourself

So, V

-*What do you suggest I do then?*

Consider taking a social constructivist view of thinking about your problem Margaret,

That sounds technical, why?

-What's a social constructivist view?

One which can enable you to critically reflect on taken for granted aspects of society, groups, relationships and the self, even the biomedical model.

And how do you make sense or interpret meaning from that ?

Margaret, by remembering to focus on an individual's beliefs, motivations, to gain understanding of social interactions. Interpretivists assume that access to reality happens through social constructions such as language, consciousness, shared meanings, and instruments (Myers, 2019, p.53).

But auto is about me V, is that not so?

Autoethnography becomes a space in which an individual's passion can 'bridge **individual** and **collective** experience to enable richness of representation, complexity of understanding, and inspiration of activism' (Ellingson and Ellis, 2008, p.448).

But what does it look like, autoethnography V

-How will I know what is ?

Autoethnographic texts can appear as writing, poetry, stories, feelings, emotions, artefacts, 'feelings sensations …which can often appear as relational and institutional stories often influenced by history, social structure and culture and can be revealed dialectically through, action feeling thought and language' in plays, dialogue, characterization, drama' (Ellis, 1997, p.127; Ellis, 2004, p.40).

Characterization ? You mean people, characters ?People I have met in my life, along the way – could be they be autoethnographic text too ?

I suppose so….but you need to think about that further……

and drawings?

-Even drawings?

Especially drawings!

Really?

The everyday is our data, Margaret, (Ahmed, 2017, p.63).

So, I can access what is going on for me by engaging with sources of information other than conventional papers and research?

Yes, very much so Margaret, you can be the 'witty hand of an artist and the sharp/critical mind of a social scientist' ! (Keles, 2022, p.2046) laughing hysterically.

I feel excited, hopeful, curious, alive and decide to get off the chair. Standing up straight I begin to feel my feet support the weight of my body as I am connected to the ground below.

I wonder who might help me in my thinking?

*I think I am going to write, V, ……. write about my autobiography and the people I met along the way, maybe they have something to teach me, or show me about myself, as some people made a mark on my life, so I may construct my own understanding or find meaning (*Elkind, 2008, p.9*) through reflecting on my experience as a student, nurse and a nurse educator…*

And

-I also want to value the people I met along the way (staff, teachers and above all persons with problems of Living (Szasz, 1960, p.55*) by telling others' stories because I want to hear their feelings, thoughts, and attitudes (*Etherington, 2004, p.75*) so I may understand mine better…*

Yes, Margaret and as you write you may wish to think about language, text and meaning and its relation to power and discursive practices (Foucault, 1967, p.100; 1980, p.22)

And

-how knowledge and beliefs influence learning, decision making, and action taking' (Feucht et al, 2017, p.235)

-Whatever you want really Margaret

All this talking and thinking about social constructivism and autoethnography and listening to and writing about stories takes me back to my own days in mental health nursing and why it still matters so much- the relationship building, subjective and empathic understanding and person centeredness (Barker, 2001, p.235) *and it nourishes me.*

-*Telling stories will help me to understand V.*

-*V, who should I read to help me understand this?*

You could read….

Ellis (2004) as she writes about personal narrative to 'propose to understand a self or some aspect of a life as it intersects with a cultural context, connect to other participants as co-researchers, and invite readers to enter the author's world and to use what they learn there to reflect on, understand, and cope with their own lives' (p.46)……

-And Chang's (2008) narration of *self* as a way of 'engaging in cultural analysis and interpretation' (p. 43) an Atkinson (2006, p.401) talks about placing the researcher at the heart of the research or full members of the research (Hayano, 1979, p.102) or you can read Reed-Danahay's (2009) paper on autoethnography and (Farrell et al, 2015, p.975) who write about the fact that research transcends the ties of traditional schools of thought or professional discipline and Bourke (2011) who wrote about power (p14) and bringing the *self* to the work (Ellis, 2011, p.160) and Fixens (2016) research titled, 'I'm not waving, I'm drowning'(p.466).

There is so much to read on this ...

And there is more Margaret, V advises….

-Creswell and Poth (2018) write about 'knowledge claims must be set within the world today and in the multiple perspectives of class, race, gender, and other group affiliations'(p.26).

This is not straightforward V

-No, it is not.

-It is messy,

-But start with you Margaret, locate yourself within your own world….

-Because …….

-The everyday is **your** data (Ahmed, 2017, p.63).

Thank you V,

bye for now.

Positioning

Feeling as if my pilot light had been fired up, I started to think about my dilemmas and my place in the world. Energized, I left my office and ran upstairs to the Pinel classroom. It was now almost 6pm and the room was empty. I try to ignore any remnants of this morning's problems.

I grabbed some of Roberts flip chart paper (he will learn soon enough to take it with him when he leaves class) and thought of how I might approach my problems from an inside out frame, writing words down furiously drawing a picture with me inside and words out so that I could visualize locating myself within my educator practice. I started to think about posing problems.

Committing the following to a large page I scrawled circles,

[9]Attuned to my(self) and positive mindset

[10]Finding my voice

ME *(Going over old Ground***)**

[11]purposeful as the role of the mental health nurse and the mental health nursing lecturer operate from a similar position of respect for the person, awareness of the self and others.

[12]writing and researching in this way was according to allowed me ‘to get free of oneself’.

[9] Delgado et al (2021, p.1235)
[10] Ellis (2012, p.2)
[11] Buchanan-Barker (2009, p.88)
[12] Foucault et al (1988, p.4)

Staying Close

I decided that I needed to stay close to this work.

These drawings helped me to understand the complexities of what I was trying to do. Navigating across the circles was difficult because each was encapsulated by its own issues, so I decided to *stay close* to each until meanings emerged. As I thought about the circles, I began to think about my autobiography and decided to write as much as I could and let the world reveal itself. This helped me to take the risks as evidenced in the stories of the characters while also allowing me to *stay close* to the work at hand, taking time to create and recreate past moments with newly formed recreations and reformations.

As the topic of my enquiry is very complex and diverse it requires a creative, flexible, and playful way into it, to see it, to feel it and to stay close to it Leigh and Brown (2021, p.423) In order to establish the right relationship to the present—to things, to others, to oneself—I decided that I wanted to *stay close* to events. This decision is supported by Sara Ahmed's work[13] in which she describes *staying close to the everyday* in terms of her being on an 'intellectual journey', going over old ground, slow arguments, retaking steps (2017, p.19). The inclusive and creative way she works offers me hope and encouragement in thinking about my own dilemma.

But for now reader
I am,

Going over *old ground*. Old grounds that are revisited through newer lenses and continue to be revisited as often as my mind sees things in plural and multiple ways. This is beginning to feel like a very *close* enquiry.

Ahmed also describes the labours of '*making sense of something* and to *free these figures from the histories in which they are housed'* (p.11). These words resonate with me and describe the messiness and laborious work and the idea of *going over ground* speaks to the context and culture of this topic. I have gone over old ground and trampled on new grounds, in new fields

[13] As an independent scholar whose areas of study include feminist theory, lesbian feminism, post colonialism, queer and race theory, intersectionality and diversity, her work seeks to be *accommodating* by learning about the techniques of power often utilised within institutional norms which often do not accommodate some members of society - women of colour, women, LGBTQ, and others.

and found myself on old ground again but it is no longer old ground as I change, so too does my interpretation of old grounded *ways of being*. Brenton (2002, p.13) reminds us of the importance of not dismissing any previous *ways of being* by adopting a position of acceptance that many experiences were of the time in which they occurred, temporal in nature and my position was necessary in that moment. This is an important consideration as I recall events and describe in honest detail some of my anticipation about events or practices that may no longer be socially or professional acceptable. *Chasing Paddy* (a story you can read later) is an example of this.

The concept of *staying close* reflects a way of expressing how to stay close to one's own self.

While the creative and playful can facilitate a way into deep description, it can also be demanding in terms of my time and attention, and I need to be critically aware of that.

But that is enough about me now.

What about the ethics of all this?

When I think about ethics, I am not entirely sure to what extent it is possible to convince myself and my reader/s that I adhere/d to the ethical obligations in this study. I was granted ethical approval by Maynooth University to conduct this study, prior to its commencement and other than adhering to my own ethical practice as a researcher and the doctoral supervision process, I did not engage in any other formal ethical review activity. As a nurse I am obligated to comply with the NMBI guidance (NMBI, 2014, 2015) as an educator/researcher I adhere to the principles as set out in the BERA guidelines (2011) and as a researcher, the Maynooth University Research Ethics Policy (2020).

Those organizational rubrics do not necessarily ensure this work is an ethical enterprise, they merely satisfy each organization's own standards/systems of compliance. Gaining ethical approval to conduct autoethnographic research is no different to other forms of social science-based research since a *one size fits all* approach seems to apply. Schrag (2011) describes the universal processes and structures which seems to underpin such approvals as 'ethical imperialism'(p.120). There is no specific ethical standards for auto ethnography/ers to follow and it has been the subject of concern (especially with the

increase in popularity of the method) within social science and healthcare research (Chang, 2016).

Writing an autoethnographic piece of work is 'a rhetorical act, ideally offering intellectual and emotional clarity, designed to accomplish productive cultural work' (Pelias (2019, p.46) and for me crafting work which demands intellectual and emotional clarity was both personally and academically challenging. The sustained and prolonged nature of such intimate, introspective work meant that the question of ethics permeates every element of this work and underpins the ontological, epistemological, methodological and evaluative aspects of this study.

Every decision I took seemed to involve an endless amount of time as I considered the possibility of my work causing harm to others or myself. Constant questions about what to write about, what to include/exclude, the representation of others, and narrative form became as important as the aim of the work itself.

Pelias (2019) describes *self-culture and writing* (autoethnography) as 'slippery notions'(p.19) and this eloquently describes the ethical challenges, which I myself encountered in this work. I will explain my ethical approach to this work with those three elements in mind. Firstly, I think about my motives for doing this study asking who is this study for? Is this going to offer anything to my world or that of others and who might possibly benefit from this study? Who are my readers ? Are they students, colleagues, line managers and how may what I write impact on them and my relationship with them? As I am claiming that this is important work what assumptions do I make about that and why? What informs my assumptions, and can I make the same assumptions about my culture/community? and who specifically is my culture/community, since this study transcends mental health/nursing/education, or should I confine my concerns to my immediate culture of mental health nurse educators and what are the ethical implications of narrowing my field of study.

All of these questions are important ones as what may present as an ethical issue in one aspect of the study may be an opportunity in another part. For example – it is considered normative within professional nursing that nurses do not use unsavory language in dialogue or written work, and I have made a deliberate decision to use words which may cause offence to some, for literary purposes. Some nurses may feel that it is unprofessional

and perhaps a betrayal of professional guidance (NMBI, 2015). In addition by today's standards chasing Paddy to attend group therapy and bartering his attendance with cigarettes can be regarded as unethical behaviour but it was normative for the culture and environment within which it was socially located at that time (Manderius et al, 2023). As a young student nurse my practice could be considered as coercive by today's standards and did not adhere to the ethical principles of healthcare - respect for autonomy, beneficence, nonmaleficence and justice (ICN, 2021, p.9) but I am mindful that such principles now inform my approach to my daily work and to the way I represent the characters in this work.

By situating myself in this study, revealing my own autobiography as a starting point and citing my reasons for wanting to do this study, my perspectives (which sometimes change), my theoretical stance, writing style, my political perspectives, the constant questioning and dialogue with myself and others, my vulnerabilities, my intention to tell the truth as best I could as the 'readers expect the truth as the author understands it'(Pelias, 2019, p.42). I believe that I carried out this study in an ethical manner.

Adopting a critical reflexive position is a significant way in which researchers have in the past addressed ethical concerns in research (Etherington, 2007) by helping us to 'notice our responses to the world around us' (p.601) so balancing the needs of the self in relation to others becomes an ethical act. What might a colleague, student, or former service user think of what was/is being said and might they think it referred directly to them? My position is made explicit from the start. By prefacing the work clearly at the beginning about the use of composite characters as archetypes of a system, readers are made aware of the intention and location of the work as I need them to help tell a story and to interpret it.

Adams (2008) asserts that 'writing about the self always involves writing about others'(p.175) but autoethnography ultimately starts with researching the self and that self can be 'fragile and porous' (Fixen, 2023, p.140) as the boundaries between self and relationships become interwoven. Doing this work felt lonely at times as it often felt heavy and messy, and I constantly questioned if what and who I was writing about was ethical, as my understanding of ethics ranged on a continuum from doing no harm to others to the need to address some of the critical challenges faced by mental health educator(s) within the hostilities of the current higher education system. I tried to write from the heart and relied on copious journals to safely hold some of my rants, particularly if I had a bad day at work. However, writing in anger and emotion

can be fraught with problems and some of my anger about perceived injustices spilled out onto paper as 'inked tattoo' (Tolich, 2010, p.1608) especially in year 1. Journalling became my safe activity in which I could write freely without the confines and limitations imposed in scholarly work.

I was and continue to be mindful to constantly reflect on my own future professional and occupational vulnerabilities in doing autoethnographic work but feel that this writing is an ethical act because it is concerned with injustice, inequality, and a medicalized and bureaucratic mental health system. My criticisms are exposed through my creative writing, problem posing and endless dialogue.

As an auto ethnographer I cannot escape the fact that I am a white able bodied educated woman with a permanent employment status which affords me certain privilege and one that I am acutely aware of particularly when writing about precarious employment and mental distress since I have not (to date) experienced any of the issues narrated by the characters in this work. The decision to use composite characters was a deliberate act and one which I considered carefully, not just for the purposes of representation, but in an attempt to understand the cultural milieu within which I largely operate. The extent to which these composites are representative of the characters they portray can be negotiated by the reader in addition to the content/narrative of the dialogue, which at times, is purposively probing and disruptively crafted.

Carolyn Ellis (1995) advised that one should assume 'that every person mentioned in an autoethnographic text will one day read it' (p.712) which is a useful way to think about what/whom to write but also raises the issue of informed consent. Consent for participation is a critical requirement in any research study and this is no exception. My characters did not give consent. I wonder if Paddy, albeit a composite character would consent to participate in this study, and if he might be pleased or not with what I wrote about him. Maybe Una did not want to be called Una and might want to be referred to as Victoria. Perhaps Robert might not be comfortable with me writing about his heavy workload. Again, I ask myself if I have the right to interpret the world of another and to what extent can I take such literary liberties to get to the heart of a dilemma and so the ethical responsibilities of auto ethnographers in health/social care research are both evolving and complex (Chang, 2016).

Relating my journey into autoethnographic research as somewhat *accidental* (Poulos, 2018, p.64) I frequently ask myself if it is possible to have an ethical autoethnography,

given the complexities of personal/ cultural work and the nature of the work which is often emotive and troubling (Edwards, 2021, p.1). Journalling, meditation, and research supervision became a way of taking care of myself especially when I felt stuck or was dealing with the exhaustion and emotional labour involved in prolonged personal writing. Andrew's (2017, p.12) book *Searching for an autoethnographic ethic* explores this topic in detail and suggests that, despite the well-meaning intentions behind autoethnography, there is a lack of guidance on how to conduct autoethnographic research in a sound manner. I consider that Ethics is not a separate element of this study but an integral, ongoing, evolving process which emerges in line with the development of the study and committed to honouring the *Oath for Ethical Creative Scholars* (Pelias, 2019, p.140).

Autoethnographic work can be described as courageous, requiring patience, persistence, and resilience (Hughes and Pennington , 2010, p.210) as excavating one's own life, both personally and professionally, can be both vulnerable and transformative and requires a high degree of self-care which is for me an ethical act.

Autoethnography is a way of caring for the self, a way of writing to *work things out*, (Ellis et al, 2014) which this autoethnography attempts to do.

Interpretivism

In taking an interpretivist approach I begin to develop an in-depth subjective understanding of people's lives as they are revealed in this research. It is the theoretical lens through which the work of uncovering what lies beneath the surface and why it might be there can be realized. I can only describe it as *clearing a fog*. Remaining open and flexible in my thinking and allowing the process to generate its own way of being without the imposition of scholarly or theoretical regimes underpinned my approach to this study.

Critical autoethnography according to Holman Jones (2016) 'reminds us that theory is not a static or autonomous set of ideas, objects, or practices. Instead, theorizing is an ongoing process that links the elements of the concrete and abstract, thinking, acting and aesthetics' (p.234).

In this work, I am both the researcher and the researched and the source of data, as are the people, both real or imagined, both of this world or not and both in and out of constructed realities as Pollock (2006, p.8) eloquently describes as *living bodies of thought*.

but

Sometimes it takes the courage to stop and ask what is going on here? What is really going on before the fog lifts. I decide to ask V about this.

I am as usual written in *italics.*

The chat

Margaret! it is late, and you have been rambling on for hours now, says V, indignantly.

I have ?

-Sorry, I was just thinking about the circles I drew earlier as I thought about positioning myself and my problems…

-I wonder if they are everyone's problems too ?

What were you thinking about ?

They are like flying saucers V, aren't they ? the circles

-Hovering about .. watching over everything with the world underneath them ..in those big wide-open spaces ?

If you say so.

Maybe everyone has circles hovering over them too V?

-But do they really want to listen to all that fanciful, complicated language about ontologies and positioning and qualitative words etc, etc?

-Why do you need to make it so complicated?

Because it is complicated!

And as a critical educator they are your words, your texts.

-I think I prefer circles than heavy, wordy, mouthy letters on pages with full stops, and semi colons, and syntax and grammar. It is supposed to be liberating.

You need to read and read the words of those who share struggles with you, Margaret

-they are the language of the academy, the discourses, the currency.

Discourses V?

Yes, the discourses.

Who talks of discourses V?

Well Foucault did.

-And his work on discourses has been referred to a lot within nursing (discourses).Frederiksen et al (2015) reported that Foucault's work in his later years was to 'broaden the meanings of the words discourses as he believed that discourses cannot be reduced to language and speech, he believed that it was more than a confrontation between a reality and a language and must therefore be treated as practices.'(p.201)

When did psychiatric nursing become about discourses?

What do you think Margaret ?

Maybe it has always been about discourses, V, but we have not been listening. Not properly. Psychiatric nursing really does not know who or what it is and an example of this is how it remains beholden to medicine or psychiatry.

-Think about this, V, if psychiatry did not exist would there be any need for psychiatric nurses?

That is a bit controversial Margaret! You cannot say that.

No, I suppose I can't but thinking and seeing problems in ways other than what the profession or employers demands of us has really left us, nowhere really. Well, stuck maybe.

I still can't see what this has got to do with psychiatric nursing.

V, the most frequent concepts within psychiatric nursing are discipline (restraint, seclusion) surveillance (specialling/ locked wards) docile bodies (sedation, rapid tranquilisation and now Zombification!) power/knowledge (medical notes, diagnostic, classification,

DSM[14].ICD[15]/labels) resistance (weekend leave, isolation, medication, clinical gaze (biomedical model, dopamine hypothesis, serotonin deficiency, doctor as expert) discipline (care plan labels, privileges, family visits, access to personal belongings, nurse in night attire)

Yes, I never thought of it in that way.

Psychiatric nurses don't usually. We are too busy.

Wasn't Foucault a bit negative? Did he offer any solutions?

Yes and no. It depends how you interpret his work.

Not solutions as such but reading his work helps nurses to move into a broader interdisciplinary arena and develop critical scholarship. To understand the why.

Back to academics again, is it Margaret?

Not necessarily V.

-I am thinking of how Foucault's work can be understood within a nursing context. Gastaldo and Holmes (1999, p.239) claim that the act of nursing itself can be a political event…

-……'Nursing care becomes a political event, nursing knowledge contributes to the regimes of truth and nurses, rather than being powerless are perceived as professionals who exercise power over society' (Gastaldo and Holmes, 1999, p.234)……..

When did you start becoming interested in discourses? What are they?

The dialogue, the conversations, what is being said, not said, being discussed.

The chats?

Yes, V, I suppose the chats.

Look Margaret, all I am saying is that you are making this very complicated, and nursing is not complicated.

-Academia makes it complicated.

I suppose so V.

[14] The DSM (Diagnostic and Statistical Manual of Mental Disorders) is a tool and reference guide for mental health clinicians to diagnose, classify, and identify mental health conditions in the USA.
[15] The ICD is the International Classification of Diseases.

Where's Robert ?

I sent him off to get a key for the office and to meet the library staff.

-First Days are awful, true.

'Do you remember your first day Margaret? Your very first day?

As a nurse or a lecturer V?

Your first day as nurse…

-Student nurse, I mean.

oh, yes V, Was it as complicated then?

No, well it did not seem so, but it was years ago.

-A very long time ago.

Tell me about it Margaret, says V.

ok

-Not much to tell really, but here goes. I will start off with a brief autobiography, so you know where I learnt the business of psychiatric nursing.

But before I do, I must tell you about the letters.

What letters?

The Letters

Dear Margaret,

We refer to your recent interview for the position of student nurse at St. Jobe Hospital. This letter is to inform you that you have been offered a training position to be a registered psychiatric nurse.

You are required to accept or decline this offer in writing with seven days.

Yours faithfully

Admissions Officer.

Dear Admissions Officer,

I accept.

Yours gratefully,

Margaret.

Dear Margaret,

We are in receipt of your letter dated Wednesday August the 3rd indicating your acceptance.

In order to commence nurse training, you will be required to purchase the following items on the list below.

1. A navy gabardine coat.
2. Hospital approved white laced up shoes.
3. Six pairs of *Silver Grey Glen Abbey* tights.
4. An approved Hospital Fob Watch.
5. A silver Parker Cross Pen.

The starting date of your nurse training is Tuesday the 18th of September 1985 at 2pm sharp.

We look forward to meeting you then,

Yours faithfully

Admissions (School of Nursing)

Dear V,

What's a gaberdine?

Where would I find one ? It's a Bank Holiday on Monday and the shops are closed.

What is this psychiatric nursing about?

What if I do not like it?

Yours worriedly,

M

Starting something

(the 18th of September 1985)

I arrived at my training hospital to start a three-year course in psychiatric nursing. A large red bricked building with giant austere walls which circled several smaller buildings. The black gates at the front were closed and seemed both inviting and disinviting. I was early. Very early.

It was 11.30 am and the invite stated 2pm. I located the School of Nursing across from the staff car park and saw the white flat building. I could see some uniformed girls coming and going from a meeting, walking across the yard in their dazzling white uniforms, sensible shoes, and starched white boxed caps. They looked like nurses, and I wondered if they were students. Maybe third years, I thought, as they seemed to have a degree of confidence, laughing, and chatting as they moved quickly. I wanted to run over and talk to them but did not. My provincial mufti did not bestow me the courage to.

My new clothes felt rigid and uncomfortable. The September sun was surprisingly warm, and my new shoes hurt me quite badly. Everything hurt. I felt homesick and wondered when I might be allowed home again. I imagined that this place was like a convent, and that I might not be allowed home ever again. I saw a church nearby, a beautiful old building just inside the periphery walls and I decided to seek asylum there.

I went into the vestibule, and it was both dark and cool. Churches are restful places for some, and I felt as if I needed to rest for a while. I walked up the aisle as if I had been there before, the ubiquity of such spaces giving me needed comfort.

Were you scared? asks V, thoughtfully

Yes, I was. Quite.

Sitting quietly and I kneeled and started to say a prayer.

I think …

And think…

What am I doing here?

What is this thing **si-key-at-rik** nursing?

What is nursing?

Where are the nurses?

Where are the patients?

Are they mad, like zombies?

Where are the Doctors?

Maybe they are all behind those red brick walls, in the red bricked buildings.

What is this, the start of?

Sit. Quiet, Margaret. Quieten the buzzing bees.

quiet. Just think.

I applied for this programme of study without really considering fully what it entailed because in the late1980s jobs and careers were hard to come by. At that time my school friends applied for the civil service, banking, teaching, or nursing.

On day one I was given six double breasted, heavily starched white uniforms with the instructions that one was to be kept specially for graduation day, three years later, which I duly did. Few of my fellow nursing students fitted into it by then, me included. My initial training was in Ireland, and I later did post registration nurse training in general nursing in the UK.

I have always had an inquisitive mind and remain eager to *find out* about things. This kind of self-study work requires a lot of self-awareness to be able to dig in and dig deep. Revealing the *personal* is a fundamental element of any kind of critical work as all research comes from a particular context and involves personal motivation (Walsh, 2015, p.158). The nature of this enquiry has required me to become critically aware of the world around me, in every imaginable

way, personally and professionally, thinking deeply but not in a technical way. It is more about questioning the assumptions which I hold about my life as an educator, exploring where I am in the world and where the world holds me, as I begin to think about how issues such as power and hegemony (Brookfield, 2017, p.39) impact on me. Some of my assumptions about the world may come from my early life experience or from life outside and inside of work and is a continual and intimate learning process. I think I have always had a curious mind and an ability to wander on and off point (this work being no exception) which sometimes gets me into trouble.

You are rambling Margaret, interrupts V,

-I want to hear about it your training!

Oh yes V sorry, it was such a long time ago and I don't recall that much except….

-I can tell you about one of the first patients I looked after. His name was Paddy, and he stays with me to this day.

-He was sixty-five, a former coalman and born and bred in the North inner City. He held the same job for almost forty years, hauling bags of the blackest coal on his small frame and is not afraid of hard work, according to his boss. But in the past, he had trouble with the nerves and wasn't the full shilling, and when the nerves got very bad and Paddy took to the bed his boss would ring the psychiatric hospital, and the men with long white buttoned up coats would come collect him and take him up the long drive and into the hospital. After a few months he was discharged but usually returned to coal delivery duties quickly. But as the years went on, he became less able to lift those bags of coal, complaining of being exhausted since starting the new drug treatment for schizophrenia. He was no longer productive.

'Tired and sleepy men don't make good workers', reported his boss cautiously, and so Paddy's coal-round ended abruptly, as did his livelihood.

You are still rambling Margaret', interrupts V, I don't want to hear about this man called Paddy, you can tell me about him later on, for now I want to know all about your nurse training.

But,

Margaret begins to think about Paddy.

Learning

Margaret ?

Sorry, Yes V, well, ok then, I found it hard to settle into the life of nursing student. To be honest I did not like it very much because I was not overly impressed with the whole hospital /institutional environment.

-I wondered V, why things were the way they were and who had organised them in that way.

- It was a three-year apprenticeship style programme leading to registration with An Bord Altranis, now the NMBI[16] as a psychiatric nurse. I enjoyed studying the contents of the psychiatric nursing syllabus but disliked the clinical or practical experience in the hospital which is somewhat unusual because I imagine my own students do the opposite. Admittedly, I was just a bit miserable generally and I hated the idea of hospitals and sickness and people who wandered around corridors with their heads down, staring at the floor, full of signs and symptoms I could not understand. Those people were often long stay patients who did not seem to get better, and I wondered if they ever would…

-…*They seemed to mirror how I felt*, 'lonely and powerless' (Graneheim et al, 2014, p.396).

(This starts me thinking again reader, about my role as an educator and nurse education in general)

What do you mean Margaret ?

[16] NMBI (is the statutory body which sets the standards for the education, registration and professional conduct of nurses and midwives in Ireland)

Nursing Education.

-Mental Health Nursing has changed in its role and function since I trained in the late 1980s and in many ways changed for the better. Gone are the long drab corridors and big psychiatric hospitals which I experienced, and uniforms are no longer a critical element of a nurse's apparatus.

-For me nursing has always been a helping profession. A helping profession is described as a professional interaction between a helping expert and a client, initiated to nurture the growth of, or address the problems of a person's physical, psychological, intellectual, or emotional constitution, including medicine, nursing, psychotherapy, psychological counselling, social work, education, or coaching' (Graf, 2014, p.4) *The helping professions deal with 'the provision of human and social services'* (Miller and Considine, 2009, p.405).

-Models of care which influence mental health are rooted in political, economic, and social factors and are much more context dependent than in general nursing (Ward, 2011, p.16). The goal of undergraduate nursing education is to provide opportunities for students to become nurses with the knowledge and skills that are needed to provide high-quality care based on patients' needs (WHO, 2020*) and I have always been drawn to that idea, even as a student.*

-Evidence from the UK suggest that undergraduate nursing education is now in a period of instability and flux and faces an immediate radical change (Hemingway et al, 2016, Connell, 2022, p.472). *Two influential reports*, The Shape of Caring (HEE, 2014) *and* Willis (2015) *reports have far reaching implications for the future of nursing in the UK and the future of mental health nursing.*

The specific challenges, such as recruitment into the profession, the loss of the education bursary, an increasingly complex mental health environment, increased legislative and policy pressures and changes to the scope and practice of nursing pose serious challenges to partnerships between service providers and the Higher Education Institutes. There are similar concerns in Ireland.

What do you mean, V asks patiently *?*

In the UK in recent years nurse academics and commentators have questioned the value and indeed the future existence of mental health nursing as a profession. Some of those concerns are shared and felt by nurse educators in Ireland but actioning those concerns seems to be a more muted affair than in the UK'.

-The current emphasis on physical health for mental health care service users results in mental health nurses needing to upskill and learn clinical tasks. The need for nurses to be equipped and knowledgeable about such diverse components of health, places the nurse educator in a constant place of stress in trying to meet the needs of a crowded curriculum. It seems as if each element competes with each other for my attention as a teacher and I teach in accordance with what is a policy priority at that time. I teach to what I think the students will understand and how it might be understood by them. Tradition and expert opinion were once the bedrock of psychiatric mental health education (Harmon and Hills, 2015, p.414) *unlike the scientific evidenced based syllabus which underpins the requirements and Standards* (NMBI, 2016).

-When I did my nurse training V, the education and training of nurses in Ireland was primarily the responsibility of the hospital sector until the transfer of such authority and responsibility to the Higher Education Institutes in 2002 following the Simmons report (University of Southampton, 1998). This heralded a significant shift within psychiatric nursing to legitimatize its existence within a higher education context.

Recalling my own student days, the syllabus was very much focused on illness/disease but now as a lecturer I see contemporary nursing curricula combine a strong scientific orientation with an emphasis on the humanities, critical inquiry, ethical reasoning, professional identity as well as the evolution of health services (Nolan, in White and Brooker, 2020, p.41).

In Ireland, although the nursing regulator (NMBI) prescribes the standards and competencies which underpin the profession, there is no nationally agreed curricula. This means that educational institutions are free to deliver undergraduate mental health nursing programmes how they see fit under the auspices of a locally agreed health with health service providers.

This localised approach to clinical varies in institutions and tends to be quite traditional in its approach. In many cases HEIs deliver at least two programmes concurrently and often share resources, including lecturers. Programme architectures are often interwoven which can

negate the presence of smaller programmes, such as mine[17]*, as they are size dependent. Smaller programmes are less well-resourced because of their size of their numbers and are often co delivered with larger programmes, mental health nursing and general nursing being the most common. This is generally because of resource efficiency but realistically often results in the*

regressive genericization[18] *of mental health nurse education (McKeown, 2023, p.1). The theoretical, ideological and practice uniqueness of each programme is different, and I wonder what that must feel like for a student. In my student days psychiatric nursing education was embedded within the walls of the school of Nursing so from the very start I had an identity, even if it was embryonic.*

Harrison, Hauck et al (2017, p.517) assert that there is a fundamental lack of understanding surrounding the role of mental health nursing and why it merits being described as a distinct specialty within nursing. Coupled with this there is difficulty in attracting students into the profession because of what Halter (2008, p.22) describes as stigma by association. Sercu, Ayala, and Bracke (2015, p.309) suggest that due to this associated stigma, mental health nursing is impacted significantly by decreased visibility and a declining growth in those attracted to this specialty area.

How did/does that feel asks V ?

As a student nurse I felt that I belonged to a specialty…

…Looking back now I found the practice placements prescriptive and routine and disliked the drab environments of long corridors, locked wards, and the endless array of keys in the hospital environment. I made no secret of it and on mature reflection I must have been regarded as an ungrateful and disagreeable student. What was most unappealing to me was the dissimulation of it all. In theory, we learnt about how the world of mental health should operate but in practice it was different. A theory-practice gap, of sorts. I enjoyed classroom learning because I equated learning with self-growth and betterment and finding out things. I studied hard and spent a lot of time trying to master all of the subjects, especially those I had no prior knowledge of, such as psychology, psychiatry, and pathology. I found them fascinating and thought that it was much more important to know these subjects well rather than immerse myself on the institutional wards…

[17] BSc (Hons) in Psychiatric/ Mental Health Nursing.

[18] *Genericization* in the context of mental health nurse education refers to the increased emphasis on generic competencies and skills rather than the individual professional skills of the mental health nurse

I see

-That must be difficult to admit Margaret.

Yes, it is. I feel embarrassed. Maybe I privileged what went on in the classroom as real knowledge and wonder if I in some way do the same today?

.

Pretending.

I was recently reminded at a class reunion, that I had no hesitation in my willingness to teach my class colleagues the theory content they professed not to understand in class. My eagerness and lust for learning was both naïve and embarrassing in my pretence to be a tutor.

Teach what! exclaims V

'You knew nothing Margaret !'

I knew something V.

What could you have possibly known; you were only a student ?

Well V, do you remember my recital, by heart of the anatomical structure of the body ? It was legendary as I assumed the role of a class teacher with unqualified ease. I liked to know what was to be known in detail and the gratification of teaching others felt immediate. The pursuit of knowing gave me comfort and curiosity kept my attention and I felt at home with it.

-It was both a performance …and a …..

-Pretence.

-I liked anatomy and physiology because it could be learnt off. When I think of my teaching practice today, I have to admit that it is sometimes easier to first explain concepts as physical or biomedical, rather than psychological, cultural, or historical, especially for first years. Take for example, bipolar disorder.[19] *There are definitions of what this is scattered across the internet. I can recall from my nursing days refers to serious mental illness, where a person's mood can be elated, their behaviour erratic and their thoughts disturbed. If I explain the diagnosis in biomedical terms, it is often easier for students to understand it as a deficiency of Lithium*[20] *and many patients often respond well to lithium therapy and recover well* (NICE, 2014).

-But as Goodwin agrees lithium does not work for everyone, and the mechanism of its action is not yet fully understood. But it remains the primary treatment of bipolar disorder, and in a way affirms its biomedical treatment basis. This is despite a major study which affirms the effectiveness of psychological therapies as being equally effective in the .

[19] Bipolar is a severe mental illness characterised by extreme mood swings and changes in energy levels. Someone with bipolar can have long or short periods of stability but can then go 'low' (into deep depression) or 'high' (experiencing hypomania, mania, or psychosis).

[20] Lithium is recommended as the first line choice for mood stabilisation in bipolar disorder by all the most credible medical guidelines NICE UK

treatment of bipolar disorder but are unfortunately not widely available in practice settings since the primary treatment is lithium (Miklowitz et al, 2021, p.141). *Examples like this affirm the tensions which exist between teaching from a what is happening now and what may happen in the future as I struggle with teaching messiness. Such struggles are unlikely to change unless mental health nurses end their complicity with pharmcocentricity* (Wand, 2018, p.5).

-But it feels like pretence.

Do you ever feel that way now Margaret? the Pretence?'asks V curiously.

All the time V. The amount of keeping up to date with current practice is very taxing- especially with all the medication updates. But back then as a student I felt as if I was acting out different roles, one in the classroom and the other in the hospital and felt in a state of constant 'dividedness' (Palmer, 2017, p.39) *being drawn to teaching and to the idea of connectedness to others, on which good teaching depends.*

But,

I was not a teacher.

Not a nurse.

Nor a nurse teacher.

> *Playing a masked professional role, pretending outwardly that I have no tensions at all, while inwardly all those tensions I pretend not to have are ripping the fabric of my life.*
>
> (Palmer et al, 2017, p.90)

What do you think that was about Margaret ?

I am not so sure V but,

Maybe we are all pretenders !

Speaking of bipolar , and *Pretenders* Margaret, remember the lady you looked after in the late 1980s when you were nursing in the UK?

No.

Yes, Yes you do…the lady, the one, you almost got fired Margaret.

Una?, Sorry I mean Victoria.

Queen Victoria.

laughing loudly

God yes !

Did *she* get lithium Margaret, can you remember?

Plenty, especially after the outing.

Oh yes...

That…

Could happen to anyone Margaret.

Could Indeed.

-Wouldn't happen now…

Probably not, too many risk forms to complete…….'

True…

We are both silent for a minute recalling Victoria. Una. Victoria.

Smiling and thinking of Her.

Wonder what happened to her Margaret ?

Una ?

-I mean Victoria.

Don't know V.

(We pause to think about what happened to Una)

The usual I Imagine.

-Admit, section, high observation, meds, night clothes, non-stimulating environment, etc.

-I'm surprised I forgot about her. It was my first proper job after all.

She is probably up there in Heaven or wherever she landed, causing chaos, because she certainly did enough of it here on earth!

Laughs

We think in silence

Glorious Victoria!

High as a kite

Happy, wonderful, healthy, energetic, and fabulous

Elated

Smiling

Up up UP

In the Sky

Red lips

Redder rouge on cheeks

No sleep

Happy

Flying HIGH Fur coats in Summer

Loud garish colours

Nothing matched

Interfering

BUSY BUSY BUSY BUSY

Rushing

Pressure to get to speak to her majesty…….

Urgent Most **Urgent** Nurse!

Got to get this letter to the Queen, today!

Can’t wait a minute longer nurse Margaret

Down the steep stairs for a cigarette, lower deck

Handbag held like the Royal,

head UP

Wearing the Crown of Life well,

Excuse me,

Shan’t be long

thank you, driver,

You’re welcome, Madam, the driver says

Normally don’t get such posh lot on the no 31 these days

Empty Una

Low as low as low can be,

Slow as slow as slow can be,

cannot think, feel, smell, touch,

cannot see the colours

Where have they gone?

cannot remember,

Regrets,

What have I done?

No more cards, no more purses with cards, no more transactions

I am ...

I am

an allowance

Fiscal Recklessness

I do not remember anything Sir.

Ten thousand and forty minutes.

The see saw of *affect* is exhausting and dark and precarious.

I am sorry.

I am sad.

I am

Una.

That is very sad Margaret.

Yes, V, it is.

People like Una /Victoria saddened me, they were wonderful when they were high and so sad when they were low and remind me of the type of work I engage in (Ahmed, 2016). Imagine knowing that you were getting low, the anticipatory low ?

-Falling back down into the blackest of depression.

And what about mental health care itself? the broader picture ?

What do you mean?

I mean earlier on today you said that you felt *lesser than* being a mental health nursing lecturer, in a small team, part of a bigger team in HE. People like Una will always exist but the environment and the systems in which mental health care operates have always been challenging because it is neglected, is it not? It has always been a *lesser* entity.

-And the many people you have nursed are examples of that Margaret

Struggling

Yes V, of course, I understand what you mean, mental health care has been described by Amnesty International (Ireland) as 'the Neglected Quarter' (Crowley, 2003, p.2), *specifically in relation to resource allocation and service priorities.*

-As a social and human rights issue, it is my view that mental health care has failed to reach the collective consciousness of the Irish people in the same way as other health issues have. The collective consciousness seems to tolerate a lesser than attitude to mental health services which one in four Irish people may need during their lifetime.

That is quite a statement Margaret don't you think?

It is now 2023, almost thirty-seven years after I started my nurse training and the funding gap for mental health in Ireland now stands at just 5.5% of total healthcare funding, compared to

10%greatly on the quality-of-service delivery and access to services particularly for new referrals or people experiencing a first episode crisis and are often in need of immediate support and crisis intervention.

and Margaret……

-Not to mention all those who now find themselves displaced, victims of war, natural disasters, persecution, and those who are homeless…….

-…..how are their mental health needs ever be addressed ?

Gosh V, when I think of my early student days, I assumed that this was how mental health care was done, long corridors in dilapidated buildings, doors locked with an array of keys, huge pots of institutional tea and lots and lots of nerve tablets. But it wasn't all bad either V...

No, most of the staff were kind and seemed content to make the best of what they had-such as it was in the late 1980s. But lack of funding is still a challenging issue today as well as the stigma, discrimination, and labelling (Goffman, 1963, p.145; Schomerus et al, 2012, p.145) *that many people with mental health issues experience. Mental health care remains a struggle for those who experience it, their families, for workers.*

and dare I say it for those of us who teach those workers?

Absolutely V. In an effort to keep up services have been introducing one policy after another and all require changes in practice and roles. There is no time to consider the long terms impact of such changes on the professions and it's a struggle to keep pace.

So, struggle is something you identify with Margaret?

Yes V, it is.

The idea of working with struggle as a concept was an important consideration for me when reflecting on my choice of approach to this research and subsequently the theoretical and methodological approaches to this type of work. I knew that I wanted to tell is as it was or rather how I saw and experienced it. The it being the concerns I had about my practice as I live and lived it. In exploring how the personal and the social intersect, research stories are often crisis precipitated (Bochner et al, 2018, p.118) *as authors navigate their own struggles. My struggles became an opportunity for the critical engagement of myself as it is socially*

constructed, deconstructed, and reconstructed and so this work became about critiquing the situatedness of myself in relation to others (Spry, 2001, p.710).

The inclusion of words which deal with the notion of the struggle with adversity, stigma, marginalization, resistance, canonical discourses, repression of the body are habituated within discourses about the struggle with recognition within mental health care. The inclusion of these specific words are those which we hear from service users like Una/Maria in this thesis and allows readers to get to know their stories better.

-Do you identify with those who struggle; the marginalized?

Yes, is suppose I do, and I think that any form of getting to know (Bochner, 2012) *which 'honours the experiences of others especially those who may be marginalized or unheard' (p.156) is that which appeals to me most.*

Why so Margaret?

Because his choice of language or words is aligned to contemporary mental health discourses, especially those which describe deprivation of liberty, medicalisation, and oppressive practices and sees such struggles as those which 'nourish the researchers hunger for truth' (p.159).

I remember some patients like Una and Maria and their struggle with the problems of living (Szasz 1960, p.115; Szasz, 2011, p.179). *Szasz was one of the first psychiatrists to question the existence of mental illness and is associated with the start of the anti-psychiatry movement, which is now known as critical psychiatry. I remember reading about him as a student in the library and was puzzled that someone thought there was a problem with locking people up especially when people had traumatic life experiences.*

Many mental health services have been accused of dehumanizing human experience (overuse of medication, forced 'treatment' issues, capacity legislation) and yet Freire's liberational approach was essentially about humanizing it . Illich's critique of medicine and medicalization emanated from his political and collective values and was not limited to medicine. The idea that our discontents are a manifestation of faulty brains that can be abolished with sophisticated medical treatment is just the sort of illusion that Illich is responding to (Moncrieff, 2016, p.438)

-Szasz argues…..

> *'the finding of a mental illness is made by establishing a deviance in behaviour from certain psychosocial, ethical, or legal norms. The judgement may be made as in medicine, by the patient, the physician (psychiatrist), or others. Remedial action finally tends to be sought in a therapeutic- or covertly medical framework thus creating a situation in which psychosocial, ethical, and/or legal deviations are claimed to be correctable by (so called) medical action. Since medical action is designed to create only medical deviations, it seems logically absurd to expect that it will help solve problems whose very existence has been identified and established on non-medical grounds*
>
> (*Szasz*, 1960, p.115).

He argued against the notion of coercive psychiatry, challenging its paternalism, and defending liberty and autonomy of all citizens. His thesis was supported by the well-known psychiatrist RD Laing (1963), *who believed that schizophrenia was a theory not a fact. Their views led to* David Cooper (1967) *to first use the term anti-psychiatry rejecting the domination of the biological model of mental illness.*

The DSM[21] *however, is still alive and well and into its fifth edition.*

Today, the anti-psychiatry movement is now represented by a global network called the Critical Psychiatry Network (CPN), which originated like its forebearers in the UK. I use the word anti purposively here as a way of explaining that the organisation was established to draw together critical perspectives about psychiatry and to provide a broad critique of mainstream psychiatry that has emerged in recent years which challenges some of psychiatry's most deeply held assumptions. Other perspectives which challenge the hegemony of the now biological view of mental disorder include social psychiatry, psychoanalysis, and psychotherapy.

What is the purpose of such a group Margaret?

The focus of CPN is to question the ongoing relationship between Psychiatry and Medicine and to explore alternative ways of offering support and treatment to patients. Information from the website explains that such critical are perspectives are intended to produce a more reflective, skeptical, and patient-centred approach to the theory and practice of psychiatry.

Membership, however, is confined exclusively to Psychiatrists.

[21] The introduction of the Diagnostic and Statistical Manual of Mental Illness (DSM) in 1968, now it its fifth edition (2013) is known as the *psychiatrist's bible* as classifies mental disorder.

Are you are obsessing about this now Margaret?

No, I am not. OK, maybe a little, but can I read you a few excerpts from articles I have collected? Please V?

So, keep it short as you are a bit one sided about this Margaret and this is not about you taking on the world of psychiatry or mental health care, it's about your surfacing tensions in your own practice as an educator M**!**

'Ok so I was reading that ……'

Middleton and Moncrieff (2019, p.50) *suggest that the link between psychiatry and medicine confers legitimacy on psychiatry as a professional enterprise because its practitioners are seen to hold and exploit expert medical knowledge.*
McCann (2016, p.5) *argues that this expertise is conflated with diagnostic perspectives and have negatively influenced how society views and stigmatizes such conditions as schizophrenia. But Stoyanov et al* (2021, p.1) *takes a more holistic values-based approach to psychiatry embracing personal narrative and person-centred care.*

But is a diagnosis always a bad thing? Some people may want a diagnosis and they are entitled to it, to know what it is that they may be feeling or to be able to seek specific help Margaret.

-A mental health diagnosis may cause the person to be stigmatized and make them feel like a *walking label* (Young and Calloway, 2021, p.272). Alternatively, some people may prefer a diagnosis as it may help them to understand their condition better and appreciate that they are not alone with their experiences (Norman and Ryrie, 2018, p.278).

But V, Raabe (2010, p.17) *makes a great point when he questions the ontological status of mental illness when it can be voted out of existence. This also includes what may be added as a psychiatric diagnosis, with internet addiction or sex addiction being an example.*

And V, I must tell you about a really interesting book Why Psychiatry Is Doing More Harm Than Good (Davies, 2013) which sets out to explain the proliferation of psychiatric disorders in the DSMV.

Let me read this bit to you V…

-*…Page 4 I think …yes he writes …….*

> *I will investigate three medical mysteries: why has psychiatry become the fastest growing medical specialism when it has the poorest curative success? Why are psychiatric drugs now more widely prescribed than almost any other medical drugs in history, despite their dubious efficacy? And why does psychiatry, without solid scientific justification, keep expanding the number of mental disorders it believes to exist - from 106 in 1952 to 374 today? what is going on?*

-He builds on Paula Caplan's work about the DSM diagnosis and the use of technical language to validate human experience inappropriately effects minority groups including women where a diagnosis can impact on a personas ability to seek health insurance and employment prospects (1991, p.166)'.

But what do the World Health Organisation (WHO) do?

They also rely on a similar taxonomy to diagnose mental illness (ICD-11) and is more commonly relied upon in Europe (WHO, 2015*). Like its American cousin, the DSMV describes a range of mental health conditions, and a formal diagnosis of mental illness is made based on the severity and number of symptoms and their duration and frequency.*

-*What is the impact of all this?* De Silva (2017, p.505) *suggested that due to the nature of subjective observation, diagnosis is open to interpretation and may change throughout the course of a person's life, depending on who is involved in their care and treatment and Horwitz (2002) argues that the splitting of psychological problems into illness categories is a social not a scientific endeavour and gives psychiatrists 'immense power' (p.80).*

Power?

Foucault's propositions on the relative nature of power and society and in particular mental illness cannot be understood in isolation from other institutions of coercion and discipline. Lakritz (2009) *in referring to Madness and Civilization* (1967) *noted that mental illness was reconceptualized as moral failure, to be treated with constant observation and regimentation, with appeals to guilt and religious sentiment. People like Una are often perpetually judged, threatened, and corrected and may internalize this authority, becoming more compliant but also more self-alienated, divided, 'stigmatized'* (Lebowitz and Applebaum, 2019, p.50) *and less free even than his or her enchained predecessors.*

Foucault wrote about what he termed as 'biopower' (p.12) in reference to industrialization and modernization in the West.

What does biopower mean?

Biopower is a microphysical sort of power in which the 'disciplinary power of knowledge and technologies produces surveillance and control over human bodies and behaviours, sensations, physiological processes, and pleasures both individually and in terms of populations' (Clarke et al, 2010, p.12). This global imbalance continues to reinforce an equity, evidence, and *implementation gap* (Puras and Gooding, 2019, p.42).

You mean a power that targets a population and an individual body?

-Could you give an example Margaret?

Well, let me think ..an example…

-*Well V remember that lovely patient I tried to tell you about earlier, Paddy, yes Paddy…he had schizophrenia…. yes that was it…I think I was in first year when I met him… he had spells of admissions in and out of hospital.*

-a big strong fella, and when he wasn't with us worked as a coalman- Gosh V, you should have seen his muscles, no gym for Paddy, he just hauled bags of coal every day- a real workhorse you could say, but as time went on and the effects of his medication made him slow down physically, and over time he put on loads of weight and then he wasn't able to work, so no longer a useful productive man. Paddy's story as productive worker is a reflection of how biopower is embodied in pernicious and invisible ways.

I see what you mean.

Yes V, the other day I heard someone on the radio talking about the burden of psychiatric disease (Knapp and Wong, 2022, p.5) …I mean the burden of being a burden.

Probably easier for Paddy to carry the burden of the coal bag than the burden of illness.

True.

So, Margaret you are saying that the mental health/illness *technological paradigm* assumes that interlinked, faulty physiological, emotional and information processing mechanisms are key to understanding extremes of human misery? (Thomas, 2014, p.4) and furthermore, the two main classification systems used to diagnose mental illness are dominated by one professional group.

Yes.

*-In her book Psychiatry and the Business of Madness (*2015, p.1) *Bonnie Burstow argues that Psychiatry is the problem not mental problems. The basic tenet of Psychiatry is 'mistaken and foundation-less'. She asks:*

> *'This is a study of Psychiatry, it is a study of an area which is officially a branch of medicine, which is overwhelmingly seen as legitimate, benign, progressive and effective, that psychiatry is so viewed is readily apparent ad may seem as a no brainer, Doctors specialize in it is covered by our health insurance and overseen by Ministries, of Health….people routinely use them to help solve personal problems and the media regularly report of discoveries and successful treatments – much as they would report breakthroughs in the treatment of cancer, but what if society had it wrong, what if this was not legitimate medicine …what if Psychiatry's central tenets and conceptualizations were wrong. What if despite some good practitioners it does far more harm than good'.* *(p.1)*

-Such is the hegemony, and so has it permeated our society that we simply cannot question mental illness. We are told time and time again that it is a disease…and all this frames how we see it.

-Burstow argues than only bodies can be ill. In mental illness an assumption is made that the mind is ill, whatever and wherever the mind is. The mind is not a material object like the brain and yet mental illness is not, in the main brain disease although some brain diseases can cause psychologically distressing experiences. The brain is an organic part of the physical body-changing one's mind is not the same as changing one's brain. The mind is an abstraction consisting of values, beliefs and assumptions (Raabe, 2015, p.16) *The mind is propositional not biological. Mental propositions consist of propositional attitudes, such as doubt, belief, desire values and assumptions among many others.*

So, groups like Critical Psychiatry challenge these assumptions? But they are medical?

Yes, V.

But what about *Nursing* Margaret, especially Nurse education? Are nurses challenging the hegemony also?

Yes V, there is evidence of hopeful work. In the UK, the MHNAUK[22] *is a politically active, inclusive group who lobby, research, and teach around the business of mental health with the aim of improving services and being a critical voice for the advancement of mental health nursing and that hope seems to be driving innovation and creativity, especially in the IT sector…*

-A post grad student was telling me of recent advancements in technology, the use of new gaming technologies and virtual reality spaces to help people with psychosis to manage their voices, this is in its infancy but being rapidly developed in the US and some parts of the UK. Imagine if people could manage their own symptoms, their own voices when they needed to?

The irony of giving voice to one's voices!

In Ireland the Critical Voices Network Ireland (CVNI) as part of an International Hearing Voices network aim to provide a collective response to concerns around the dominance of bio psychiatry in Irish mental health systems (Sapouna and Gijbels, 2016, p.397).

[22] The MHNAUK (Mental Health Nurse Academics) UK are an authority on mental health nursing education and research, with representation from many Higher Education Institutions including some from Ireland

This is very much led by service users, carers, and supporters with the support of the professionals who view themselves as a politically engaged movement and to influence mental health issues at a wider socio-political level and to engage more explicitly with social activism and acts of resistance (p.403) respecting differing voices and perspectives.

It's all about the patients, the service users, the people, isn't it?

Yes, it is, they are the most important in all of this.

And the students, don't forget your students, Margaret!

Yes V, of course them too!

-I suppose I draw on my own experience as a student when I am thinking about patients and bringing their stories into my teaching. They all leave their mark.

Can you recall any patients who left their mark on your memory as a student?

Well apart from Paddy?

Yes, I can, let me see…em…was it Jane, or was it Julie, who had the misfortune to have a child out of wedlock in Ireland a reminder of the power of church-state control (Fitzsimons et al, 2021, p.52). *There was no reason for her incarceration for years in a locked hospital ward other than that* (O'Sullivan and O'Donnell, 2007, p.32*). She was an old lady now having spent fifty years on the same ward. I could not begin to imagine the boredom and despair of being confined indoors for no reason other than, no reason at all. Many stories were similar. I loved to read their sparse medical admission notes, because that was the only information about their past existence outside of the asylum…*

-I read illegitimate and wondered what that really meant. Was being illegitimate a diagnosis or was it something else? whatever it was it seemed to be a problem as it was recorded in the case notes. I read her notes over and over and imagined that she might have had a better younger happier life, because I couldn't bear to think that this was her whole life. All of her life spent in a place like this. Unimaginable. Those patients were older and feeble now, the years had not been kind to most of them, but I still wanted to see the person, the younger version of them which lay hidden behind their current presenting self…

And that term illegitimate was only removed after sustained campaigning by feminist groups especially the organisation (Fitzsimons, 2021, p.53).

How did that make you feel Margaret?

-I sometimes wondered that if I had remained there on the wards, might have become institutionalized too? As if the place might hook me in and I might never get out. That was unlikely because I did not feel like I fitted in. I did not feel the maternal bond for psychiatric nursing but grew to love it and learn from it especially the parts of psychiatric nursing which I find joyful- listening, talking, reassuring, coaching, being present, showing up for others. I liked theory and learning while my class peers were delighted to be out in the wards doing real work and learning to be real nurses.

Did your experience improve Margaret?

-It did because, in year three, I started to enjoy the wards, especially caring for the long-term patients, and enjoyed learning about their often sad and lonely lives and made more of an effort to work on my interpersonal skills. There was less focus on their diagnosis and symptoms and more on care and comfort. I found that I liked working with people and as my confidence grew in myself as a person, I began to enjoy the work (mostly).

-I watched the 'good nurses' go about their work with good humour and ease and decided that nursing wasn't a bad career after all. They made the performance of caring look effortless, knowing what to do and when to do it. Some were kind, others were stern and official, but in each one of those nurses I learnt something new. How to be, how not to be. How to do, how not to do. Some of them were wonderful nursing role models.

How do you feel about sharing that openly Margaret?

-Looking back from that past life through the lens of the present I feel embarrassed by revealing this. Surely all nurses want to be nurses and all nurses enjoy what they do. Is that not why we do it? Because we love it or the idea of it. Is it wrong to claim not to like nursing or to find the environments distasteful and unappealing?

-I wonder what students might think if they were to read this.(Lambert and Mahon, 2021, p.4)

How would you feel about a student reading this?

-I hope that if a student nurse reads this that they might feel ok about not liking some of the work in psychiatric nursing because it is difficult work, emotionally draining and at times dangerous. But it is also joyful, engaging, and skillful and attracts the absolute best of staff, just not enough of them anymore, which is a pity because I think that psychiatric nurses are wonderfully skilled. Some are outstanding.

-And from time to time some of those staff seem to leave their mark.

Like Betty.

Betty

Betty was fabulous, large, and lovely with great hair and a permanent healthy suntan. Her uniform was always sparkling white, her cap was heavily starched with *Robin* starch. White clips supported her immaculately groomed hair. Her shoes were always white (unlike mine) and she wore the *proper* silver-grey tights, unlike me who opted for the cheapest version that my monthly allowance could buy. I was frequently rostered to work with her and would follow her around the long ward continually asking her questions like an over enthusiastic five-year-old.

'What is dementia?'

'Can young people get it?'

'Can *I* get it?'

'Why is that patient so thin?'

'Why does he not have any visitors?'

'Why is it done this way in the hospital, when I learnt to do this another way in class?'

The woman must have had the patience (and patients) of a saint. I imagine that I was very annoying, pestering her with daft questions well above my level of learning requirement as a first-year student nurse.

Sometimes, when we were scheduled to work the late shift together and her being an avid early morning riser, she made brown bread and brought it into work. Fresh brown soda bread. It smelt delicious and was warmly shared out with the older patients. It was a lovely gesture which brightened up the long monotonous day for both the patients and for staff.

Highly organized task allocated prescriptive routines meant that things happened when and how they should, but I found the rigidity dull and monotonous with *care* routines organized around a system of task allocation and students doing a lot of the physical work. Break times were always welcome, and students were generally on second breaks together, except on the weekends. So, when there was a disruption of any kind to the ward routines, it was delightful as ward routines often felt stale and mouldy.

Back to bread.

'I was making some for my house, anyway!' Betty said, disregarding her own soulful enterprise. Unwrapping the soda bread from the large brown parcel, Betty beamed openly much to the delight of her aged patients.

Cutting it up and buttering generously she gave it to those patients who were still able to eat solid food. I watched her closely.

'I wonder if nurses are actually *allowed* to do *that?',* I asked myself.

'To bring food from their own home and give it to hospital patients!'

I wonder if *that* is *really allowed*.

I must ask a qualified nurse about that. Is that an acceptable thing to do?

But not Betty.

That might be hurtful and unkind of me to ask her if she was allowed to bring in home-made bread and give it to the patients.

'Better not ask.'

I watched as all the older feeble patients smiled. Their long staying faces moulded into institutional *Buxtons*[23]. Thanking her, as they watched her unwrapping the brown parcel

[23] A type of reclining chair with an optional table used in inpatient settings and that, in reality, was often used to restrain patients.

bursting with large mounds of freshly baked brown soda bread, sitting more upright now, eagerly anticipating, the home-made nourishment.

A different procedure today. This was not the usual washing, or wiping, or meds rounds or packing wounds from invading mauling pressure sores.

'I baked that specially for you Sheila' , she would say, handing the bread out in neatly cut lines.

There was an air of warmth and love as the old people smiled and mumbled in gratitude.

I watched the bread round, again and again.

In delicious asylum, they ate and enjoyed.

'Thanks Betty, God bless your hands'.

Nicer than that shite, in them packets they said.

Silent smiles.

They ate until the last crumbs disappeared from their laps and listened as Betty promised to do the same again *soon.* A slanted truth perhaps if clinical conditions allowed.

The staff joined in with the group of older patients and asked for her recipe, commenting on its flavour and how soft the crumbs tasted.

Enjoyed the same home-made bread, they did. In unison.

No difference between staff or patient.

Between dementia or non-dementia.

Between them and us.

Between classroom and clinical.

It was just a group people enjoying home-made brown bread together. In harmony. In love.

Margaret, why is Betty's story woven into your memory?

V, It was one of those moments that laid down something in my head and my heart. The kindness and caring shown by a woman in baking and sharing bread with brethren. Even at a young age I became aware of things which happened in the classroom and things that happened on the wards and how things seemed different in practice…

…-Despite the nature of the act, I was confused by it, even disturbed by it then. It broke the rules, I am sure. Betty broke the rules, even if it was a small rule. Patients should have their meals in the way that is provided for them by the hospital kitchens, at least in those days they did. For that is what I understood from class. From theory. No none told me that it might be different…

-My body liked the atypical act of kindness, but my head did not. My body physically relaxed because the patients seemed happy, but my head hurt trying to scan which procedure to follow.

-I liked seeing the disruption this brought to the long tedious routines on the wards, and the anticipation of what was in that big brown parcel, but I disliked the uncomfortableness of working outside of procedure. Betty showed care and attention. It was unauthorized but was real, embodied and felt the right thing to do. It felt like an act of love.

-It was an experience that had an impact on me because I learnt that care meant more than learning how to perform procedures and was more than competence and conformity.

What has Betty taught you?

Looking back now I think that she was probably connected to her practice, embodied that in her physical and emotional presence and cared for her patients in a person centred way (Gabrielsson et al, 2016, p.438). *Even in my youth I wanted to be her. No degrees or Masters, or discourses but psychiatric nursing at its best, attending to the needs of her patients holistically and doing it in an effortless way infused with humour* (Dunn, 1993, p.14) and a smile. *She cared in an interpersonal and therapeutic way* (Peplau, 1952; 1994) *building an alliance with her patients caring for and with her patients rather than about them* (Barker, 2001, p.330)

But her act of nourishment puzzled me…

Why Margaret?

…I recall wondering at the time if there was an article or chapter in a book on it and that might make it more acceptable. Doing something in practice which I had not learnt in the classroom…I had learnt about the importance of caring for others as a mental health nurse, but this became disrupted when an act such as Betty's did not seem to be framed within a syllabus, or I could not locate it within a policy or procedure or rules.

…My socialization into being a nurse was anchored by the curriculum. I simply could not think for myself…

…And now I can see that.

Her caring intervention was not colonized by theoretical frameworks and an evidenced based paradigm. A gap. Not in the traditional sense of theory- practice gap which is evident in nursing (Freshwater, 2008, p.281; Dyson, 2018, p.75) *but that nursing encompassed more than learning to do something and that care of others could possibly occur in other forms. It encompassed both doing and being.*

Being and doing. Above all, being human..

I have listened for hours now, maybe you need to write some of this down Margaret your journal…

Yes, I will do that V…

I sat down and started to write as V had suggested. My friend Hattie had bought me a lovely notebook with pretty flowers and nice colours on it- maybe a subtle effort to get me to write something or at least do some journalling, I started to write but I couldn't. The words just would not appear. I should write something clever, and insightful and academic and articulate because it's not that what academics do ?

Not me.

Nothing

No words

If I can't write, how am I going to know what's going on?

My head was full of snippets of memories, about my training and thoughts about all the people were everywhere, Una, Paddy and Betty I was 'trína chéile' (McCormack, 2014, p.163).

I wonder what Betty would make of all this theorizing and thinking and writing and worrying. She would probably say very little and carry on with her day with smiles and kindness and without the *burden* of thinking too much.

Working

I drove home that evening and retired early. The next day I drove to work thinking about the calamities of yesterday and starting the Doctorate. My head was full of noise. To get myself out of my head and into my body, I decided to record myself on my phone. There were no questions from V just ramblings and reasons on what Betty taught me about care and love and attention and the simplicity of being fully present. I had over the past few years observed that during times of high stress most of my anatomy was franchised out elsewhere such was my feelings of disconnection from myself.

I wanted to feel connected again.

----------Recording ----------

For me the focus of psychiatric nursing is on helping people by trying to understand *the world of another* through empathy, kindness, and compassion. As a student I learnt about unconditional positive regard, congruity, and person centredness (Rogers,1950, p.444), but I could not equate such wholesome concepts with my experience in hospital practice. I saw kindness and compassion in practice, but I also saw the grey old Victorian institution. I expected to be able to heal or fix people and the idea that I was learning to be part of the only branch of nursing that detains and treats people against their will (Rose and Kahathil, 2019, p.4) troubled me. A lot.

I recall a retired colleague telling me of an incident from his training days when he *chased* a *temporary* patient , down a hospital driveway to give him a depot injection as he had left the ward without permission. I worried I might be asked to do the same thing as him…..because sometimes patients got injections against their will……

Sometimes practice was very different from the lofty ideals of the classroom…

Margaret?

..*Yes, what is it V?*

-I'm trying to record something V, something important about my student days…

-stop interfering please !

Sorry Margaret… but I was listening when you were talking about your older colleague chasing that man ….

…and it reminded me about all the classes you had on a Tuesday afternoon, you really enjoyed those…

…what were they ?...

Yes, V I did. They were my favourite topics…

-I studied self-actualization (Maslow, 1943, p.382), *person centredness* (Rogers, 1961, p.23), *therapeutic milieu* (Abroms, 1969, p.556*) and stigma* (Goffman, 1963, p.12) *in class and began to form the idea that mental health care was best delivered within environments that were conducive to valuing person centredness and caring for the self. This was re-enforced by dominant individualist nursing models of care, the most influential of which was the Roper, Logan, Tierney model of nursing first developed in the 1980s but still prevalent today* (Roper et al., 1990).

For me, what was conflicting was that, despite these grand narratives, what I experienced in practice was quite different, not because care provision was poor, but because it was ritualized, task orientated, custodial and medicalised. I learnt quickly that I would get on if I kept my head down, kept busy and just worked, as learning clinical skills became the primary focus. The curriculum was the principal medium through which I was socialised into mental health nursing (Kelly, 2020, p.1252) *and not the hospital. Learning about mental health nursing was derived from the classroom but learning how to act or work was what I did in the hospital…*

----------Stop Recording----------

Thinking …I am thinking and ask myself if….

.Are my students socialized in the same way ?

Do they know or work with *a Betty* ?

Would they ever run after a patient down a hospital drive?

How will they know what to do, how to do it?

Is nursing work socially constructed?

How will they feel connected ?

Are they feeling disconnected too ?

How would I know ?

Do I create conditions for them to be able to express themselves ?

Recording again

There is something about recording my own voice which is liberating to me. The gaps, the pauses, the *emms*, me and my audience in my car. I started to think about my nurse training in Ireland in the late 1980s and the power that hospitals and schools of nursing held over people. The system was problematic, and I recalled some of the more local problems with training.

I recorded that ……

Fealy (2005) describes the apprenticeship model of nurse training in Ireland as of 'dubious quality' citing that 'nurse training was conducted in a way that fostered subservience to authority and compliance with rules that appeared more often concerned with personal behaviour than the professional development of the role' (p.155). While it was referred to as subservience, essentially what Fealy was referring to was *power*. Hospitals were powerful places, with strict systems of command and control, operated by a ward sister, usually a catholic nun. They understood order and efficiency and showed little concern for staff, particularly students, as evidenced here: 'through the curriculum she was given to understand that *she* was

first and foremost a worker who was expected to be passive, compliant, and willingly to serve' (Fealy, 2005, p.144).

From my experience as a nursing student, power was everywhere but, given my learner status, I was mostly concerned with complying with the rules of training within my own small world. Institutions were powerful places and the structures (legal instruments of the 1945 Mental Treatment Act, buildings, institutional architecture, the medicine trolley), the systems (policies/regimes/ status /uniform apparatus) and the culture (authoritarian but caring, unquestioning but clever) all ensured a climate of discipline was followed, although I did not see it as anything other than being grounded in how things were supposed to be at the time.

I followed task allocated orders, my body diligently accommodating incremental skills without question. Foucault's (1995, p.138) referral to 'docile bodies' describes discipline as a form of domination which he viewed as a specific technique of power that regards individuals both as objects and as instruments of its authority. Perhaps like *zombies*. As a student, I was both an object and an instrument of power as indicated in my fleeting thoughts of reporting Betty for breaking the rules shows.

Uniforming

Nursing students functioned on a basis of service to others and were required to serve patients, serve staff nurses, managers, and doctors. Every day I dressed up and served someone, acting the part in a well ironed uniform, which became an apparatus of my nursing identity. I disliked mine intensely because it was tight fitting and restrictive. Deliberately. It had a tight thick waist band with stainless steel buttons which popped open when I bent down to tie my laced-up shoes. I could not wait to get out of it and into qualified gear as staff nurses could choose their own style of uniform.

I wore a white double-breasted uniform with the full nylon *underslip* underneath and silver-grey tights and a boxed hat. That awful *wingy*, starched hat. It is hard to believe that mental health nurses wore hats but at least *the psyches* were not mandated to wear veils, like our general colleagues. Large canvases which got routinely caught in bedcurtains.

I am of course referring to females only. Perhaps a relic to stereotypical, romantic notions (Greer, 1971; 1987; 1999) of what a nurse should look like (Tiffany and Sparrow, 1987, p.40).

And the nurse's cardigan !

It had a huge significance. My student's cardigan was a sky-blue boxed type, worn only on the way to and from tea break or on a borrowing errand and never in a clinical or direct patient area. When I qualified, I was allowed to wear a navy blue one. The recognition was enormous- the visibility of proudly wearing it in the canteen announced to my peers that I had *qualified.* I had arrived.

Such fabric accoutrements allowed for easy recognition by the public that I was a nurse or at least looked like one. Its whiteness reminded of cleanliness, preparedness, order, work ethic and of where I belonged in the hierarchy of service which, as a student, was below everyone else (Brien and McAlistair, 2019, p.102).

The *lads*[24] were not tied down with the same double- breasted restriction and wore a navy trousers, a white short sleeved shirt and tie and in some care areas (usually elderly care), a long white coat, buttoned up at the front. Made of heavy cotton it had a pocket on each side, to hold a pen and the sleeves were difficult to roll up both literally and metaphorically. Looking back now I wonder why they wore that coat or why they needed to ? That coat seemed to separate students by gender and that coat seemed to bestow a degree authority over females because it looked like a coat worn by the medical staff. From my experience males were less likely be involved in the personal care of patients and were often redirected to other less laborious duties.

Thinking about nursing today I wonder to what extent such gender disparities exist and how students perceive them as, traditionally the nursing profession has been perceived primarily as a female profession. In Ireland 90% of students studying nursing are female, of the cohort of qualified nurses only 9.3% are male (HSE, 2019) and most of those work in mental health services. Conditions of employment have in the past varied greatly between mental health nurses and other nursing cohorts, an example being that mental health nurses can (pre-2004) retire after 30 years' service in the same way as the gardai (police) and prison officers can, as psychiatric nurses traditionally aligned themselves with custodial service agreements.
This entitlement not afforded to general nurses or midwives.

[24] The students in my class who identified as male. According to the Royal College of Nursing Congress meeting in Belfast (2018) only 10.8% of nurses are male and this is 9.3% for Ireland(Republic).

Nursing is considered a women's profession, limiting male participation (Morales et al, 2022, p.21) and the inclusion of the story about John attempts to situate him within a largely female dominated workforce. While employers are keen to recruit more males into the profession, the profession is often seen as being synonymous with 'being female and with femininity' (O Connor, 2015 p.194). The public identify females as inherently better suited to nursing than males due to their perceived ability to be caring, nurturing, and detail-oriented nature (le Blanc et al, 2019).

Several factors predispose nursing as an 'oppressed profession' as the majority of nurses are female; the role of the nurse is often seen as being under the direction of medical hierarchies, where one group or individual uses power to maintain privilege and dominance over another (Treinen et al, 2022). Such oppression is often expressed through a lack of autonomy and agency, inequality, and poor professional cohesion. An example of this is the way that nurses are treated differently depending on which part of the register they are attached to.

The development of nursing within a social context is shaped by gender stereotypes (nurses as female, carers, women subservient) which influence public perception of what the role entails. The work carried out by nurses is assigned a low value by society as it is regarded as being suitable for women, who are frequently underrepresented in senior management roles.
Male nurses encounter different stereotypes, which question their masculinity, their control over their sexual impulses, and their professional competence (Morales et al, 2022) but are often ore visible in senior leadership positions, particularly trade unions.

An exploration of gender disparity in nursing is beyond the intention and scope of this research but given the various references to issues of gender throughout I cannot ignore it, particularly in the context of oppression, power, and identity. Seeking to better understand the ways in which the objectification, subordination and commodification of nurses continues in 2023 requires a wide and critical lens to explore these complexities further (Bearskin, 2023).

I finished recording, got out of my car, and went to find Robert. He was already in the building.

It was his second year of teaching and I wanted to see how his first long holiday went.

Year 2

Sighing

(Robert and I are meeting in his office after the summer holidays)

(I am in italics)

Morning Robert…

Morning Margaret, welcome back to year 2, lovely day, isn't it?

Yes lovely, did you have a nice first summer break?

Yes, was great but I was exhausted, so much to learn and so much teaching last year!

-how was your Summer Margaret?

It was fine. Spent a lot of it reading and studying.

(The office phone rings. It is the Boss. The call is for Robert)

Margaret decides to leave him to take his call privately….
….. and heads down to her office,
……sits down and starts to write in her journal …

…Or journal**s**. There were so many of them now. Those loud coloured books which had been bought for her because everyone in her immediate circle knew she had embarked on his Doctoral journey and as it was, lonely and difficult at times, having nice journals felt important.

…Journalling became a catharsis and these pages, in fact this particular purple journal, seemed to be full of names and quotes and pages.

…Read this …and that…and this…and

…..

…She read her words which were written in bold bright coloured markers, each trying to be louder and more important than the other flicking over the pages, one by one, heavy important referenced words about **autoethnography** and everything - who said ? The words vulnerable, transformative, resistance

Autoethnography seemed to be where I was at, relieved to read about others being too terrified to write in case there was nothing (McCormack, 2014, p.213)

'I am accepting myself as socially constructed …I am 'messy[25]' ……. capturing the cultural day-to-day identity work as messy'.

[26] **'right relationship to the present— to things, to others, to oneself— one must stay close to events, experience them, be willing to be affected and affected by them'**

'I am taking all my clothes off'[27] freedom …uniform/wrapping

'I am learning to write and tell stories of self against the grain of hegemonic discourse'[28]

subjugation[29]

'as individuals are made social, discursively constituted fleshy moments'[30]

Writing as freedom[31].

[25] Grant (2010, p.581)
[26] Foucault (2005, p.18)
[27] Speedy and Porter (2014, p.187)
[28] Davies et al (2004, p.369)
[29] Foucault (1997, p.7)
[30] Davies and Gannon (2006, p.4)
[31] Jackson and Mazzei (2022, p.102)

Reimagine characters (Una, Robert, Betty), academic, reflexive, emotional [32]

How else would their stories be told?

How can I tell my story???

As Transformative

'I am writing at the *micro* (personal) level, autoethnography invites identity work: who am I; how did I become this variant of myself; how might I become more compassionate, understanding, and engaged; what social locations do I occupy, and how do those foster, shape, and constrain my opportunities and challenges?' [33]

'Autoethnography is **vulnerability, fosters empathy, embodies creativity and innovation, eliminates boundaries, honours subjectivity, and provides therapeutic benefits**'[34]

a shift in the person's meaning perspective [35]

Autoethnography and' 'the methodological margins'[36]

[32] Baum (2021, p.90)
[33] Adams et al (2021, p.21)
[34] Custer (2014, p.13)
[35] Mezirow (2000, p.81)
[36] McCormack (2018, p.82)

entanglement of method, analysis, art and representation and is both a product and a process[37] (Ellis, 2011, p.27).

highly subjective [38]

emerging from agitation……. personal or cultural awareness.., curious, frustrated and committed to social advocacy, equality and change[39]

Resistance

academic labour in an age of uncertainty[40]

> 'Because the research practices of autoethnography are indivisible from its moral commitments to empowerment, relationship, possibility, and ontological reflection, it clearly stands in opposition to neoliberalist values of conformity, objectivism, free market capitalism, and protecting the status quo. Neoliberalism frames individuals as units of production whose value resides in their ability to navigate through and 'win' the game of life—presumably by dying with the most toys. In contrast, autoethnography calls human beings to reflect on their experience as agents in relationship to others and to derive value/meaning from that experience and those relationships'[41]

Vulnerability

[37] Ellis (2011, p.27)
[38] Chawla et al (2018, p.3)
[39] Pelias(2019, p.20)
[40] Foster(2017, p.320)
[41] Bochner and Ellis (2016, p.320)

'position of vulnerable self-disclosure'[42]

'a back-and-forth movement between experiencing and examining a vulnerable self and observing and revealing the broader context of that experience.'[43]

observe ourselves observing, that we interrogate what we think and believe, and that we challenge our own assumptions, asking over and over if we have penetrated as many layers of our own defences, fears, and insecurities as our project requires.

that 'human beings are relational beings, and thus every story of the self is a story of relations with others'[44]

focus on relational patterns of personal experience—encounters, reactions, and interactions that happen repeatedly-and our close connections with friends, families, workplaces, and face-to-face and virtual communities[45]

My phone pinged. A text message from Robert. I put my journal down and looked at my phone.

Sorry about that. Almost done here, free now.

[42] Du Preez (2008, p.516)
[43] Ellis (2007, p.14)
[44] Bochner (2017, p.76)
[45] Adams et al (2021, p.3)

Margaret walked over to his desk in another part of the building and decided to put away the thoughts about her journals for the rest of the day. They had a habit of unsettling her.

He was just finishing his call

so

….she decides to get him a ..

.. coffee from the shop….

'of course, see you then'. Robert says flatly, putting the phone down.

He sat and looked at his laptop and all the paraphernalia on his desk.

Another year, still on a temporary contract and the precarity continues (O Neill, 2015, p.6). Still unclear about what subjects he is teaching, and he was now a year leader for first years. So much work in first year undergraduate nursing.

How am **I** ever going to **know** all of **this**?

Exams, assessment schedules, planners, marking grids, assessment workloads, feedback, moderation, failing, timetables, teaching plans, learning plans, action plans, Moodle, marks standards, grids, reference tools, modules, outcomes, objectives (are they the same?),

Sigh

meetings, boards, programme boards, assessment boards, curriculum, descriptors, designs, continuous assessment, summative assessment, formative assessments, external examiners, internal examiners, online, offline, clotheslines, deadlines, learning, collaborative, support, contacts, contracts, probation, drafts, papers, posters, plans, spiral, emancipatory, collegial, stationary, white boards, flipcharts, bluebooks, black books, new books,

Sigh

inclusive, exclusive, deep dives, literature, libraries, local, focal, coffee and cake on a Friday, supervision, indicators, texts, methods, meanings and motives, conferences, critical, reviews, evaluations, probation, vacation, key fobs, access, platforms and plateau, chips on a Monday, calendars, spaces and places and so much to learn. Hitting the ground running, short-staffed.

Robert sits and looks at the blue book, recalling his first day , last year.

What a flapper Margaret is, he thought.

Flapper or not, she had already landed him with repeat papers to mark, which needed to be marked by Friday. The turnaround times were ridiculous, he thought.

How am I supposed to do this? I didn't even teach the subject!!!

-This is just not fair, I'm only in the door, just one year behind me……this isn't sound educational practice, not fair on the student, not fair on me, not fair at all, he muttered.

Asking for help on year two might not look good and anyways, he would figure it all out as he went along. He hadn't corrected repeat papers before.

He decided that the best way was just to start, hearing the words of his late mother and mentor mar a deir an seafhocal, 'tús maith leath na hoibre'.[46]

He opened the essays and began to read an essay about the local history mental health nursing.

[46] A good start is half the work.

But he was only a junior he thought to himself, on a temporary contact.

He had just better get on with it.

Better not to make a fuss. Another year's contract is another year's work.

Precarity is a great sauce.

Margaret returns with coffee

Knock Knock? Anyone in?

*-Anyone **in-sight?***

Not funny anymore Margaret!, Robin says curtly

Sorry, can't help it. Classic. You look busy

Yes, yes I am . Marking essays.

Ah corrections. Marking is a curse but needs to be done. I know I left you with the repeats, but we are so short staffed. Psychiatric nursing never gets its fair share of anything. Never did. Never will. And that includes the number of lecturers.

Seriously?

Fraid so.

Why is that?

Because that's the way it's always been. Well yes and no really. There are lots of reasons for it, but we are smaller and less significant. On the margins, I suppose.

Even though you have the same student numbers?

Yes, despite that

-I think that general nursing is seen as a priority because medicine is seen to be more important than psychiatric. General nursing is seen as better, and everyone knows what a general nurse

does, not so with psych[47] *nursing. Many psych nurses do not know what they do anymore or indeed who they are. Many lecturers do not really know what mental health lecturers do and --we hardly know ourselves these days !*

-Seriously, the CAO points are higher and there's less stigma. You won't hear too many people with schizophrenia or psychotic depression ringing up RTE complaining about their treatment or not getting a bed, but you will when it comes to Accident and Emergency or cancer. Bodies matter and that's the way it is.

I know it's a lot of marking Robin, but I really need tomorrow off to study. I am so behind.

..I've left you some notes on marking and my papers also, so you can see how I marked.

Oh, great thanks appreciate that, how's your research going?

The Doctorate?

Yes, what is it again, ?

Higher and Adult Education.

I meant your research?

Oh yes.

It's about my professional practice as a mental health lecturer

In what way?

Everything. I just want to rant. (laughs loudly)

…O.K. Then ranting is good.

-Theoretical Ranting.

-But seriously what is it about?

-It must be about something ?

Lots of things.

Its everything !

[47] Psychiatric Nursing is often referred to as *Psych* among mental health nurses.

Look around you Robert !

…Me, these walls, these windows, my story, the self, auto, mental health, education, mental health education, why we do what we do, and we continue to do it without asking questions and the why and the why and the why of it all. Teaching to order-feeling like a robot half the time. The medical model. The medical model and psych nursing and pathology and the biological construction of mental illness, and all the waffle and higher education and feeling small and being small in a big pond, neo liberalism[48] (McGregor, 2001, p.83) *and social justice and people who are treated badly and so on and so on…and not really about the medical model, partly…mental health nursing, why are we not active?*

Neoliberalism ? In mental health ?

Yes !

What do you mean?

I mean that, for one thing, neoliberalism is encroaching on my capacity to keep mentally well because of the ongoing demands it places on my life (Fraser et al, 2019). The constant busyness *is detrimental to my health.*

How does this relate to others ?

Well, neoliberalism is at odds with mental health policy as it emphasizes self-interest, competition and efficiency (Gooding, 2016, p.33) '*and, as you and I both know, many people who use mental health services have multifaceted complex problems of poverty, isolation, lack of support, difficulties in accessing healthcare and education, etcetera, so solutions are not always immediate.*

Now we see increased privatization, commodification and franchising out of certain elements of mental health care like alcohol, drugs and anxiety' (Esposito and Perez, 2014, p.420).

These are more lucrative and let's face it, if a patient relapses it's easy to lay the blame on them.

[48] Neoliberalism is a doctrine that spans economic and social philosophy, characterized by individualism, decentralisation, and deregulation. The theoretical assumption of which is that the free functioning of the market forces leads to a better utilization and allocation of resources, guarantees a better satisfaction of the requirements of consumption and bigger balance of the foreign trade, and altogether produces higher economic growth and therefore development. Neoliberalism defines human beings by the market (Monbiot, 2016)

Look, Robert who is really interested in older people who are deemed SMI[49]' (NICE, 2018) *and in poor physical health, dependent on psychiatric drugs, no longer able to be as productive as they once were? Like the Paddy's and the Una's of this world.*

Think about the impact of the Biomedical model……

Not that again Margaret !

*Listen to me please, even the biomedical model fits in well with market principles due to its emphasis on standardised treatments, such as medication, managed healthcare for individual pathology (*Brijnath and Antoniades, 2016), *again neglecting the social and emotional elements of people's lives.*

…It's not just patients who are impacted ……..

-Nurses too !

…the amount of excessive compliance driven administrative work, filling forms to support such systems, taking nurses away from their patients, the risk forms, the protocols, defensive practice even the care plans[50]…….writing about writing about what you intend to do instead of having the time to do it !

But care plans are a legal requirement, Margaret.

-I know that ! But why?

…I don't recall Betty spending her time away from her patients filling endless forms and yet she might have been the most politically active in the way she cared for others, weaving as she did in and out of those day room chairs, smiling, embodying care as simply nurturance. (Duffy, 2005, p.67)

…I've never met a patient who complained about not having a care plan[51], but I've met loads who have been treated badly, spoken down too, discriminated, and not given proper access to care options. It's as if the art of keeping distance and writing about people is more important but this is all administrative governance is really about 'control and power,'(McKeown et al, 2017, p.455).

[49] SMI refers to Serious Mental Illness which includes Schizophrenia, Bipolar Disorder.
[50] Care plans provide a record of care interactions and progress of patients and have been a mainstay of nursing since the 1980s

-Coffey and colleagues (2017) argue that care planning endeavours 'may be an illusion, grounded in fictional narratives surrounding record keeping and the records themselves et or outright delusional (p.12)

...And

..Furthermore

...How many TDs were nurses ?

-why are we as nurses not politically active? more engaged like mental health educators are in the UK? More vocal, look at the nurses strike at the moment, even the RC[51] *are supporting it?*

Now there's an Act of collective resistance!

We don't stick together Robert. We are compliant, docile how can we shape future nurses to go out into the world and change things if we can't change things ourselves

Like what, Margaret?

-What do you want to change?

Everything!

-Our identity, mental health care, feeling small, power, resources, mental health nurse education, fighting to be heard, to feel heard, we are up against it, even from within nursing itself. Even inside these hostile walls.

Maybe it's about honesty!

And photocopiers? he asks smiling broadly.

Yes, very funny ! I am steering clear this year too, Robert.

Blazing embarrassment freezes my vocal cords giving me time to think.

Dishonesty?

About the photocopier?'

-No! the dishonesty about what we do Rob, about what we teach, why we teach it, our inability to resist what we are up against, - a small team in a bigger team.

[51] Royal College of Nursing is a trade union for nurses in the UK.

-Robert, I think I am burnt out. I am anhedonic.

-Like the burnt-out schizophrenics who lie on their beds all day?

-A catatonic, anhedonic in need of gin and tonic…

The playful words break the flow.

We both sit and stare at the large institutional walls in the office on a tired Tuesday.

(I am a little worried that my discontentment may infect him)

Imagine if people were watching us now from the old days, the patients laughing their heads off at what a mess we were making of it all. And us thinking we were smarter, more sophisticated, enlightened than they were. If the institutions knew what was ahead of them maybe, they might not have closed down. Hospitals becoming places of learning while still behaving like hospitals.

Sorry Rob, I am rambling.

Your thesis, Margaret?

-There is a thesis I assume.

Oh yes, a nod to convention for sure, there is a thesis. A scholarly insipid exercise. And I have no idea of what to put into it. There is so much to be said.

So much I want to give voice to so I will start with myself.

-In research, it is better to start with first principal Margaret, says Robert seriously.

-Above all else this is about…I start to wonder what is about…

…I inhale deeply and on expiration mutter……

It is about my practice as a nurse educator still inhabiting psychiatric nursing education.

No one will read that Margaret, sorry.

-Why not do something on injections, everyone loves injections, nurses will read that.

I could not stick four years of thinking about injections, I am not that way minded, Robert.[52]

No, I want to do something about the way I am feeling about this work.

That is, it?

Yes, that's it.

What do you think? Honestly?

You want me to be honest? With you Margaret?

No! (laughing nervously)

It's a bit been there, done that, we all know that. Nothing new to see here, move on. Hardly going to light any publication fire now, is it?

-I know I am being candid, but I have a few publications under my belt which should help with securing a permanent post… (Singh et al, 2020, p.736).

Yes, I saw that.

Well done you

But how old are you, Robert?

Twenty-seven.'

A child.

I have been qualified for as long as you have been living, scary.

God, I want to retire. I have a novice telling me what to do !

Well, a PhD is a marathon, long haul so you need something that sustains your interest and is of interest to others, your peers. So, you get published.

Maybe I do not want to be published, Robert.

You will want to be published. Believe me.

-What's your population size?

One.

Sorry?

[52] I need to confess to the reader that I started the Doctorate with the intention of researching knowledge of injection technique, but my supervisor advised that I should think carefully about what really mattered to me before choosing a research topic.

One.

…Just me.

You?

Yes, just me.

-I am researching myself, sort of.

How so?

Autoethnography.

Ethnography?

No. autoethnography.

-It is a creative, critically reflexive approach to research that involves me writing about my practice.

Qualitative Research ?

Perfect for mental health. Messy ambiguity, where everything is contested.

Ok.

-But with all due respect, Margaret, no one really wants to hear what you have to say about whatever it is that you are saying.

-My PhD looked at 'Compliance with the new restraint framework in mental health.

…Big survey. Big data. Lots of impact.

Well done Robert!

That's our problem Margaret.

'Our?

Yes, our, mental health nurses I mean.

…We are always at the back of the queue when it comes to everything. Resources, budgets, priorities, research.

…Research is the way forward. The more mental health nurses become involved in mental health research the better things will be for us as a profession.'

-You don't agree Margaret?

I suppose Rob, but I see things differently. I think turning the gaze inwards might not be a bad idea.

How so?

Instead of counting compliance rates with the new restraint framework I would want to know why there is a restraint framework in the first place. Might it not be better to ask why restraint is commonplace and that nurses are actively retraining people or even why there is a need to count how many times it is done to be compliant? Whose compliance is it anyway? Surely this is about the why rather than asking how many?

Was it Steiner (2000) *who said that 'education becomes either an instrument to help learners deal critically and creatively with reality to transform it through participatory action or an instrument to integrate learners into the present system by means of conformity?*' (p.10)

Dialogue, Discussion Democracy, Robert, I argued.

Ok don't get on your high horse Margaret.

…Change of subject now, sorry.

-Did you collect your pass key, to sign into the building?

Sorry Robert I promise to get onto it on Monday…. It was so hectic last term I forgot to do it….

Can you sign me in please Margaret?

No problem, Robert, I will sign you in for now.

Only temporary. Promise.

Like the 45?

Indeed. Like the 45.[53]

Robert made himself comfortable and started to read Margaret's marking notes before marking the repeat essay.

The essay title was….

[53] The 45 was in reference to the 1945 Mental treatment Act (Ireland) and the *temporary* nature of committal of patients to psychiatric hospitals which was often in reality not temporary resulting in lengthy hospital stays.

Discuss the historical development of psychiatric nursing in the West of Ireland. In your answer make reference to the building you are currently studying in and the historical implications of that. ***(100 marks)***

As he started to read the student's work, his mind started to wander, his attention waving between thinking about his role as a lecturer and hoping that year two was just that bit easier on him. He felt constantly tired and a bit stressed.

Signing in

This old, very old building was once St Mary's Hospital. A large rambling building with several wards, a hospital infirmary and its own farm ensuring a large degree of self-sufficiency, it provided psychiatric care for the people of Mayo and beyond.

Ireland, not unlike other countries, has always found ways to lock up mentally ill people and the asylums were an effort to do that according to law (Kelly, 2016). A nationwide asylum system was established in Ireland in 1817 which set the foundation for a culture of public asylum confinement and provided the legal basis for the establishment of a network of district asylums throughout Ireland. The state authorized the creation of public asylums intended exclusively for the *lunatic poor* and these institutions, which became known as district asylums, (Finnane, 1985 cited in Mauger, 2017, p.4). Many people were not mentally ill but the legislation in describing pauper lunatics afforded the poor and destitute a refuge from poverty despite their poor conditions.

Less that seventy miles from my favourite classroom lies the origins of the first psychiatric institution in the West of Ireland. The Connaught District Lunatic Asylum (CLDA) was established in 1833 for the care of the lunatic poor (Walsh, 1999, p.132). Kelly (2019, p.60) explains that the 'counties in the west of Ireland, such as Galway, Mayo, and Roscommon, were particularly badly hit by poverty.'

As Ballinasloe was a purpose-built modern building and there was a concern about insufficient numbers of lunatics, an advertisement was placed in the local papers advising the public that

the asylum was now open for admissions. The invitaion was, not unsurprisingly, well received with admissions pouring in from neighbouring areas and included families in dispute who wanted to *sign in* their relative. Familial disputes about farm holdings and succession rights were not uncommon reasons used by families to commit loved ones to institutional care. The absence of a recognised mental illness did not seem to deter many referrals. As the numbers increased in Ballinasloe it was decided to transfer people who had originated from Mayo back to their own county where provision for their stay was now finally possible.

The Institution

St Mary's Psychiatric Hospital, the original building we were now in, was opened c1866 to accommodate an ever-increasing number of patients from St Bridget's Hospital Ballinasloe (Connaught District Lunatic Asylum) which had opened in 1833.

It is reported that 132 patients were carried by donkey and cart from Ballinasloe to Castlebar into the newly established hospital because of overcrowding (McDermott and McDermott, 1999, p.15). Ireland readily adopted the asylum system because there were numbers of *lunatic poor* people who had nowhere else to go and resulted in a growth in the number of patients in institutional care. This further compounded fear and stigma about mental illness in Ireland at the time. Moral treatment (which is the basis for the Recovery Model of Care) was first introduced in the UK by William Tuke[54] and was based on treating the mentally ill with compassion, kindness, and the pursuit of useful activities to improve mental health. This was not widely evident in Ireland.

St Marys hospital, not unlike others, became a place of refuge for the poor, the miserable and the hungry. Inpatient numbers grew in the Castlebar facility not unlike other institutions in Ireland., with a worldwide growth in the institutional care of the insane (Walsh, 1999, p.30).

Between the 1800s and the 1900s there was an *epidemic of asylums in Ireland not an epidemic of mental health problems* (Kelly, 2019, p.953). There were over twenty thousand (20,000) people incarcerated in mental institutions, again not because of an increase in mental illness but

[54] Sir William Tuke (1732 – 1822), an English tradesman, philanthropist, and Quaker, earned fame for promoting more humane custody and care for people with mental disorders, using what he called gentler methods that came to be known as moral treatment.

because of social, political, and economic factors which impacted on the rates of admissions to hospitals (Robins, 1986). Such institutions were run like prisons with intolerable conditions and an absence of any evidence of care. Most counties had a psychiatric asylum as it was a policy of Robert Peel (1820) who, as Home Secretary of the United Kingdom and Ireland, was an advocate of moral therapy at that time.

The importance of the psychiatric institution to the locality against the backdrop of a colonized country with little economic activity could not be underestimated, as the institutions generated the only source of wealth - employment. Kelly, in his book, explains that,

> Everyone else, they were all either working in the asylum, supplying the asylum or had a family member in the asylum. So, when doctors tried to reduce the size of the asylum then local and national politicians blocked it immediately because these were economic powerhouses for towns. (Kelly, 2019, p.206)

Soon these institutions became overcrowded, and their organization and management became problematic due to the high number of patients, the complexity of presentations, the escalating costs of running such places and the increasing attitude from the public towards the inmates as they were then described (Robins, 1986, p.55)

This era of large Victorian mental institutions providing care for the mentally ill was not unique to Ireland. In the UK the experience was similar. Such institutions were not attractive places to work, and the recruitment of staff became so difficult that in many cases the primary asylum carers were often former *inmates* themselves who later became known as *attendants* according to Nolan (2003, p.33).

The role of the attendant was exactly that: to attend to the needs of the patients as they presented. Many of the original carers in such workhouses and infirmaries had been inmates of these institutions and after their care were allowed to remain in exchange for assistance with ill and infirm residents (Walsh, 1999, p.20). There are well documented cases of such staff being difficult to manage, with drunkenness and a lack of any caring disposition (Walsh, 2005, p.135).

To improve the profile of the asylum employee some institutions in the UK began to identify such carers as *attendants* or as *asylum nurses*. The men wore long white coats which were

buttoned up, a tradition which remained until the late 1980s in some psychiatric hospitals. The role of the attendant still casts a long show over psychiatric nursing. Similarly, there were attempts to upgrade asylum nurses (a term which seems to be more commonly used in the UK), who benefited from the implementation of skills proficiency training in some of the mental health institutions (Kelly, 2016, p.100).

However, this did little to improve their image and such asylum nursing became associated with immorality and brutality (Brimblecombe, 2006). It was considered the least attractive of all nursing disciplines. The image of asylum nurses as being, collectively, largely involved with the physical controlling of violent lunatics and, individually, being unreliable was perpetuated in popular fiction. Charles Dickens, in his 1844 novel, *Martin Chuzzlewit*, described this articulately in his depiction of the asylum nurse *Sairey Gamp*.

The well-publicised nursing efforts of Florence Nightingale in the Crimean War (1853-1856) did not benefit asylum nurses to the extent to which it might have. Asylums were mainly runto keep *lunatics* away from their communities and the emphasis was on the smooth running of the institution rather than on clinical diagnosis or therapeutic interventions. In Ireland the situation was similar as it was more preferable for females to work *in service* as servants rather than to work as attendants in the asylums. Conditions and renumeration were better than in the asylum. Psychiatrists were seen as powerful figures, and many were employed as RMS (Registered Medical Superintendent) with accommodation privileges on the site of the institution and a generous allowance. Some of those buildings remain intact today.

The End.

Feedback as follows:

Good attempt but the ending needs a lot of work. Try and consider the reader. Make an appointment with the Help with Writing Centre (HwWc) who will teach you how to do this. 40 marks awarded.

Dr Robert Williams

Lecturer in Mental Health Nursing.

Margaret sits down to study but feels guilty about asking Robert to mark.

Thinking

The sooner he learns the better for himself, she thinks. It's hard on everyone at the start. But as educators my sense is that sometimes we can forget that new colleagues are learners too.

Do you agree?

All around me I see the weight of history bearing down on practice today. The reliance on the custodial and medical model, care which was highly structured and regimented delivered by staff who were themselves graduates of the asylum, echoes in the walls of the classroom where I work. I wonder if remnants of that era remain in the hearts and minds of some psychiatric nursing staff.

Robert is *still* marking.

One more to go.

Year 4. Thank Heavens, this essay might be better, he thinks.

Critically discuss the professional development of psychiatric/ mental health nursing in Ireland. In your answer, refer to your current learning environment. (100 marks)

As nursing became regulated, due mainly to Nightingale's (1859) seminal work, the asylum nurse did not benefit from this newfound respectability and developing nursing knowledge. *Asylum nursing* was considered lower class or *lesser than* whereas general nursing was considered more middle class. One of the main reasons for this discrimination was that asylum nursing was seen as a very basic form of domestic service (Kelly, 2016, p.40).

At the time, staff in St Mary's Hospital who cared for patients were referred to as *attendants* or more commonly *keepers* (Mc Dermott and McDermott, 1999, p.22).

Attending, Keeping and Nursing.

In the UK, there were many attempts to *professionalise* asylum care with attendants attending training sessions with a view to increasing the number of 'intelligent nurses in asylums'

(Stewart ,1876, cited in Sheridan, 2006). It was also suggested that staff should not be selected from the same ranks as patients but *rather should be better educated, more refined in feelings with sympathetic hearts*. Stewart (1876) further identified the absence of an adequately trained staff within the asylum system as one of the primary causes of the lack of advancement of psychological medicine in Ireland.

However, it was not until 1889 that a certificate of competence was introduced as a way of enticing attendants to learn new skills and 1890 the Medico Psychological Association (now the Royal College of Psychiatrists) established the 'Certificate of Proficiency in Nursing' to improve the training of mental asylum attendants. The MPA's *Handbook for the Instruction of Attendants on the Insane,* was first published in 1888. By that year, a full three-year curriculum had also been developed, although it was not implemented until after the war in 1919, which had the impact of professionalising nursing work. The curriculum placed emphasis upon the practical elements of patients' physical needs – there were chapters on The Body, Nursing the Sick, the Mind and its Disorders, Care of the Insane and the General Duties of Attendants – and kept the increasingly scientific discourse of psychiatry in the hands of medically trained men (Walsh, 2005) in deference to the medical doctors who were considered the only staff with expertise. Such was the advice on which such nurses operated.

> *'Never express any opinion to the relatives or friends of the patient as to the progress of the case, but refer them to the medical officer, who alone can give a correct opinion'*

(Winslow's Handbook for Attendants on the Insane (1877), cited in Walsh (2005, p.12))

The task of professionalizing mental health care was also made difficult from within the profession itself because of disagreements between employers on duties, pay and responsibilities, which varied greatly within Irish institutions. The profession of mental health nursing has always been trying to improve its status, through pay and conditions and education and its relationship with the public. Similar experiences were felt by their general nursing colleagues at that time but to a lesser extent.

The move to establish a nursing union to seek better terms for workers saw the establishment of the British Nursing Association (BNA) in the UK. Despite an agreed protocol for training

asylum attendants to become nurses there was general acceptance among the wider nursing community that asylum nurses were not and could never be proper *nurses*. This was evident when, in 1928, an attempt by asylum nurses to join the BNA was expressly refused on the grounds that they represented an inferior category of carer. Mrs. Bedford Fenwick, the founder of the British Nursing Association, was absolutely opposed to the admission of asylum nurses to the BNA, declaring 'one can hardly believe that their admission will tend to raise the status of the Association',(Walsh, 2005, p.29).

It could be argued that psychiatric nursing suffers from an image problem. The transition from the attendant to nurse has been a challenging one for the profession and this has beleaguered the profession in both the UK and Ireland to this day. Similar experiences were shared in America too. The formation of a union in 1917 (The Lunatic Asylum Officials of Ireland) to address terms, working conditions and the unskilled tasks which trained keepers were now being asked to do yielded little reform (McDermott and McDermott, 1999, p.4). Life as an attendant nurse was difficult with long hours, poor pay, and conditions.

Attempts to address role clarification in psychiatric nursing became problematic as there was no formal agreement on what asylum nurses did. The idea of classing psychiatric nurses as domestic servants continued up until the 1970s in America which resulted in keeping the status and salaries low and the profession remained unrecognized by employers (Peplau,1978; 1994; 1997).

In Ireland the attraction of receiving additional renumeration for successfully completing the MPA training was instrumental in encouraging attendants to train as nurses and in 1898 seven attendants received such certificates and an annual wage increase of two additional pounds in Tullamore. In 1950, the GNC was replaced by An Bord Altranais (Irish Nursing Board) and in 1955 the Psychiatric Nurse Training Syllabus was revised.

The practice of training attendants to become psychiatric nurses continued and they were admitted to the newly formed An Bord Altanais (ABA) in 1951[55]. Poor working conditions within any mental institutions in Ireland resulted in psychiatric nurses becoming increasingly

[55] An Bord Altranais (the Board) was established by the Nurses Act 1950 to take over the functions of two bodies: the Central Midwives Board and the General Nursing Council, which had been established in 1918 and 1919, respectively. The Board was reconstituted, and its functions were redefined and expanded by the Nurses Act 1985 and 2011.

militant and in 1970 the Psychiatric Nurses Association (PNA) was formed because of increasing industrial unrest. This remains the majority trade union today.

The End.

Robert enjoyed reading this student work but did she put enough emphasis on professionalism, on what it means to be a professional?

Feedback as follows:

Good attempt but the ending needs a lot of work. As a year 4 student you really need to be able to consider what it means to be a professional nurse and what that might mean for mental health nursing today. 60 marks awarded.

Dr Robert Williams

Lecturer in Mental Health Nursing,

That is enough work for today, he thought. But he had not finished yet.

But

Did that work deserve a 60 or a 70 or maybe a 40 or a 50? he asked himself? Who decides? Marking schemes are useful deciding actual marks feels 'fuzzy' and imprecise (McLoone, 2012, p.2).

Maybe I am being too strict he thought, but it was an important topic. Being *professional* is an important part of psychiatric nursing, for a variety of reasons. Firstly, there was belonging to a professional group, being educated to a certain, prescribed, standard, ongoing CPD,[56] a rigorous

[56] Continuous Professional Development.

Code of Ethics which is determined by the NMBI (2016) as the nursing regulator. But was that the same as 'professionalism'[57] (NMC, 2022) he thought ? It is a 'problematic concept because it is socially constructed and in a state of flux' (Fitzsimons, 2017, p.199).

But did *being professional* mean the same thing for nursing students as it did for nursing staff? Was it fair to expect students to be professional when they were still learners? Did one negate the other? What did that actually mean and was professionalism the same for all disciplines[58] of Nursing? Might that mean therefore that mental health nursing is a *lesser* profession? Or was it possible to be professional in the absence of a professional identity? (Connell et al, 2022, p.475). Robert thought about his feedback, and the idea of thinking of students as *professionals*, he was beginning to think his role was much more complex and messier than teaching alone.

It was now 6.30 pm and the afternoon had escaped him. The day was hectic, spending time trying to plan induction for the *first years,* and he was already tired. Nurse education was, he agreed, a complex and demanding role.

He started to think about class content for the first years next week and how he might approach the subject of Professional Development and what it means to be a professional care giver, deciding that his first class could explore *The closure of Psychiatric Institutions in Ireland*. He felt that it was important for student nurses to have some sense of the history of their chosen career but would that work? I wonder what the learning outcomes say about this?

He jotted down some ideas, starting with the closure of the old psychiatric institutions and the move towards community care. Maybe a walk around the building might be in order.

Changing Times.

For many reasons the transition from hospital to community care (DoH, 1984; HSE, 2006) has been slow. As Kelly explains,

[57] Professionalism is characterized by the autonomous evidenced based decision making of an occupation who share the same values and education. Professionalism in Nursing and Midwifery is realised through purposeful relationships and underpinned by environments that facilitate professional practice, demonstrating and embracing accountability for their actions

[58] Disciplines of Nursing refers to Divisional Registers in which Nurses are registered. These may be psychiatric (mental health) General Nursing, Intellectual Disability.

‘The old concept of nurses protecting and caring for the patient, attending to his every need, is, in many cases now seen to be damaging to the patient and detrimental to his chances of recovery. The nurses’ job is now seen in the context of his helping to build a free, independent, and self-reliant person and by permitting and encouraging the patient to do things for himself, thereby maintaining and if necessary, restoring his independence and self-respect’.

Kelly (2016, p.223)

However, the pace of mental health reform in Ireland has been very slow and despite the 1966 report on planned closure, little was done until 1984 when an updated report *Planning for the Future* (DoH, 1984)) was issued to plan for the closures! The economic recession of the 1980s in Ireland meant that little mental health reform took place, and it was not until 1996 that an action plan for the 1984 policy in the form of a comprehensive community based mental health care service was published. Again, reform was slow despite being advocated by the WHO[59] and the WPA.[60] And this was mainly due to the poor economic climate at the time.

For me, the seismic shift in policy was as much to do about the people who lived and worked in those institutions rather than the buildings themselves. The impact of this transformation from hospital to community was described as *bewildering* for some nurses.

The narrow emphasis by policy makers on the closure of buildings and the geographical reallocation of patients from old institutions to community care was pitiful and disturbing and not without its criticisms. In the UK, concerns about increased homelessness (Leff, 2001, p.381) and complaints of a lack of integrated system of care for high-risk patients following the death of Steven Zito[61] necessitated a policy change to improve the interface between hospital and community care. But, despite concerns, psychiatric hospitals have closed, and all the patients have moved out despite living there for years. (HSE, 2006)

No one asked the patients how they felt about leaving their homes.

[59] World Health Organisation
[60] World Psychiatric Association.
[61] ~~Steven Zito was killed in1992 by a~~ man with a long history of paranoid schizophrenia and who had stopped taking his medication. Criticism was not supported by services as he migrated between various healthcare jurisdictions.

Jan's story - Pretending to Transition

I worked with Jan in the UK in the early 1990s in one such community-based transition care project.
It was Jan's role to oversee a group of six men to leave the mental institution where they had each lived for over fifty years and move them one hundred miles away to their newly identified home.

It was a Friday morning. The weather was sunny but with a strong chance of sadness. Jan had just arrived at the office and was late as usual. Laz, a colleague, had already started the coffee pot. *Mental medicine* as he called it.

Jan was feeling agitated and was smoking her third cigarette and it was not yet 10am. She had a headache and had not slept. Her head felt sore.

'I don't feel great about this, to be honest Laz, I just don't.'

'It's progress Jan, just think of it like that.

'Progress, *my arse*.'

'Language Jan!'

'Sorry.'

' it's not progress, it's sad. Just sad.'

' How can they do this? to them?'

'Above all people.'.

'I know, I know, but as they say 'not my circus, not my monkeys'. Whatever that means'.

'…To lock them up for years…and years. No fault of their own. Rotten Laz'.

'Those were the times…back then. They did what they could …what they thought was best'.

'That's what when on back then' 'People taken under the '45 Act[62] away from their homes, and families. *Social deviants*.'

[62] The 1945 Mental Treatment Act (Ireland).

‘But they were not deviants.’

‘Persons of Unsound Mind,’ said Jan

‘ Well, my mind is unsound now, Laz’, said Jan, wistfully.

‘They were the poorest of the poor, trouble over wills,

unmarried mothers, learning disability.’

‘What time Laz?’

‘About 11, I think. The bus is booked for 11. So that way they will arrive there just in time for lunch, Jan.’ ‘All sorted then.’ (sarcastically).

‘They know, they know. I just know it.’

‘Yes, Jan they do.’

‘*Blessed be the cracked, for they can see the light…’(Milligan)*

‘Looks like it’

The bus arrived just before 11 o’clock. The six men were waiting, eagerly anticipating the move.

Christopher was a man in his sixties, or so it was thought. No one including himself knew his actual date of birth. He was given the nominal birthday of the 11th of August by staff at the psychiatric hospital, when no record of his birth was produced.

He was a LEO. He told people that.

‘like the lion, I’m only stronger,’(wink)

He had been in the institution forever. As long as he could remember. Forever.

‘the nerves, the nerves got to me, and I wasn’t sleeping.’

‘But I sleep great now.’

‘I hope I sleep in the new place. I’m getting a new room all to myself and a double bed, fit for a King, and there might be room for you, Jan, what do you think?’

The men smiled at Christopher’s brazen, delusion of grandeur. But inside they were scared.

Tom was seventy-two. The second eldest of the men. He was admitted when he was thirty and never went back home. Rumour had it that he did not get on with his elderly father and there was a dispute over land inheritance and the woman he had chosen to marry. She *was nothing* and *had nothing* and by marrying her he *was nothing* too. He reportedly assaulted his father, who later begged the judge for him to be committed for treatment as he was not right in the mind. He didn’t want his son going to prison. He wanted him fixed.

‘Are you ok there Tom?’

‘Yes thanks, nurse, I am.’

‘My name is Jan; call me Jan I’d prefer that.’

‘I will nurse, I will.’

Liam Og was the 7th son of the 7th son. He was special. He brought honour to his family in joining the seminary to become a priest.

He committed a crime. Falling in love with a man was shameful and broke the law. He was both 'mad and bad'.

Michael Mc was now 72.

An old man with a new suit. He couldn't understand why he got a new suit. It wasn't Christmas. It was a nice new tweed suit, *nothing spared*, he thought gratefully. But why did he get the new suit? It was a nice suit and fitted well. But he hadn't asked for it. They said it was for the move. The move to his new house, his new room and he needed to look smart.

He hoped that things could just stay the same, that's all. He was tired now and just wanted to sleep.

Frederick was the youngest of the men. English by birth he had always felt he was an outsider. He went to public school in England and was well versed in poetry. He had paranoid schizophrenia with delusions of grandeur. He liked literature and knew all the classics.

He liked to read philosophy and had collected a huge array of books. His favourite was Moby Dick (Melville, 1892). He read it over and over again. It was a joy. It told a different story every time he read it and felt that it was a parable for the world today, such as it was.

He watched as Jan gathered the case notes and put them into her black handbag. She was one of the nicest nurses he met, but she smoked too much. It made her hoarse. Today, she seemed to be smoking a lot and seemed preoccupied in her thoughts. He felt that she was avoiding him

He was angry. Very angry.

He watched in disdain and disgust as the staff gathered up all the men and herded them onto the bus. Jan would not look directly at him. Laz waved them all goodbye.

'I will not be herded, like cattle !!', he said

‘I want to speak to the Manager, right this minute.’

‘We have been over this a thousand times Frederick, and this is what has been decided.

It’s for the best. Please do not make a fuss.’

‘Look at him’

‘Look at him. ‘He’s barely able to stand.’

‘Tom is fine, aren’t you Tom?’

‘See? Everything is grand.’

(Jan felt exasperated and irritated with Frederick. Always speaking up for others in that grandiose voice of his. This morning was not the time for dialogue and arguments. It was the time for moving these men out of the old building and into somewhere new).

Rubbish!!

She knew he was correct in opposing the transfer to the new home but what could she do? It was policy-move them all out into the community. Close down the red bricked Victorian Institutions and move everyone back to where they belonged.

Frederick watched.

Raged and watched.

They were being hunted like the whale. Like that poor whale in Moby Dick.

His heart was sad, speared and sad.

Hunted and herded by the people who once cared for them.

Said sorry they did but hunted and herded anyways. The worst kind.

‘Such a crew, so officered, seemed specially picked and packed by some infernal fatality to help him to his monomaniac revenge’

(Melville, 1851, p.307)

James was tall, very thin. A willowy man with a hollowed out inside.

Black, but not coloured with depression.

His case notes were the leanest of all the men.

Thin and empty. Like him.

Waiting in line, with his white enamel mug like he did every day for forty-two years.

A gross economy of words, the Chief Psychiatrist said.

This patient has…

Poverty of thought,

Poverty of ideas,

Poverty of speech,

Poverty of feeling.

Their consent was not sought, and they had no choice about where they were going to live. They were allocated a nice house with a local lady (Maire) who popped in each morning to get them up for breakfast and usher them onto the local bus which would take them to the day centre.

In echopraxias, the old men left the mental institution and were taken by bus from their home of fifty years to their new home. The men protested at the idea but were reassured that it was all for the best and that their doctor had decided that it was best for them. None of the men had a medical assessment or had a medical review for years. There were no family members and they only people to wave them goodbye were the staff members whom they had known as family.

Jan and her colleague were the last to board the bus and instructed the driver not to delay. None of the men looked back. They sat facing forward in silence and fear.

After a few weeks these six men, who were similar in ages and who knew each other intimately, began showing signs of deteriorating mental health, with altered sleeping patterns and an increase in low mood and agitated behaviour. My colleague Jan, protested to the psychiatrist in charge about the move and asked if the men could be returned to the hospital. He quickly reminded her that, as a nurse it was her role to follow instructions as it was all part of their care plan. Community care was best for people, and they would settle in, in time despite what she had read from Bennet and Morris (1983, p.8) and Craig and Timms (2009, p.265) who wrote expressed concerns about mental health and homelessness in the UK following the closure of the many psychiatric hospitals.

The men showed little signs of *settling* into their new home. Maire who called to supervise them every morning became concerned about the men because they were becoming increasingly anxious and distressed if there was a slightest change in the daily routine, an example being that on Shrove Tuesday, her daughter made them pancakes with additional sweet treats. The men refused to eat the pancakes and despite the young girl's insistence that she was eating some too, only relaxed when she reluctantly made them their daily porridge. These men had had the same breakfast for fifty years. The young student took a keen interest in the men in showing them how to operate the remote control for the television and offered to plan out their TV viewing preferences each evening. This proved a fruitless exercise as the men simply could not decide for themselves.

This pattern of institutionalised behaviour continued until one morning as Jan was due to go into a meeting, she got a telephone call from the lady in the house who demanded that she come immediately.

'Come Quick nurse !'

'Sorry?'

'Come Now, come Quick, Quick!'

'Tom has locked himself in the bathroom, and he won't come out.'

'But the bus is already here, all set to go up to the Day Centre-and the bus driver is anxious to get moving'

Jan approached Tom slowly, he had locked the bathroom door, speaking to him through an open window in the bathroom, He was very distressed, clutching is Rosary beads tightly.

Tom: 'I'm dying nurse, I'm dying!'

Jan: 'No, you are not Tom. You are safe. I am here now.'

Jan: 'What's making you so upset?'

Tom: 'I'm dying. I have the green water. I went to the toilet and now I've the green water.'

Jan: 'What?'

Tom: 'The green water nurse, I'm dying. I have the green water.'

Jan: 'What do you mean?'

Tom: 'Look!'

Nurse: 'I can't see anything Tom.'

Tom: Look down there.

Tom points to the toilet bowl agitatedly. Jan proceeded to look in the lavatory bowl and seen that where Tom had urinated the water was indeed coloured green. She explained to the unfortunate man that the disinfectant used by the house lady had changed the water in the lavatory bowl to make it green to keep the toilet fresh and that it was no harm.

He never accepted her explanation.

Six weeks later two of the men died. One man from a chest condition and another died by suicide. The project was closed, and the remaining four men were transferred to nursing homes. As for Jan, she became depressed and lost faith in her role and the decision makers she worked with. She later described it as a *cruel project* and was angered by her experience. She wanted to dissociate herself from it. Firstly, that psychiatry and society could take grown men from their homes, could with impunity detain them for fifty years. To layer injustice upon injustice, as if that was not enough, they would not be allowed to live out the rest of their days in the comfort of that institution with their own family of friends, with familiarity and whatever sense of agency remained within their beings.

Jan became quite despondent and found it difficult to talk about her own feelings after this episode. She became argumentative and confrontational. I recall her saying that she wanted to *disconnect herself* from this type of work, for it was not the work that she wanted to do. She felt part of a system, a system that assumes that exerted power and control over those whose rights and interests were eroded (Carney, 2008, p.102) a system that continued to be abusive and paid no heed to the voice of the needy and vulnerable person or patients, a system that alienates nurses from patients as nursing work is often organised in ways that squeeze out possibilities for human connectedness (McKeown et al, 2011). These men had no choice or free will in deciding their fate and neither had their nurses.

They were not patients really, they were detainees. To name them as patients meant that they were ill. They were not ill or diseased. They were detained because society made the decision to detain them in line with the societal norms of the time. Their illness was constructed purposefully and continues to be constructed today, albeit in more nuanced and pernicious ways

My colleague Jan left mental health nursing after a long period of extended sick leave.

New beginnings (for some)

Tom's experience was part of Ireland's closure of its mental institutions following release of the influential *Planning for the Future* (DoH, 1984). This landmark policy set about the closure of many large institutions and outlined future plans for reform of mental health care in Ireland.

The planned closure of hospitals, as discussed earlier, necessitated not only service reconfiguration and reorganisation but a significant shift in the way that mental health nurses practiced, moving from task orientated ways to a more collaborative interdisciplinary approach to care. The mindset the profession was transforming was from viewing mental illness as a medical pathology to a newer, holistic care approach, involving hope, emancipation, and recovery.

This had a major impact on the profession as it began to reform itself to keep with the changing policy directives. Increased rights of individuals with mental health problems and the move towards a philosophy of mental health care which was based in recovery and wellness (Barker, 2011, p.60) rather than a medicalised model underpinned by a DSM (2013) diagnosis. The implementation of the new Mental Health Act in 2001 (enacted 2006) to replace the 1945 Act placed legal responsibility on service providers to provide basic standards of care for those who required in patient care, although the act has not been without severe criticism. Services are directing how registered nurses practice within practice, and this is felt by those in nurse education.

Jan's experience of being part of something which she does not agree with, is a reminder to me as an educator, that my role is often conflicted. I often draw on stories from my past to illustrate a point (or more truthfully as a diversion to the handouts) as a way of bringing them with me in class. This is one story I do not tell because I fear that it may sour their taste for this type of work and that such injustices are not so distant, they are often quite close. In addition, it somehow feels that as an educator I am endorsing government policy by translating and teaching it.

Nurse educators are choking with the amount and volume of material to be covered in syllabi in order to meet service demands. The role of the mental health nurse has changed, and it is my experience that the *role and identity* of the mental health nurse educator has changed in line with that. Demands to have *off the shelf nurses* ready for practice impacts on my practice as an

educator, which I can claim to be often *futile* and *frantic* and disconnected with building relationships with people, which is at the heart of psychiatric nursing. (Connell et al, 2022, p.472).

2022 celebrated twenty years of the journey of undergraduate psychiatric nurse education in Ireland and curricular content bears little resemblance to earlier programmes in terms of content, design, and pedagogy.

We have come a long way.

I wonder what Tom, James, Frederick, Liam Og, Michael and Christopher and all the others would have thought of all of this.

Robert and Margaret are in her office upstairs. They are both stressed. Margaret is particularly stressed, pacing up and down wondering how she might avoid the inevitable fallout.

I thought you did it Robert, How could you not think of this !

…Gosh we are in so much trouble, mutters Margaret.

How was I supposed to know? This is only my second year here, asks Robert.

You are Year 1 Leader; ordering uniforms is part of your role! is the reply.

It's not an official role, not on my JD and no one explained that to me, replies to Robert, indignantly

-Damn what are we going to do Margaret?

I am not sure; we have never forgotten to order uniforms for first year students before.

I am so sorry Margaret, but I wasn't told that it was part of my role.

No problem. You should have been told when you were asked to take on the task.

-It's ridiculous that our students are wearing uniforms anyways. So outdated.

Maybe we can gets some plain polo shirts, Margaret?

Doubt it, the Uniform is still a big thing in nursing.

-The health sector still expects it.

-Even in mental health nursing.

Buttoning up

John and Mary are both second year student psychiatric nurses on the four-week mandatory general nursing placement in a large city hospital. The ward is an acute medical ward with a mixture of respiratory and hepatobiliary (liver and gall bladder) patients, and most are older men.

John sees himself as a *people person* and dislikes that it is frowned upon to sit on hospital beds and chat to the patients (Kameg et al, 2009, p.503). He hates general nursing and feels out of his comfort zone. He thinks that hospital and in particular this ward is too rushed and many of the staff are not approachable. He feels he cannot risk asking questions in case he is expected to know what he does not.

Mary wants to move back home to Galway after she qualifies but knows that she needs to do her general nursing before she can even be considered for a permanent job in her hometown. Such is the scarcity of permanent jobs, and she needs one to build her own home. Being dual-qualified will help her, she thinks. She enjoys learning new skills and quickly become adept at many of the clinical nursing procedures. She wants to be offered a place to do her post registration nurse training at the hospital and is prepared to put up with whatever is thrown her way to *get on*.

The ward sister sits in the office and eats chocolates. She is respectfully described by all on and off the ward as *old school*, but everyone gossips that she is mad and ill tempered. She has a shrill voice and commands fear in most staff . Most of her time is spent nibbling sweets (with Jan it was cigarettes) in her panopticon office, apart from the odd appearance on the floor when matron *rounds*.

John detests the place, despising the never-ending busyness of the weekday work.

Monday to Monday, every day was busy, busy, busy

the sickness and the smells,

the drips and the drains

the routines and regulations

One biscuit per person.

One visitor at a time.

One staff nurse per ward.

Two students from psych

Two others from general

Two days off

Three new admissions

Three new charts

Three sick people.

Four calls for help

Four legs running

Four rounds of

One thousand

Two thousand

Three thousand

Four thousand

Five thousand

Wait

‘Start again please’

‘How long down?’

Sister comes tearing out of the office and barks an order to *call* arrest. The 'crash team' need to[63] come all the way from casualty on the other side of the hospital and so the two general students and the only staff nurse available, quickly take the lead at the cardiac arrest removing the headrest from the patients' bed and placing the patient flat on the bed. They remove the *bed rails* and throw them under the bed out of the way. Mary runs with the cardiac arrest trolley towards the patient, her heart pacing frantically.

John freezes and decides to walk towards the kitchen. Surely *someone* needs a cuppa.

Sister wants to know where this new patient's chart is.

Mr. Eamon Salter 64 M

is he

An angina?

An asthmatic?

Who clerked him in?

Where is the doctor that admitted him?

She looks around and sees John walking briskly near the end of the ward.

'You, you, yes,you!'

'Come with me now!' she roars out at John.

She runs down towards the kitchen and grabs the second-year student of psychiatric nursing by his coat and drags him over to the patient whose face is smothered by an airway mask.

'Where is *that* arrest team ?????' she barks.

'Bleep them again, staff !!!'

'He needs a line stat. Get that adrenaline into him now, IV 10mg stat !'

[63] The *crash* team refers to the clinical emergency team who are on call in all acute hospitals to respond to an emergency situation where there is imminent risk to life

‘But he has no line.’

‘He needs a line, now!’

‘*You*, useless, put in a line now, stop staring into space and put in a cannula now! Get a cut down set if necessary, plasma expander, get that BP[64] up…. Fluids, where are the damn fluids??

(Did she *say* Damn)?

‘*But, but…’*

‘Do not …But, but me, just do it !’

‘Siiissster I am a ….’

‘Sister, I am a student.’

‘So, what!’ she screams loudly,

‘You will soon be a qualified doctor, won’t you?’

Everyone is too terrified to explain.

‘I said put a line in now or else I am reporting you directly to your consultant!’

John is frozen. Fixed and frozen. He feels faint.

He hears

‘What is the matter with you, you useless person?’

John runs away into the sluice room at the back of the ward. Bedpans do not bark. He closes the door- the familiarity of the bedpan washer’s humming soothes his distress.

The crash team finally arrive and resuscitate the man for thirty minutes. He survives and is transferred to the Intensive Care Unit.

Hiding at the back of the sluice John stays until he is eventually discovered and summoned to sisters’ office.

She has it in for him. He feels sick. He does not know what happened.

[64] Blood Pressure

He walks into her office.

She talks and talks, and he does not.

He cannot hear her properly as the words will not stay in his ears. He is terrified.

The nurse tutor, Miss Cullen is there also –

'This is serious,' he thinks.

'One last chance,' he hears.

'But I didn't do anything wrong Miss.'

'You broke the rules and nearly killed a patient.'

'I did?'

'You did. Sister does not want you to set foot on her ward again, you will finish your placement on St Philomena's.'

'Thank you, Miss Cullen.'

'I do not want any more of this behaviour there, do you understand young man?' Sister announces.

'Yes Sister. Thank you, Sister.'

Miss Cullen and her young charge leave the office and walks down the hall. The sun is shining, and John wants to run away out of this horrible hospital.

'Just close your coat the next time, doctors wear their white coats *open* and male nurses wear them always closed. Fully buttoned up.'

'Why didn't you do just do that?'

'I didn't know, Miss.'

'Well, you *know now.'*

He walked home alone rejecting the offer of therapeutic pints with friends. He was sick of it. How was he to know that doctors wore their coats open and male nurses wore them closed?!

No one had told him. No one asked him either if he was a doctor or a nurse.

‘I am not even a *general* nurse!’, he protested in his mind.

Every nurse at that incident knew he was a mental health student nurse, but no one spoke up for him. Why didn’t they? Why didn’t he? He reprimanded himself that he had not spoken up but agreed that, in the cold light of day, he would see that it was better he did not. Not worth it. Only another eighteen months of this, he thought. Sister was a powerful woman who ruled by fear and no one, not even her own staff, questioned that.

Stupid rules.

Things had to be better elsewhere. The dreariness of the eighties had to end sometime, he thought, and then he might emigrate to London or Australia, like many of his friends.

John’s story reminds me, *and us,* of the challenges faced by many students (including myself) in their nurse training, particularly in Ireland**.** Fealy (2005) describes a training regime which demanded subordination and docility (p.115) underpinned by service needs rather than education but historically nursing had been closely allied to the medical profession as an ancillary occupation or that of a *lesser* partner (p.151).

Here and There in Hope

From an Irish perspective, there was a sense that psychiatric nursing was changing elsewhere. as many of the nurses who had previously emigrated to the UK and to Australia began to return home to Ireland in the early 1990s with anecdotes of a more liberal approach to care practice in Australia and less emphasis on uniform and the roles therein. In many places uniforms had been dispensed with, many nurses wearing civilian mufti. One nurse who had returned from Brisbane, outlined some of her work practices in Australia which sounded very different from traditional hospital led mental health care in Ireland during the 1980s. She told me about nurses working in different and diverse settings and working with independent patient caseloads, practice autonomy, decision making, nursing leadership and role advancement. I recall this making me think that that the world was changing and there were better days ahead for us nursing students and for mental health in general.

It was well known that many general nursing students experienced much tougher regimes, particularly in practice, with less time off than *the psych students* and less kindness shown to

them by their mentors in the larger general hospitals. In some cases, the ward sisters there, were unpleasant and often quite unkind in the way they treated more timid students. It was not unusual for such a ward sister to bully her deputy, the staff nurse ,and for the staff nurse to bully the third-year student and for them to bully the second years and so on. It continued a culture of compliance, subservience, and oppression by *eating their young*; the '*great fleas have little fleas'* analogy (Begley, 2002, p.313), describing midwifery training in Ireland also.

I remember how, as an apprentice learner my role was to learn on the job. *Learn* as others were *doing* so that I could learn to do independently, and this cycle of instruction continued in Ireland within a nursing apprenticeship architecture until 2002. This highly structured system of producing mental health nurses was a joint effort between hospital and school, between theory and practice, and conjoined in its effort to shape nursing into subservience at the time, especially so in Ireland. Subservience to the religious orders, to hospital employers and to medicine. It relied on conventional pedagogy and was often operationalised through religious orders, many of whom were nurse educators. Conventional pedagogy in nurse education was based on the integration of theory and practice, with equal emphasis placed on theoretical knowledge to underpin practice and acquisition of practice skills. *Banking* was the predominant style of teaching.

Dyson (2018) explains that the 'apprenticeship style training in nurse education relies on occupational expertise and identity, social and personal maturity, and locational or close association between the qualified nurse and the student' (p.73).

The apprenticeship model of nurse education was operationalised under a *learner as worker* mentality with the emphasis on *worker* rather than learner. The dominant social forces at the time (hospitals, medical staff, government through the department of health) promoted the continuation of the *nurse as worker* through the nurse education apprenticeship model as it meant a constant source of labour for employers and resource stability. The act of shaping *us* into nurses was a deliberate act to maintain workforce stability rather than advance the role of the nurse in terms of developing its own nurse identity and agency.

A natural consequence of that order was the validation of a culture of subservience to others, particularly medicine, as the nurse was *in service* and nursing actions were dependent on the instructions of the doctor (Boling, 2003, p.28). Despite the efforts of nurse educators working within the confines of the classroom to develop more humanistic and interpersonal ways of

teaching, the focus of the nurse was therefore on completion of tasks allocated by the medical staff.

The transfer of undergraduate nurse education into the Higher Education landscape in 2002 was an attempt to comply with EU legislation at the time and was introduced onto an 'unsuspecting public' (Fealy, 2005, p.60).

In my opinion, the interests of employers and governments departments in retaining a cost effective highly mobilised workforce to resource future health care needs underpinned the transfer to higher education. Dominant discourses from employers, the nursing regulator (An Bord Altranais), religious orders, hospital managers, and government departments all focused their attention onto general nursing, rather than on its lesser cousins of mental health and learning disability nursing, in terms of shaping the future of the model of undergraduate nurse education. The regulators had wanted to follow the model adopted by the UK called Project 2000, with a core entry for applicants, but this was rejected by the Department of Health at the time, again because of workforce supply concerns, although Ireland moved fully to the undergraduate nursing programme before the UK. Nursing policy remains under the governance of the Dept of Health who decide on the number of future graduates to enter the profession.

As a nurse lecturer I am aware of the continued importance of the nursing student to the workforce. This was evidenced in the pandemic when the Dept. of Health (2021), in conjunction with the regulator (NMBI), made decisions which impacted on student nurses and their ability to work as health care assistants, for the purpose of recognition later as mandatory clinical placement. Such decisions had an extraordinary impact on student nursing placement and the ability for students to complete their undergraduate nurse education. It would appear, pandemic aside, that nurse education serves the interests of higher education, vested and service interests, health care agencies and remains rooted *in service* rather than *education.* This has not changed over the years as I reflect on my own nurse training.

In a sense we were *unfree* to learn anything else other than what the structures, systems and dominant beliefs permitted. But, on reflection, if I was to ask myself what might freedom to learn look like, what might a counter hegemonic response, to *being unfree* to learn anything other than what is permitted, be ? Might it be political? How may I acquire my own agency within the deeply embedded structures and systems of psychiatric nurse education and, if I do, are my actions then political? (Giroux, 2011, p.50).

What might Freire say about how I should name my world in order to transform it ? Might he say that my role as a mental health lecturer is to shine a light on the relationships between authority and power, what is taught and what is not, and the conditions to produce specific knowledge? If so how might that be represented ? and how might issues of power, social justice and feeling lesser than be explored within my work ? An alternative approach can become a critical pedagogy when issues such as voice, authority, disclosure, representation, and reflexivity are addressed (Leavy, 2020, p.10).

Critical pedagogy offers me a way of thinking about my dilemma and how I might negotiate the relationship between my teaching, the production of knowledge, the institutional structures of my employer (bureaucracy, systems driven), and the wider social and political context within which that takes place. Fundamental to that is a perspective is the possibility of constructing alternatives to or counter hegemonic forms of knowledge (biomedical model) and therefore to change power (Freire, 1970; 1977).

The focus on dialogue and consensus (Freire 1972; 1987) (listening, interpretation, meaning making), experience and love ((hooks, 2003) and pedagogy as praxis offers opportunities to reframe my work in *Pinel* from conditions which are tied to hegemonic processes (layout of classrooms, *banking* and the obsession with outcomes driven teaching). Both Freire and hooks (above) offer dialogue as a way of engaging with my educator practice with hooks writing that 'to speak of love in relation to teaching is to engage in a dialogue that is taboo'. But such love is not confined to realtionships between student/teacher it is also about 'caring deeply about our subject matter, loving what we teach and the process of teaching itself' (p.127) and I care for my subject matter greatly.

In many ways I was shaped by my own experience as a student nurse, and it wasn't until I begin to critically explore and unearth my own professional dilemma(s) that the possibility of my own transformation started. And Continues.

My identity as a former nursing student was constructed within a set of conditions, authoritative and socially mediated, and now as a lecturer many of those conditions remain. I see myself, not as a body of knowledge, but as a progressive critical educator deconstructing authoritarian modes of discourses in traditional classrooms and circles or perhaps someone who wants to live an authentic life. 'A progressive position requires democratic practice where authority never becomes authoritarianism and where authority is never so reduced that it disappears in a climate

of irresponsibility and licence' (Freire, 1987, p.212) But this is not confined to nurse education and is evidenced within healthcare that nurses historically struggle to be able to contribute fully to policy making and high-level decision making on healthcare issues (Dyson, 2018, p.59). But while the WHO advocate for nurses to contribute fully to policy and practice, they do so with certain conditions attached. In developing a global framework, including global standards for professional nursing education, the WHO seek the harmonization of nursing education through the creation of global standards (WHO, 2020).

Dyson (2018) writes that:

> 'the need for global standards had arisen due to increasing complexities in healthcare provision, increasing numbers of health professionals at different levels and the need to assure more equitable access to healthcare. In recognising complexities in healthcare provision and inequities in the quality of nursing and midwifery education globally, the World Health Organization officially made the link between standards of initial nursing and midwifery education and the quality of the nursing and midwifery workforce and in so doing paved the way for the establishment of global standards for the initial education of professional nurses and midwives'
>
> (p.68)

The introduction of such global standards came about at a time when Covid-19 was prevalent and there was an increased focus on the mobilisation of nurses and the resourcing of healthcare teams in many countries. Standardizing nurse education on such a scale and with such prescriptive detail, particularly during a pandemic, may impact on nurses to absorb the implications of this new way of planning and operationalizing nurse education. In addition, the WHO advocate for specific types of curriculum design, for schools of nursing and midwifery to design curricula which deliver programmes that take account of workforce planning and national and international healthcare polices (Dyson, 2018, p.70).

Worryingly, for mental health nursing, there is a marked absence of attention to mental health and undergraduate mental health nurse education, with the assumption that these global standards can be applied across all nursing and midwifery disciplines. The need for global standards in nurse education according to Dyson (2018) had arisen due to 'increasing complexities in healthcare provision, increasing numbers of health professionals at different levels and the need to assure more equitable access to healthcare'(p.60). The problem with these

standards is that they do not consider the complexities of psychiatric nursing and are largely focused on skills acquisition, primarily tasks and procedures which may be considered as a drive towards genericism (Connell, 2022, p.474), meaning generic rather than specific approaches to nurse education[65].

Every year, I am asked to explain to frustrated graduates who wish to practice as psychiatric nurses in the EU why they cannot do so. The explanation I am forced to give them is that there is no EU-wide agreed definition on what a psychiatric/mental health nurse is and this impacts on graduate Irish nurses' right to travel and work within the EU under Article 15 (EU, 2007).

Lifting this prohibition has not been considered a priority for the regulator (NMBI) even though general nurses can travel and work within the EU, like their European colleagues. This is also further complicated by varying levels of service development in mental health care within EU countries, with some countries more advanced than others. The WHO (2020), in seeking to prepare for the future health needs of the world, seems to have neglected mental health nursing and the specific requirements of undergraduate mental health nurse education.

It seems that little has changed since the days in which I was a student. Psychiatric nursing continues to be seen as unequal to other forms of nursing and experiences its own stigma from inside and outside the profession. Psychiatric nursing is concerned with individual human experience and the promotion of the idea of the person as an agentic self, which traditionally has not been honoured within mental health care. My experience of learning how to be a nurse within that model is that it did not pay sufficient attention to the importance of the self and what it means to be *self.*

By that I mean that, as Carolyn Ellis (2017, p.19) explains 'in order to understand something it is necessary to get into the world of another.'

[65] In this discussion I am referring to the NMC Standards for Undergraduate Nurse Education which has placed an increased emphasis on genericism and physical health skills rather than the development interpersonal and therapeutic skills.

Self as patient.

Self a learner.

Self as student.

Self as psychiatric nurse.

Self as human.

I

Wonder

if

the

WHO knows

that.

To separate or not to separate: for that is the Question

Robert and I are planning the clinical skills teaching sessions for the following week for the first years. It is an onerous task , both the planning, organising into groups and all the associated documentation. We are reading the lists of clinical skills to be taught which seems to be increasing year on year. Services are demanding that students arrive on clinical placement with skills proficiency in a range of procedures from care assessment, documentation, personal care skills, clinical observation procedures, infection control and many psychosocial skills technically known as how to be a human skill (these include communication, maintain a safe environment, professional etiquette and team working).

Robert, do you think that we should teach blood pressure skills separately to the mental health nursing students?

Separately?

Yes Robert, I mean we teach the skill to the psych students and the generals lecturers' teach it to their student groups?

Absolutely not! is the reply.

-Why ever would you consider doing that?

-That sounds ridiculous, he retorts officiously.

-Blood pressure is just a skill, the theory and practice of taking and recording blood pressure:
-It is the same for everyone.

-Why would you think that Margaret?

Margaret asks V what she thinks but V seems to be quiet and does not reply.

I think it should be taught separately.

Why?, he asks.

Because the blood pressure needs of a mental health client are different Rob

How can you say that? That is separatist outdated nonsense.

Is it Rob? Is it really? Look at what the NMC[67] (2018) did with the new standards in the UK, I bet we won't be far behind them.

Look Rob, its fine taking blood pressure on a person who does not have thought disorder but what about a client who is paranoid? Who thinks that the nurse is poisoning him, by putting things into his veins and listening to his thoughts? The physical act of wrapping a cuff around his arm may be restrictive and oppressive to him. We are reaffirming his paranoia when we inflate the cuff, then obliterate the radial pulse, and listen for the lub dub?

If that is not a practice risk then what is?

You are being awkward Margaret. Those scenarios are not that commonplace.

Half of the patients on the acute psychiatric wards are paranoid, even without a diagnosis of psychosis. Just think about it Rob.

It is not about technical skill, that reduces the task to a set of instructions, this is much more and I feel that we need to contextualize it for our students. Bring them into the milieu. Generalists cannot teach this, not in this way.

…Not the way we do.(Lakeman and Hurley, 2021, p.577).

That is a luxury we cannot afford and besides we do not have the staff to do this.

My point. Exactly.

-Resources are driving what and how we teach and there are three times as many general nurse lectures so it will end up being taught by them, irrespective of what we want.

-Pick your battles Margaret and believe me, this one is not worth worrying about.

-So, it will need to be taught in a generalist way.

-Along with all the other skills we now need to teach.

-But it is very important that mental health nursing students can learn physical care skills.

Why so Robert?

-*Why do they need to learn all these skills?*

-*Why has mental health nursing been consumed by physical tasks?*

Because the Commission wants it? Because mortality is much higher in SMI patients (Serious Mental Illness) SMI groups, read Finnerty (DOHC, 2006) and MHC (2019) and Rodgers et al.'s (2018) work on it.

You know why, Margaret!

Because more and more antipsychotic drugs are being prescribed to people (Shoham et al, 2021, p.97) *with horrid physical side effects, which we spend our time monitoring under the guise that we are actually doing something useful and positive about it.* !!

But Rob, are we not supposed to be developing critical thinkers? People who will shake the system, challenge the status quo, do things differently, disturb the undisturbed …

We do *do* things differently now Margaret.

Really? I don't feel it.

Well, that is your problem, Margaret. The system is continually improving.

-Look how things have changed and improved since you were a student nurse all those years ago? No more uniforms, no more PUM forms, no more padded cells. The high walls have gone Margaret, they are only in your mind.

(that told you, interrupts a smirking V)

-You need to be pragmatic, not idealistic.

-Margaret as you are well aware there is a worldwide shortage of mental health nurses, general also, but mental health is in dire straits, low recruitment and a professional image is a major problem….

-You think filling their heads with anti-psychiatry rhetoric or critical psychiatry is going to settle young graduates?' You think that will entice them to stay in the profession?

-You have been around a long time Margaret and what exactly have you done to help the profession? Apart from criticizing it. It's easy to manage from the side lines…

Well, I wasn't always working in mental health I was in general nursing also.

Doesn't matter. That's not the point, is it?

It's not about the clinical tasks or the physicality of the role it's about teaching students to love what they do so that they at least stay within the care system.

And spending their days taking blood pressures will?

*Have you asked yourself why we are now having to teach all these skills Rob? It's not because every psych patient suddenly developed hypertension, it's because a person with schizophrenia is likely to die twenty years before his non-SMI counterparts. Not because of schizophrenia or hypertension, it is because of the serious side effects of psychiatric medication, such as weight gain, diabetes and metabolic syndrome,(*MHC 2019).

And you feel that we are contributing to that?

In a way, yes, I reply sharply.

Resisting

We paused for a few minutes each of us aware that emotions were running high in the knowledge that the weekend was approaching. In saying that…

I could not let it go.

Robert, we should resist, resist the idea that psych nurses need to learn a whole lot of skills just because the regulator or employers says so. Who is driving this profession? It has always been other people; outside influences and we should resist that. We should fight back.

Resist what exactly Margaret?

Resist the notion that the professional identity of a mental health nurse is determined by outside interests, by interests outside of the profession, who we are, what we do.

Not teaching blood pressure is a form of resistance Rob.

If you say so, Margaret.

But this is *your resistance* Margaret, not mine, not theirs, yours.

-Yours alone.

Why did he not share my view on this?

Could he not see as I did?

I decided that I needed some theoretical clout and outsourced it to the peer reviewed.

You need to read this Rob, as I directed him to a paper on the generalist crisis impacting mental health nurse education from the MHNAUK [66](Coffey et al, 2015).

I also figured that Connell et al[67](2022, p.472) was a great place for Robert to start.

(Pity the printer was broken and I would have happily printed it out for him says, V sarcastically).

I have one for you too Margaret!. He handed me a paper which reflected his views on the future and direction of mental health nursing albeit it dated and from Australia.

It was now Friday at 4.30 pm. We had no work, no proper work done. No schedules organised.

It had been a fraught afternoon one which started out with a simple exercise and ended in entrenched positions. His clarity impressed me, but I had expected him to at least agree and be more willing to agree with me than resist what I assumed was some sort of medicalized orthodoxy. I had always operated under the assumptions that I was right, on this issue at least. Maybe he thought that I was a *liberal* and that everything was to be resisted.

As I began the Friday evening journey home, I began to think about everything. The Doctorate was making life very difficult for me because nothing was clear. I started off on a simple quest to surface my concerns about my practice, the trajectory of an anti-biomedical explanation for mental illness (Deacon, 2013, p.847 Moncrieff et al, 2022)) wandered in and out of my role, my practice my epistemological stance. My research was now bigger or seemed bigger. Was it becoming more about inequality and social justice and who's equality and injustice was it? Mine or others?

.

[66] MHNAUK: Mental Health Nursing Academics UK Publications and Position Papers (MHNAUK, 2023). Coffey et al (2015) is a paper in which the authors state their concern about the future of mental health nursing in the UK.

[67] This paper discusses the changes to the standards in undergraduate Mental Health Nurse education in the UK (NMC, 2018) and is concerned about the move towards *genericism* by the emphasis on skills and procedures. The authors suggest that's these changes impact of professional identity of the Mental Health Nurse (MHN) in the UK

How did the task of organising a teaching session on blood pressure become political? About inequality, inclusion, and education? Or was this issue rooted in issues of power and privilege within an education process in the same way as sometimes happens in mental health care. Is it my assumption that mental health nursing students are not afforded the same teaching experience as their general nursing counterparts? If so, what informed my opinion, was it socially mediated or internally constructed from my own experience as a student albeit a long time ago? In other words, was the personal becoming cultural?

I heard a psychiatrist say recently that the *lobotomy of today is how we treat mental illnesses* in reference to how society continues to view mental illness as a *lesser than* entity. People with mental health problems continue to experience significant discrimination and stigma because suffering from mental health problems impacts opportunities in employment, promotion, relationships, housing, and finances not unlike the Mental Health Foundation (MHF) have found in the UK.

Kelly's (2020) asserts that psychiatric diagnoses are based on *symptoms and stories* rather than *tests and scans*. Each person comes with a unique set of troubles and strengths, problems and solutions. Everyone is different, nothing is stable, everything changes, and each person is unique (p.4) for me this person centredness is the heart of mental health nursing, the symptoms and stories and the uniqueness of the individual. Much like autoethnography.

So, teaching blood pressure is not simply a skill to be taught, it is an opportunity to teach students how to be in the world of another, particularly a person who may be experiencing mental distress and who may not be able to express it in a way which may be readily understood. It is a commitment to an act of solidarity with the learner/caregiver and the care receiver and is best done within an environment which espouses individuality and person centredness.

There are voices that support this assertion. Cleary (2018, p.114) asserts that emotional intelligence, self-awareness, and resilience are crucial skills for nurses to facilitate patients' recovery. Peplau (1988) viewed the nurse patient relationship as the foundation for psychiatric nursing practice.

Phil Barker, who is synonymous with developing the Tidal Recovery Model viewed the role of mental health nursing as more concerned with the future development of an individual, rather than with the causes of an individual's mental health problems (Barker 2001,p.215). Such *causes* are, to a large extent, irrelevant because, like the two men we meet on page 191 with a diagnosis

of schizophrenia, the origin of their individual distress is unique to them and their own life story.

The business of *blood pressure* rooted itself in my thinking and stayed with me throughout the course of the evening. I decided to sketch out what I was thinking and feeling and why I remained agitated about the issue in the hope that *staying close* to it and with it might free me from my own entanglement. I wanted to make sense of a sense of almost oppression and began to think about what Paulo Freire might say about my insignificant dilemma as I thought about him earlier that day, when I was thinking about my own nurse training.

I wonder what he would say ?

I decided to ask V……

V, do you have any thoughts on what Freire might say?

Margaret, I have been doing a lot of the telling so far, how about you tell me what you understand of what he might think of your dilemma?

But you have been with me on this journey so far V, I am not sure if I know enough, or if what I know is aligned to his way of thinking?

Tell me what you have learnt so far Margaret?

Well V, from reading his work I see that he was an activist, a scholar and above all he placed the person, the human being at the centre of his work and our understanding of learning and education.

How did he do that?

Well V, the political nature and social justice aims of education are very explicit throughout his work (Freire and Macedo, 2005, p.229), *particularly in his book Pedagogy of the Oppressed (1972; 1997), where he emphasizes the transformative potential of education and criticizes the banking system of education, where teachers as seen as the experts and students are the empty vessels ready to receive canonical, fixed knowledge and facts.*

Tell me more Margaret.

He described what he termed as critically consciousness pedagogue. Applicable to everyone. By that I mean conscientization which was his way of describing the development of critical consciousness by people who have been marginalized by the dominant forces in a society (Freire, 2000). *The process of conscientization involves 'learning to perceive social, political, and economic contradictions, and to take action against the oppressive elements of reality'* (p. 35).

Why are you drawn to him as an educator and what, if anything has this got to do with nurse education?

-I am drawn to his work with marginalised communities, the idea of working with people who are oppressed aligns with my own values, interests, and commitments to working in the field of mental health nurse education. This autoethnographic work has essentially about surfacing the problem of feeling lesser than working in an area of nurse education that has always been on the margins, either within Higher Education or in practice and Freire helps me to understand it.

How?

Freire exposed how systems of education dehumanise and divide to ensure '*what serves the interest of one group disserves the interest of others'* (Freire, 1970, p.126). *I could say the same thing about psychiatric care and systems of care which control and contain people with mental health distress. He recognised the structural and systemic ways power is evident as a form of everyday violence when working within the formal education system*. (Freire, 1972, p.39).

What do you mean violence M?

I mean I understand it to mean the hierarchies, the limited ways knowledge is understood in nurse education and the imposition of external forces which drive curricular content.

Then how does Freire help you?

By helping me to access the problem through problem-posing pedagogy which challenges my own thinking and practice. As a critical educator by becoming aware of the world around me and my place in it. Critically examining my assumptions, my own experiences, values and what I can also offer to my practice, including the ways in which I may contributing to

my own dilemma. Recognising the visible and visible ways in which power is evident in pernicious ways (timetables, resources, curriculum content,). Showing me that as an educator my understanding of education and the position I take through my pedagogy is the foundation for how education is experienced by both teacher and student.

Any other ways he is helping you?

Perhaps helping me to develop an identity V?

-Not just in terms of nurse educator identity, but an activist teacher identity.

-But I haven't time to think about that now V.

You seem distracted Margaret.

Yes, I am a little, but I need to reflect about the Business of Blood Pressures!

And I did…and about research and about Freire, and about my studies, as they..

…*had* grabbed my attention and was occupying space in my head meandering its way around my body like a sort of intellectual metastasis. I was deeply enmeshed in it without being entirely sure what it was becoming. It felt at times that my grand concerns about mental health illness, mental health nurse education and the business of medical psychiatry were beginning to emerge or surface into issues about professional identity(s) but, who within the landscape of higher education, even nurse education, would have any interest about this? Steiner (2000) stated: 'historically, educational institutions have followed an intellectual path of least resistance' (p.12) and I understood that to mean that this issue may not be of interest to many. If mental health nursing students began to demand mental health skills specific education, there might be those who could consider it both *ephemeral and lofty*.

Why did he or could he not support me? Why did he not feel the same way as I did as a mental health educator? Did he not feel that it was important to resist teaching mental health nursing students separately so that they could be better socialized into a mental health environment? Like I was? Why would he not protest, resist like me? State emphatically to his employers that those students needed to be taught in a specific way. Like I intended to do.

For me, problematizing this issue in a way that encourages epistemological curiosity which, according to Freire (1997), embodies a critical reflection unveiling the conditions which make the situation possible in the first place. But awareness of a problem is not enough.

The idea of seeing the educator as a whole person with emotions, feelings opinions and experiences feels congruent with my ontological position as an educator and a person. Looking at the *blood pressure teaching* tensions as being solely oppositional or binary (he is wrong, I am correct) in a Freirean way offers *hope* as a way to navigate difference in praxis.

By now I was home with my thoughts of blood pressure skills teaching and research forefront in my thoughts.

But was it really about Blood Pressures?

Was it ?

Or was it about the *Business* of Blood Pressures?

I mean is it not about the problematising the pathologizing of mental illness and the over-reliance on pharmaceutical solutions?

Robert and I are part of the problem and the solution. By continuing to uncritically question the medical model, nurse education is actively maintaining the status quo. But should both of us not ask much bigger questions about the medicalisation of mental illness.

If education and practice (my practice) is to change or have any impact on such problems, it must be done through the lens of transformation and assuming a *political* position.

Freire (1994) argued that if 'an education that is not only centred on the teaching of content but also challenges learners to venture in the practice of changing the world, also making a true commitment to that change' (p.43).

But change requires hope and Freire (2005) offers *liberation* as a way of progressing an issue, such as the teaching of a basic clinical skill, promoting pedagogical dialogue as the way to hopeful and liberating pedagogy.

But critical pedagogy is also requiring the critical educator to 'value the exercise of will, the role of emotions, of feelings, of desires, of limits, the importance of historical awareness, of an ethical human presence in the world and the understanding of history as a possibility and never as determination, is substantively hopeful for this very reason produces hope'(p.24)

While Freire's notion of *Hope* describes my state of 'incompleteness, from which they(me) move out in constant search' (1972, p.64). Hope is the idea that I might find joy in what I am doing and be able to impact change or *be the change*. That might mean being a better educator or working in ways which encourage my students to critically engage with their own worlds.

The nexus between research and education, practice and pedagogy is messy, and I wondered if all researchers who journey from practice to academia encountered the same degree of critical angst that I did. This business of seeking to understand and indeed finding *Hope* is a messy and undefined trajectory. Maybe I was an 'inveterate dreamer'(Freire, 1998, p.26) 'hoping for the sake of Hope' (Freire, 1978, p.60), an 'eternal seeker' (1998, p.58) but my journey was about naming my world and eventually 'becoming more fully human' (Freire, 1972, p. 41).

Maybe the argument between Robert and I was in fact an Act of Hope.

Year 3

Paddy.

Getting lost in the afternoon

I am late.

I am lost.

I am lost and I am late.

Almost ten minutes late now. Almost lunchtime. ‘Not a good time to be lost’, V says.

My frontal lobe is doing overtime. I feel so stressed. I am late to collect a patient.

‘God I’m going to get into so much trouble’, I thought.

‘Margaret, you got lost. It’s ok, you couldn’t find the group therapy room’, I reassured my first-year self.

The *group room* was used for group sessions and was purposively situated, far away from the hospital ward where I am on a six-week placement. This means it’s in a part of the hospital I have never visited before.

When I finally arrive, I am greeted firstly by an agitated patient who is pointing his forefinger onto his wrist, indicating the time, and wagging his finger annoyedly, at me.

Maybe he has tactile hallucinations I think hurriedly or maybe it is just that, I am just late.

I hope for the perceptual disturbance, but no, he is just annoyed because I am so late to collect him.

The therapist Carolyn Kane appears from behind her office door, and she too seems like she wants to scold me.

‘Group finishes at one o clock sharp nurse!’ she says and ushers me outside the door muttering about being late for lunch and having *respect for peoples’ time*.

I am late for my lunch too I retort, (cerebrally).

‘Paddy is anxious about having a cigarette’, she says.

I accept blame for my tardiness willingly. As a student of nursing, apologising seems to come easily to me.

‘Is he?’ I ask the therapist, pretending not to notice as Paddy quickens his pace up the long corridor.

‘Sorry, I got lost.’

‘It’s your job to know where your patients are, nurse.’

‘Ok.’

‘Sorry, Paddy, I got lost.’

‘I know, I know you did’, he says impatiently.

Paddy and I walk together, along this miserable dark corridor. Horrible old walls with dated floor covering peeling up at the sides. ‘I really do not like this place’ I think to myself. ‘Imagine it is so dark already and its only lunchtime’. He walks briskly, impatient to get back to his ward and his routine. I am trying to keep up the pace in my white double-breasted attire.

Maybe he wants his lunch or his smokes, I think to myself quietly.

I wouldn’t mind either myself as hunger was making me irritable.

Suddenly…

I hear a voice shout,

‘Nurse, nurse nurse!’

‘Excuse me, please.’

‘Nurse, help nurse.’

‘We need help nurse.’

‘Help’

I walk quickly up the long corridor.

‘I think they mean *you,*’ says Paddy, sharply.

‘Me?’

‘Do they?’

‘Yes, you! – you are a *nurse,* aren’t you?’

‘I suppose I am Paddy.’

I ask Paddy to wait for a moment while I locate the source of the voice.

Turning around I see an elderly couple.

They are shouting ‘nurse!’ waving their arms about pointedly.

‘Jeepers, do they mean me?’

I walk gingerly towards this old couple, who are by now looking for a chair. The lady appears tired and wants to sit down.

‘This place, nurse, this place it’s huge, no signs and we are lost’.

‘I know exactly how you feel,’ echoes from my head. V thinks this is amusing.

‘Hello?’

‘Are you ok there?’ I ask.

‘Do you need assistance?’

‘Oh, thank God nurse, thank God, we found *you.*’

(‘They must be desperate’, V intrudes)

‘We’ve been walking around this place *for ages,* and we got lost.’

‘My wife’s arthritis is bad and there are no signs in this place, and her knee hurts badly when she walks for more than ten minutes,’ says the old man, sweat dripping from his forehead.

‘I see.’

‘I’m only a student.’

‘A student nurse,’ I say, quietly.

Paddy walks over.

‘Where do you want to go?’ he asks.

‘The canteen. We want to have our lunch. Save us the trouble of cooking when we get home.’

(Hardly an emergency V thinks.)

‘You are not far from the canteen at all folks,’ Paddy says.

‘Isn’t that right nurse, not far at all.’

I ignore Paddy’s kind advice and wait for him to lead the way. A voice inside my head criticizes me for not thanking Paddy publicly as he was the only one of the group who knew where we were.

The couple are relieved, and the man shakes my hand firmly, in gratitude.

‘Thank God we found a lovely smart nurse like yourself, in this place.’

I ignored Paddy. They ignored Paddy.

‘Full of sad cases in here. Locked up because they can’t be let out. God help them. Not their fault, but they need minding and protecting. The poor creatures but this is the best place for them. Some of them the mind is gone, fully gone,’ the old man advises.

‘Marion knew a fella, a fine-looking fella from the parish, only in his twenties when it started you know what? Well, he started chatting away to the noises in his head, inside his head, they were. All in his mind.’

(‘He has company,’ V says)

‘Came into one of these places and they cured him for a while. But he had to go in again and well I don’t know what happened to him since.’

‘Do you know, Marion?’ he asks turning towards his arthritic wife.

‘Know what’? she asks impatiently.

‘What happened to that lovely lad from Darby Road. Kelly, young Kelly?’

‘Killed himself,’ she says.

‘The mind is a funny thing, once it goes, its gone forever,’ said the woman.

My heart was racing. These two were getting on my own nerves now. My legs wanted to run but I had no idea where to go. Maybe if I gave them some random directions I could just get rid of them, I thought. But the risk of *getting into trouble* again would not permit me.

By now, I had enough of the unfolding drama in the bowels of the hospital.

My heart was racing.

The voices grew louder and louder in my head as my impulse control dwindled.

Will you please

SHUT UP!

They seemed like nice people, but I wanted them to stop talking. Stop saying what they were saying and just go away. But I couldn't tell them to shut up.

I was stuck.

Under the misapprehension that I was a nurse. A proper nurse.

I was lost.

Place Space

Temporality.

I looked at my shoes. My sensible white nurses' shoes.

In double-breasted reflection,

An immaculate perception.

Centering myself in my own story,

and stepped into an identity. and then

I decided that if I looked like a nurse. I might as well act like one especially one, that knew what I was doing. So, I suggested that I move my newly found family down along the corridor and along the right-hand side of the front of the building. Where there was light. The light would guide us in a sort of evangelical way. Delighted in my ability to help the lost souls escape this institutional maze and in time for their Wednesday lunch.

Ten minutes later,

We remain lost.

It was now one thirty-five. By now the best of the chips would have gone.

All Hope lost.

Showing the Way

Paddy spoke up.

‘Will I show them nurse?’

‘Will I show them the way?’

‘Yes Paddy.’

The former coalman knew his way around this building and after a short while the older couple were headed for the canteen. Paddy and I returned to the ward where our prolonged absence was remarked by an officious staff nurse. At this stage I did not care if I was in trouble.

I should have thanked Paddy. Properly. In front of that couple.

I never did.

I gave him cigarettes instead.

After lunch I sat down and began to think about how Betty might have handled the situation. Better for sure. Kinder at least. And maybe with a bit of her brown bread.

Up until that point I had not seen myself as a nurse, not even a student nurse, but the uniform made me a nurse. In the eyes of the public, at least. I appeared as a nurse. What is it about clothing myself in a particular garment that gave me importance and power and the ego driven idea that I could try to act the part? A pretence at least. It gave a visceral legitimacy, an authority bestowed on me by institutional dress. My failure to acknowledge Paddy’s existence might be easily regarded as the behaviour of an unlearned novice beginner.

Thinking about that situation almost *forty* years later I can see why I might have behaved as I did, in relying on the uniform and shoes to show me the way. Even though I was a first-year student who could not find my way to the canteen, I became part of a system, the psychiatric nursing system. A hierarchical and ordered system which conforms and confines and was, and remains, mediated through the educational system. In Freire's *Pedagogy of the Oppressed* (1972) he argues that the education system exists to facilitate the integration of people into capitalist logic and conformity, and I wonder if being a nursing student was an example of that. Was that what Freire meant when he wrote,

> 'Education either functions as an instrument which is used to facilitate integration of the younger generation into the logic of the present system and bring about conformity or it becomes the practice of freedom, the means by which men and women deal critically and creatively with reality and discover how to participate in the transformation of their world' (p.5).

Paddy knew the way and in this instance was the teacher, but the conditions did not exist in which he might ever be asked his opinion. The set of assumptions made about Paddy by that couple, albeit indirectly, inferred an inferior status on Paddy because of his status at a patient. I reinforced that by uniform, by not asking his opinion, by not valuing it and by giving him cigarettes instead of Bettys loving bread. I did not acknowledge his existence as a human being publicly in the same way as she would.

Benner's, now 40-year-old, influential work on the development of nursing skills and knowledge argued that nursing knowledge was not confined to academic or faculty knowledge and that in order for nurses to develop expertise (1982, p.132) they must also appreciate that knowledge has many forms and encompasses a knowing *how* and a *why*. She encouraged nurses to value personal knowing as a core component of professional nursing practice. That *knowing* which was internally constructed from experience but socially mediated in many ways like Freire (1972) did. Betty did not teach me much about psychiatric diagnosis, other than telling me that Bridget needed extra help with eating or mobilising or whatever the activity of living demanded. Labels did not seem to matter to Betty.

I wondered if I would ever do something like that and break the rules like Betty. I like and dislike following rules, an example administering medication: I follow the procedure meticulously but then question myself about my actions. A Foucauldian perspective might view

rules as forms of social control or 'governmentality' (2007) arguing that it should be understood as a powerful web of power relations that links together distinct forms of power: sovereignty (legal), discipline (sanctions), and government or procedures and 'tactics that capitate a form of power that has the population as its target, political economy as its major form of knowledge and apparatus of security as its essential instrument'(p.108).

Paddy did not lead the way because he was a patient and as student with no knowledge of my surroundings, I still held power over him. Thinking deeply about the meaning from this situation felt disorientating and unsettling for me. Betty cared for her patients in a way that left its mark on me, not just by the act of physically nourishing those patients, but by showing me that *being* with others entailed more than following a particular doctrine or orthodoxy. I had, in my ignorance, privileged a particular way of knowing as that which belonged within a specific setting until it was disrupted. I learnt much later that Paddy was the teacher in multiple ways and not me.

Denzin (1989a) describes such epiphany moments as "interactional moments and experiences'' which leave marks on people's lives. An existential, unstructured act, a minor epiphany: 'the meanings of these experiences are always given retrospectively, as they are relived and reexperienced in the stories persons tell about what has happened to us' (p.3). But Paddy's and Betty's stories are now aged, and my interpretivist self-arrives at newer understandings by *reunderstanding* them as they are situated now (Scott, 2017, p.9).

I decided that I wanted to be a *Betty* and that there might just be a place for me in clinical nursing after all, but I was not sure where.

Chasing Paddy.

It is Wednesday. A dreary long, long Wednesday.

Paddy is sitting on his bed at the end of the corridor on in Bluebell Ward. The only male ward in the hospital.

He has been on the ward, now, for almost six months. Schizophrenia. Hearing voices which tell him that he is useless and no good to anyone. He is termed as *chronic*. A *chronic schizophrenic*. His fingers brown and burnt from smoking. His hands black and cindered. His case notes read that he is, 'no management problem', but needs to be more cooperative with ward activities and learn social skills with the intention of helping him to become more *sociable.*

The sun is shining outside on this warm September day.

'If I keep quiet, the day will go quickly,' he reassures himself.

Margaret is on duty, on a long day. Wednesday is always the longest day of the week and today seemed no exception. Starting her shift at 7.30am and working until 20:30hrs. Thirteen hours. Who else works thirteen hours at a time, she asks herself? Is it just nurses? Is this it? At least she gets two days off together unlike some of the hospitals where a day and a half is the norm. That must be illegal, she thinks. There must be no union for nursing students, or maybe just a bad one.

Although she is only a second-year student and knows little about the world of work, she promises herself that she will not work thirteen-hour shifts when she is qualified. The utter madness of it. Imprisoned in this place. She thinks she might just go mad if she spends too long

behind these institutional walls. But, for now, the tasks keep coming and she might as well get on with it.

'If I keep busy, the day will go quickly,' she reassures herself.

She decides to take some blood pressures but first its *group time.*

Time to chase some patients.

'Time for group, Paddy!'

'Fuck off and leave me alone.'

'No need for that language Paddy, come along to the group session now,' I said impatiently.

'Sorry nurse, but yez are recking me head with *them groups*. The other one, the tall nurse, was in earlier asking me the same thing over and over… 'Paddy come to group'…. I don't like them. I told yez I don't like the pressure. It's bad for me nerves nurse. Sitting around in a ring, like a bloody fairy fort, looking at people I don't want to be looking at.'

'Lookin' down at me shoes, that's all I do in that group, nurse.'

'I don't want to go. I'm not well today.'

'This will make you better now, Paddy.'

'No! It bloody wont.'

'You're only a flippin' student anyways, you can't boss me.'

'You can't make me go to group.'

'Of course, I can't make you go Paddy, you can't be forced to do anything you don't want to. It's a free world. You are free to do what you want, whenever you want. We are here to help you, that's what this award is all about, helping people to get better. Helping people to get over their problems and to get home to their families,' I replied, exasperatedly.

Standard Issue response.

'Well nurse, I'm not going to group today and that's that.'

'Entirely your choice Paddy.'

'But, *going to group*, will help you,' I continued.

'How, how will it help me?'

'You can get the opportunity to talk out your feelings, verbalize your fears and anxieties,' I replied, the words in freefall out of my mouth having learnt the jargon in class.

'I *have already*, nurse,' said Paddy.

'Have already *what*, Paddy? '

'Verbalized my fears'-

'about going to group!!' (Laughing out loud)

(Dare you not to laugh reader)

'And besides….'

'Besides what, Paddy?' I retorted defensively, back on the therapy saddle.

'I have schizophrenia, I don't have any feelings, or so they say, nurse. '*Disintegration and* Depersonalization*'* that's what I was told would happen to me, when I was a young man. It's in my brain you see …can't be helped. It's a disease in my brain, I don't feel like myself not since I went on those tablets nurse. The largactil[68] makes me tired and hungry, and I can't sit still.'

'They are just the side effects Paddy, can't be helped, at least the voices don't persecute you anymore.'

'I rather they did nurse, at least I could tell them voices to go away and leave alone, not like you lot. But that medicine, in the big bottle, *that largactil* is making me worse.'

'But nurse! look what it's doing to my tongue nurse. It won't go back in! I've no control it keeps sticking out. The others laugh at me. My daughter won't come near me; she thinks I look

[68] Largactil (Chlorpromazine) is a first-generation anti-psychotic medication, used to treat psychosis. (MIND, UK). Concerns about its widespread use were reported by Warner et al. (1995, p.237)

strange now because of them tablets nurse. I am an embarrassment to her now. She's ashamed of me now. I'd rather have the voices in my head, nurse, than take them rotten tablets anymore. I could control the voices, but I can't control my tongue.'

'and them tablets make my head fuzzy and tired.'

'and look…look at me belly nurse, see?'

'What is it now Paddy?' I said sternly turning away to look at the clock to check how many more hours were left of my thirteen-hour shift.

'Look at the size of me belly nurse. I look expectin' I do.'

'How can I lift coal with that in the way?'

'Don't be exaggerating Paddy. You just eat too much, that's all.'

'But I can't stop eating nurse. I can't. I just can't. I've put on loads of weight in here and I am tired all the time and I am fed up in myself.'

'I want to go home to my own house and my own bed, back on the coal, get off these tablets and be with my daughter and family.'

'I want to go back to how I was before I was brought in here.'

'Ok Paddy, you seem to think the cure is worse than the cause!'

'Now, enough of that talk and come to group room. It's only a short walk down the corridor.'

The midday bell is about to ring.

'Please Paddy, please just for today.'

'The group will help you, honestly.'

'And I'll get into trouble' V whispers.

'Dr. Barry will be pleased to see that you went to group.'

'I don't care about Dr. Barry or any of them head shrinkers, psychiatrists. They don't help me!!'

‘Paddy, just go and sit there. You don’t actually need to do or say anything.’

‘You can listen to the others, quietly.’

‘No nurse I won’t.’

‘*They* are all mad, proper mad. Let them all go to group then! There was nothing wrong with me until I came into this place…now I’m not fit to leave it nurse.’

‘Paddy, if you don’t go, I’ll have to tell sister that you are not being cooperative… about going to group today and it might go into your record. She sees everything.’

‘What record?’

‘Your care records. The notes that we write about your progress every day.’

‘Progress? I don’t feel any better since I was forced to come into this awful place, nurse.’

‘That’s because you don’t go to group. *If you did you would feel better*.’

‘Ok then Paddy, I’ll have to go and let Sister know and she will have to let Dr. Barry know too, that you won’t go to group.’

‘Sister will want to know who goes to group and who refuses to get better’

I turn slowly and walk in the direction of the ward door, knowing that Paddy had a choice to make.

‘Please don’t tell her. She doesn’t need to know nurse.’

‘I *have to* Paddy, or else I’ll be in trouble *myself*. She knows everything.’

‘I am sorry about that Paddy, but I’m only a student nurse’.

‘I have to do what I am told to do’.

‘I am only learning on the job. That’s just the way it is’.

‘This is not fair on me nurse; you are bullying me’.

‘It’s just a group Paddy! Only one hour. To help *you*, that’s all.’

‘With your feelings, and your mind and your social skills’.

‘Nothing wrong with my mind’.

‘Please Paddy.’

‘Please?’

He sits on the edge of the bed. Head down. Despondent. His battle is lost.

‘Fags.’

‘Sorry, Paddy? What was that?’

‘I want **five** after that group.’

‘I’ll go then, I don’t want you to get into trouble with the bosses. But I want me fags.’

Paddy gets up from his bed and puts on his shoes.

‘Two cigarettes, that’s it, Paddy’.

‘Ok.’

‘But this is the last time I am going nurse, I mean it.’

‘Of course, Paddy.’

Controlling

In his 1896 book, *The Crowd: A Study of the Popular Mind*, Gustav Le Bon argued that a person's behaviour is affected when they enter a group setting. His thesis was based on the observation of how people gave up personal interests in favour of the group interest. Paddy's resistance to attending group provides an opportunity to think about how I, and psychiatric nurses like me, insisted patients attend *group* thinking that it was the right thing to do. Groups were often something to do and somewhere to go but the underlining principle was the idea that the group represented a source of healing or improvement. Pratt (1907, p.40) is credited with establishing the idea of the group as a source of help for patients suffering from Tuberculosis, when he developed his *thought control classes*, acknowledging the unique properties of the group experience and the idea of universal *group think*.

It is a practice that has remained in one form or another and is one of those things that seem to bother me every now and then. As a student, I had chased Paddy and others, often under the guise of *behaviour therapy* and bartered their attendance at *group* with the highest prized commodity in many long stay psychiatric institutions - cigarettes. It seems shameful now to think that I, as an enlightened nurse, and others like me, might have considered such an unethical act as appropriate, but it worked because, again, just because it did.

Cohen (2016) argues that the *psy professions* (those professionals working in mental healthcare) operate from a fundamentally flawed position and have done so for a very long time. Paddy's diagnosis of schizophrenia is a common example of a 'psychiatric hegemony', the idea that ruling class values and norms have become naturalised within the scientific research and knowledge-production on mental illness. Cohen explains that 'over the past thirty-five years, this process of expert claims-making by mental health professionals has expanded and become a dominant frame of reference which we now use to speak of and understand ourselves and others arguing that people's behaviour, personalities, and lifestyles are now closely observed and judged under a psychiatric discourse which has become totalising.' (p.2). Accepted as a form of truth.

Cohen presents an argument, the basis of which is that the psychiatric profession operates to serve elite classes by exerting control over individuals that do not reflect the values and

behaviours of neoliberal society. I wonder if he means the elite as those who are fit to work, docile and compliant. When Paddy's body tires from hauling bags of coal he could be considered of no value to society. In my nursing career I can think of hundreds of people whom I made into *docile beings* by the act of medication, behaviour treatment regimens and care plans which were designed to ensure compliance and concordance. If I think about the mental health care system through a critical lens, I might argue that that the *psychiatric professions* do untold damage to mental health service users by marginalisation, stigma and the psychiatric diagnosis which can be described as *privileged knowledge* (Cohen, 2016, p.20).

Cohen also argues that the mental health system 'demonstrates how categories and symptoms of mental disorder have come to increasingly mirror the dominant norms and values of neoliberal society' (p.21). An example of this is the idea that being in a same sex relationship used to be a crime but is no longer so because society accepts it as normative.

Despite the infancy of my career as a psychiatric nurse and my status as a student, I held a position of power over Paddy. The environment and context within which our (un) dialogue took place reinforced the notion that this was an acceptable thing to do.

How could I ever have thought that was so?

Two men

None of it made any real sense to me, especially the business of *madness* itself. I recall working on a male acute admissions ward in my third year as a nursing student and, keen to impress my mentors, I asked if I could admit a new patient. This generally meant completing a lot of documentation and conducting a thorough nursing assessment. This man was admitted to the ward reportedly because of some sort of paranoid ideation, complaining that the IRA[69] were going to kill him because he was an informant. He was deemed to have paranoid schizophrenia. He was articulate, well-spoken and gave a very detailed account of why he considered his life to be in grave danger.

[69] The IRA (Irish Republican Army) is a paramilitary organisation in Ireland which had an active in a military campaign in the 1980s and 1990s in Ireland and England.

I wrote down my observations in my nursing admission notes, stating that he appeared withdrawn, suspicious, not forthcoming with information, in classical behavioural language, giving little regard for this cognitive or affective mind, or even that the man may have been frightened. In *Madness and Civilization* (1967) Foucault describes this madness by writing:

> 'we have yet to write the history of that other form of madness, by which men, in an act of sovereign reason, confine their neighbours, and communicate and recognize each other through the merciless language of nonmadness; to define the moment of this conspiracy before it was permanently established in the realm of truth' (p.11).

I understand Foucault's description of the *merciless language of nonmadness* to mean the ways in which people are confined and diagnosed with labels within a system that feels like a conspiracy (biomedical) without addressing how people may relate to others within their own world. Perhaps that man was being targeted by the IRA and that he had good reason to feel suspicious and was acting appropriately for a man with concerns about his safety. How could we possibly know?

Later that day, I had the opportunity to admit another man again with a similar presentation. He was admitted on a *temporary form* which meant he could be detained for assessment for some time, usually indicating the presence of psychosis or a serious mental illness. Again, this man was diagnosed with paranoid schizophrenia but the content of his delusions, revolved around the Catholic Church in Ireland (Dunphy,1997, p.248) and, in particular his troublesome feelings of persecution.[70] The exact source of this man's troubles was that he had *impure thoughts*, sexually orientated, and believed that because of this he was condemned by the Catholic Church. I remember being puzzled about the way in which both men were diagnosed with the same condition although the basis of their delusional content was very different.

It was not until I worked in London many years later that I began to appreciate that people with mental illness often locate and express their distress from within their own social

[70] In 1988 following a long campaign by David Norris and others the European Court of Human Rights found Ireland's legal prohibition of male homosexual acts to be in breach of Article 8 of the Convention on Human Rights. The Catholic Church in Ireland had strongly opposed the reform as did much of the state.

worlds and this is often a complex and layered process. I worked with many African men, the basis of their psychosis was rooted in their social, personal, and political contexts and because of that they presented clinically very differently. I wondered if it was the environment that made people unwell and that their way of coping was essentially what Szasz described as *problems of living* (1972, p.40).

But when I think of **Paddy,** I am reminded of his malleability which ensured that the values and practices (docile patient, psychiatrist as expert, obedient nurses, task allocated[71] care) which were/are imbedded within the psychiatric culture continued and I played an active part in that. His diagnosis of schizophrenia and all that entailed-the medication, side effects, the

dyskinesia

akathisia

amnesia

ensured that he was seen by the *psy professions* as disordered in some way or *lesser than* those without a diagnosis. His diagnostic label consumed his personhood. This type of stigma is both discrediting and devaluating (Goffman, 1963, p.131).

Foucault's description of *nonmadness* is a construct which is heavily rooted in power and the pathology of human experience, and I came from such a tradition where experiences like this were not uncommon despite the introduction of more moral therapies. Newer, more nebulous forms of control replaced the traditional locked doors, padded cells and poor conditions seen

[71] Task allocation in Nursing refers to a system of organising nursing care which divides work into tasks assigned to nursing and ancillary personnel based on the complexity of the task. The Registered Nurse addresses more complex tasks, whereas lesser skilled staff undertake more routine tasks.

in early Victorian asylums and my behaviour towards Paddy was an example of that. Under the guise of being *helpful* and threats to tell the doctor about Paddy's refusal to attend group therapy I maintained a sense of power and control over him, rewarding him with cigarettes when he finally acquiesced.

Tischler (2010) in reference to the (1967) book Madness *and Civilisation* wrote that,

> 'Foucault contended that the new discipline had introduced more sophisticated forms of control. Instead of chains, more subtle ways of restraining the mad were developed: patients were induced to construct their own 'chains', but these were mental in origin and served to constrict self-expression or any deviance from bourgeois ideas of decorum. Such ideas are often those which seek conformity, concordance with institutional regimes and a deprivation of liberty.'(p.14)

I often think that some of the so-called accreditation schemes such as *Restraint* policies are often forms of control under the guise of quality improvement and risk management**.** For me risk management itself is a problematic concept and from my experience seems to reduce risk and liability for organisations rather than improve patient care.

Sohn (2013, p.50) argues that the current risk aversive nature of contemporary mental healthcare takes away the mental health nurse away from forming/building therapeutic relationships with patients/service users instead of what Hildegard Peplau (1992) described as 'busy work' such as record keeping and medication rounds (p.14). Perhaps my own "busy work' as a mental health nursing lecturer also takes me away building closer relationships with students and colleagues, innovating, going off script (from syllabus) and pausing to sit with what I am and doing at any one time, before moving on to the next 'busy task'.

In the days when Betty and I worked together we did so, in the absence of risk forms, risk assessments which reduce individual patient *Activities of Living* (Roper et al, 1996) to elements of organisational risk, to be quantified, reduced, and eliminated. This fragmented way of seeing people as discreet units or subsets was not how Betty saw the world, instead seeing people as individuals, in person centred ways which is the antithesis of the biomedical model. Much like Freire's work on developing critical consciousness which encourages individuals to affect change in their world through social critique and political action.

How much has really changed?

This process of critically unearthing my role(s) is both uncomfortable and equally liberating and autoethnography has provided me with a way into and out of that experience. I cannot claim that what others did and didn't do was neither bad nor good without looking at my own contribution to mental health care and how I carry that with me into mental health education praxis. Reading the world and its power plays gives me (us) the ability to scrutinise my (our) practice and learn from it effectively (Ryan and Walsh, 2018, p.2) and an area of concern about my practice was medication and my role in it. In my days as a student I learnt about medication *compliance*, ensuring that all patients received their medication, because it was on their prescription chart and that it was good for them, the power of ……

Prescribing and ordering

Counting and checking

Doubling up

crushing, mixing, and diluting,

eye levelling

Good to go,

Throw your eyes on that Kate, sign there, should have finished meds at 10.30!

There now you go Paddy, it's for your voices, to get rid of them…….

Drinking down crudeness

Not goodness

Slippery shackles

I won't nurse, I won't……

It's pure rotten, rots my teeth

and fuzzes my mind,

That's *your diagnosis* Paddy! All in your mind

Will I get you a yogurt for you?

Here now be a good man will you!

Tea pots in the Day Room, be quick now, drink it down,

No. It makes me sick, my belly hurts, makes me worse nurse.

Ok ok then, if you won't take it *this* way, it will be the *sharp* way

Stand out of the line then, you are delaying the others, they are following the doctors' orders, they are taking *their* meds

Green needle is fine Kate, thanks

Prodding, poking,

Exposing

Bums, hips, dorsal gluteal

Upper outer quadrants, tracking zzzds

techniques, not leaks

Rub it all in

<u>Muscles not mouths</u> from now on…

Hurry for the Tea(s)

Four over 52

In the diary- see you next time.

Same again?

My role as a student was to learn how to administer medication properly in line with the hospital's standards and little else. I don't recall ever asking any patient how they felt

about taking medications and worked under the assumption that medication *compliance* was my priority. Asking people to open their mouths, stick out their tongue, turn to the left and the right, drink a glass of water, chew a sweet in case that they might refuse to ingest the tablet. I never once asked if a drug worked or asked about alternatives. I don't know why. My role then was about ensuring compliance and it was a powerful role, despite my novice status.

But then compliance became *concordance*. A softer word denoting agreement participation and active decision making between the prescriber and the patient (service user). It is described by the Royal Pharmaceutical Society of Great Britain as an….

> agreement between the patient and healthcare professional, reached after negotiation that respects the beliefs and wishes of the patient in determining whether, when and how their medicine is taken, and (in which) the primacy of the patient's decision (is recognised). (Blenkinsop et al, 1997, p.11)

Such words take on new meanings and shapes our understanding of *what's really going on*. Ahmed (2017, p.174) refers to the attention placed on the use of words rather than what they represent (or not).

The idea of concordance has found its way into the current discourse of medication policy and praxis and, while welcome, has been largely driven by pharmaceutical representative bodies and adopted by government agencies and the nursing regulators through the implementation of standards. Less attention is paid by regulators and agencies in Ireland on the continued and widespread prescription of mental health drugs, especially commonly used medications such as anti-depressants as Moncrieff et al (2022) 'we suggest it is time to acknowledge that the serotonin theory of depression is not empirically substantiated' (p.12).

The notion of concordance and all it entails (conformity, lack of resistance, power imbalances) is not confined to medicines; it is also seen in other elements of my life and work. In some of the work I do in the classroom I too am participating in ways which may be perceived as powerful, exerting control and influence over a group of students, in subtle ways, the ways of the classroom environment, in what Blake (1794) calls *mind forged manacles* a sort of academic hegemony - getting students to speak up, to perform, to behave as students, praising some and not others, being the expert and most commonly drawing students into groups, small

groups and big groups, despite protests after protest from them. Is my practice as an educator an extension of my role as a nurse? In addition, to what extent is my teaching transgressing the normative? How can I inspire students to change the system when I am an agent of that system, freely participating in it?

Is my role to inspire, to demand of undergraduates that they go out and change their worlds and address inequality, poverty, marginalism, and stigma in mental illness when I did not have any impact myself? Am I living vicariously through my students by putting them into groups because it seems the right thing to do? How will that help Paddy?

Peplau albeit back in 1995, reminded nurses that despite 'our current emphasis on medical diagnosis, sophisticated technology, economic cutbacks, and quick fixes, what most patients need most in the midst of this healthcare maze is sensitive and caring individuals who are willing to enter into interpersonal relationships that fosters *Hope* and prevents *Hopelessness'.*

Honouring the experience of another human is the basis of Recovery based approaches to care (Barker, 1995) and is congruent with the work of Freire (1972), in that he (Freire) in using a problem posing approach to issues 'evoking, rather than prescribing how one thinks'(Norris and Saudelli, 2018, p.3).

The roots of the Recovery movement in mental healthcare are based in service user and activist organisations such as the Tidal Model (Barker, 2001) with the focus on relationship building in mental health nursing (Peplau, 1992) and the uniqueness/person centredness of the individual person (Rogers, 1961). Freire also values the uniqueness of persons and sees the goal of people as *beings for themselves*, subjects of their own experience and of their own free will. Valuing a person's humanity as central to social change, justice, and the fight against dominating ideologies of evidenced based medicine and the medicalisation of human distress. (Proctor, 2006) Freire in this way offers *Hope* to Paddy and to others like him.

And to me.

Perhaps my role as a critical educator is also to offer *Hope.*

Watching

Psychiatric inpatients are well accustomed to being observed. More so than acute general patients, I imagine, because of the psychiatric environment and because of the nature of mental illness. I have *observed* many patients over the years, and it is an activity which is often an *invasion* (Bowers et al, 2000) an act of 'regarding the patient attentively, minimizing the extent to which they feel they are under surveillance, encouraging communication, listening, and conveying to the patient that they are valued and cared for' (p.437).

Admission to a psychiatric unit often involves patients being observed to assess their *Affect*, *Behaviour* and *Cognition*. This *ABC* is a self-taught mnemonic which helped me as a student to think about how best to observe those in care and what I should take note of when observing their clinical status. Most are admitted on a voluntary basis, but some are detained in accordance with mental health legislation. Today, many psychiatric patients are often first admitted into the *observation area* of the ward where nurses regularly observe them discreetly to aid *diagnosis* and document their findings to support care planning and treatment. I recall that it was a routine and common practice.

Sometimes patients are observed for risk of self-harm or for side effects of medication or for risk of absconding. Some patients are special category in that they are *special obs*- meaning that they are observed on an eye-to-eye basis meaning continuous monitoring even to the bathroom and during moments of intimate self-care. The degree to which this occurs depends on the persons clinical status and their risk profile. Such nursing observations can be considered as an important daily function of nursing in hospital settings (Nightingale, 1860, p.61) and are considered within nursing praxis as *observation* rather than *surveillance*. Psychiatric surveillance is now becoming an increasingly acceptable nursing practice, specifically within risk mitigation contexts. 'Surveillance is a key concept in psychiatric care and is constituted in part by the practical activity of making observations' (Salzmann -Erickson et al, 2012, p.2) and such observations are becoming increasingly discreet with the aid of technology thereby negating the need for human interaction.

Florence Nightingale (1860) noted 'it may safely be said, not that the habit of ready and correct observation will by itself make us useful nurses, but that without it we will be useless, with all our devotion' (p.63). The observation by nurses, of psychiatric patients in the absence of conversations with them, is *mere surveillance* according to Hamilton and Manias (2007, p.338). Surveillance in mental health care is often regarded as a custodial activity, not a

therapeutic activity (Martin and Street, 2003, p.550) but from my experience a mundane and utilitarian nursing activity and one which is often currently mediated through risk assessment approaches. I recall the *watchers* (usually nurses) and those who are *watched* (psychiatric patients) and sometimes student nurses who were both *watching and watched*. In my practice I also participate in *watching* students by taking an attendance register and watching who comes late to my class.

Such surveillance is not necessarily situation or person dependent. The psychiatric environment is often considered as an important treatment modality in its own right and is often referred to as a *therapeutic milieu,* implying an impact that the environment contributes to patient recovery (Thomas et al, 2002, p.102). Such environments are often strictly managed and highly controlled in the interests of patients, but staff welfare needs are also paramount. Consultant psychiatrists decide on the level of clinical observation required and instruct nurses to conduct nursing surveillance in accordance with their clinical advice and treatment plan. Nurses do not make this decision about nursing surveillance only to ensure compliance with prescribed regimes. Such regimes are often medicalised with orders of *nurse the patient in night attire* still common practice. If ever there was an order which I cannot abide it is that a practice which is designed only for the purposes of continued confinement a reminding and reinforcing illness.

Most of my student experience was on the long stay or psychogeriatric wards where the attendees were residents but were still called patients. It smelt of 'oldness' and *'sudocreme'* and was run efficiently and effectively. Hospital managers rarely visited except when a patient died. The ward was located on a third floor with a service lift on one end and a *dumb waiter* on the other. There was one door which served as both the entrance and exit and was controlled by a mechanical *buzzer*.

Controlling the movements of patients and staff, supported by a building infrastructure has its origins in the Panopticon system of architecture. This refers to cylinder structure, originally designed for use in prisons, with cells along the periphery and a tower at the core enabling supervision from a central, raised point allowing maximum visibility of prisoners. The idea that an architecture or building may be considered as enabling a form of social control was introduced by Foucault and Sheridan (1977), borrowing from Bentham's original ideas on prison architecture (1791) 'from the situation where the many see the few to the situation where the few see the many' (p. 217).

This was the case when I was a student and remains so in many psychiatric inpatient units today. The Ward Sister could see me, but I could not see her. The possibility of being *seen* was enough of a threat to ensure that we conformed to whatever demands were made upon us as students. It also ensured that her presence was always felt, even in her absence. as her authority and power were often mediated through other staff. One way I tried to negotiate this was to keep busy. Keep doing and keep busy. Be seen to be busy, not idle.

As I knew I was being watched I became quite adept at avoiding her panoptic gaze by pretending to be busy, when I was not. Perhaps her control over me, led me to exert a similar control over Paddy by chasing him to attend group therapy.

I thought that by working hard and being constantly busy that I was a good nurse but quickly learnt that I needed to think before I acted. I had a rethink about my hospital career after the denture episode and retreated to the classroom where I felt I could do less harm. The classroom felt safe - it was where I could do the hard work of thinking and reading. The separateness of *thinking* and *doing* emerge from my earlier life as two separate entities albeit in binaries. By that I mean the *thinking* part, or the cerebral part was limited to the classroom. The theory part.

The *doing* part I began to know as the practical element which took place in the hospital setting mainly, although there were some community placements also. This was where the *real learning* to nurse occurred and was, in my experience, markedly different to the ideals of the classroom. I learnt later that this is described as the theory-practice gap, which is not uncommon in mental health nursing (Hopton, 1996, p.227; Kellehear, 2014, p.141; Happell et al, 2022, p.811) and remains a relevant issue today.

Warrender (2022) describes this gap as a 'civil war' (p.1). This has been an accepted norm in nursing, especially among nurse graduates. Meissner's (1986) article asking '*Nurses: are we eating our young*? (p.52) in reference to newly qualified nurses' experience of practice theory gap, was written when I was a second-year student nurse. Thirty-six years later it remains problematic.

The culture and context of separation between learning and practice was felt by long before I became a nurse teacher. I have experienced it as a learner and a teacher but from different perspectives. The disembodied notion of *thinking and doing nursing* had a marked impact on

my professional career and of the way I began to think about learning in all its forms. But this notion of *thinking and doing* is a false binary (Miller-McLemore, 2016) little in terms of imagination about how to reconcile two distinct learning experiences from spatial dislocation.

In my attempt to *re-understand* my student learning experience I linger more, and potentially learn more about psychiatric nursing from Betty, Paddy, and to a lesser extent from the classroom. Perhaps this is a false binary, a narrative created between the inside and outside of the walls in which theory and practice are located.

I was so enthused by Joseph Robins interpretation of mental illness in Ireland *Fools and Mad- A History of the Insane in Ireland* (1986) and his assertion that 'what contemporary Ireland has inherited is not a high level of mental illness but an excessive commitment to the mental hospital and the mental hospital bed' (p.44). This seemed to support my own expereince of large wards and many beds.

But in 1985 things were different so I began to equate learning with the classroom and sought refuge there.

Or perhaps, I just did not want to be eaten.

In my encounter with the older couple who were unable to find the canteen, I am shining a light on the power privileges I held over Paddy and continue to hold today, as a lecturer. The frustration I feel sometimes working within hostile milieu erodes my sense of autonomy and empowerment as an educator. Sometimes that frustration is of my own making- feeling as if all the problems and dilemmas of my role as a nurse educator are solely mine to solve or that my dilemmas are everyone's else fault. This research shines a glaring light on some of those issues albeit in intimate and personal ways.

In telling stories about Paddy and stories about my own experiences as a learner and an educator it exposes the complex connections between what I (we) think and who we are, our personal values, ideas, emotions and feelings.

Revisiting Paddy is a helpful hopeful way of doing that.

Year 4

Checking in

In the early 2000, I completed some studies in the UK where my experience of learning was so different to what I had experience previously. In line with Freirean philosophy, I recall that my fellow class participants were seen as knowledgeable individuals and 'teacher' and 'learner' voices are both equal and heard. Our facilitators at the time embodied a pedagogy of care which was both emancipatory, attentive, and liberating (Freire, 1998).

Exemplars such as listening to students, showing empathy, supporting students, actively fostering learning in class, giving appropriate and encouraging feedback and praise, having high expectations in standards of work and behaviour, showing an active concern in students' personal lives are listed in Walker and Gleaves (2016, p.66) work as the basis for framing a theoretical approach to understanding caring in teaching. A relational, compelling imperative to care summarizes the foundation on which care is described in this study and was echoed by my experience.

I think of my own students and wonder about my own teaching practice.

In the book, *Teaching Critical thinking; practical wisdom (2013)* hooks argues that education is about 'the practice of freedom' and that teachers have a responsibility to help students build self-esteem as a prerequisite for learning.

She writes:

> 'Teachers can promote healthy self-esteem in students by showing appropriate appreciation and awareness of their potential. This does not mean that praise should be given indiscriminately. It does mean that calling attention to strengths a student may possess and encouraging her or him to work from that foundation can provide the necessary confidence that is the key to building healthy self-esteem. In my classrooms, I work to teach students how to evaluate their own progress so that they are not working to please me to get good grades. They are empowered by working in a manner where they recognize their responsibility and accountability for the grade they receive. That empowerment reinforces healthy self-esteem' (p.125).

hooks did not confine her attention to the individual learner needs. She saw education as a loving act, not merely in a traditional romantic sense but instead meaning love as *action*

towards social change for the betterment of humanity (hooks, 2000), 'to speak of love in relation to teaching is already to engage in a dialogue that is taboo' (p.127).

From my experience in nurse education, I have not equated good teaching with *love,* or at least have not yet. I wonder what hooks might think of this aspect of my practice.

But, as I write now, I am reflecting on my current role as a teacher and wonder if, despite my own efforts to work reflexively, and my commitment to critical education practice I, at times of *busyness and stress,* resort to the *banking system* of education, depositing snippets of knowledge into students (Freire, 1972, p.64) as I try to manage a loaded curriculum and a full timetable.

Loading *Moodle* pages with content to *cover myself* in case I might forget something is an embarrassing thing to admit even if I am the author, narrator, and character of my own story (Randall, 2014, p.5).

Such conflicts about and within my practice are at the heart of Freire's educational philosophy. I want to work in ways which are liberating, dialogical and liberating but find myself struggling with a system which is hostile, oppressive, and unequal. Surfacing such oppressions can be according to Freire (1972) dialectical, both disturbing and liberating at the same time. This research mirrors that as it is an intentional and constant critique of my own positionality, my identity and pedagogy as a way into understanding what it feels like to work within a neoliberal and often hostile system (Schultz, 2014, p.222) while also looking for ways to be *Hopeful*, courageous, and helpful in the world.

I start to think about Hopeful, courageous, helpful people and think of Betty, again.

But why about Betty?

She was a consummate professional, diligent, attentive, dutiful and a great nursing role model. Helpful, courageous, and kind,

For me. Perhaps her care was

an act of love.

an act of courage

and a political and moral practice (Freire, 1972)

as she had a capacity to love and that the institutional walls did not limit how that was embodied. She brought love back in from the outside to the inside and perhaps took it back out again. Maybe that was her *social justice*, her commitment the voiceless, to those who were locked up behind big, bricked walls.

Perhaps that was her way of breaking free. A liberating act of love and courage. What I saw as a first-year student nurse initially considered as an unprofessional act, was love and care for others, in a way that she knew was best.

The patients momentarily tasted liberty: they tasted love.

Freire (2005) suggests: 'It is impossible to teach without the courage to love, without the courage to try a thousand times before giving in. In short, it is impossible to teach without a forged, invented, well-thought-out capacity to love'. (p.5)

hooks (2003) also conceptualize love from a more radical perspective and states, 'there can be no love without justice' and 'love will always move us away from domination in all its forms. Love will always challenge and change us' (p.137).

Again, hooks speak of moving away from domination, which is often mediated through power relations and control. Betty relinquished control. The facilitators on my doctoral programme in modelling their work in ways which are participatory, inclusive, and engaging and make the students *feel part* of something.

Attending to, giving voice to, checking in and out of, actively listening, observing, telling stories, resisting conformance, celebrating performance.

I feel cared for.

Settling.

Safe

Listening

Communicating

Validating

Just

helpful

welcoming

people.

My prior experience of group learning was very positive. As a student, I found the idea of sitting in circles difficult, feeling vulnerable as a learner again, but encourage its use within my own practice as an educator. My own assumptive world at odds with my educational practice.

This sounds rather hypocritical and disingenuous of me

but

I am not sure about how I feel about circles or even groups arranged in circles. It feels like I am being watched again, although the circle arrangement should not make a difference. Because everyone is being watched. There is something warm and welcoming about it but there is also something *troubling* about it for me. Circles of participants feel like groups and groups feel like some sort of therapy. Like a group of souls have come together *to do* something and not perhaps *be* something.

Mental healthcare is full of groups. They are everywhere.

Rehab groups, recovery groups, psychosocial groups, social groups, anxiety management groups, bereavement groups recreational groups, relaxation groups, psycho educational groups, eating disorder groups, substance abuse groups, skills formation groups, wellness groups, *notso*wellness groups, let's herd everyone to a group, group.

As a student I recall running around a psychiatric ward gathering up patients to go *to group* every week. Most did not want to go but it was considered a *good thing to do*, to join fellow patients in a group and to be part of something. The idea behind which albeit socially constructed (McNamee et al, 2023) that patients were better off *doing something* rather than *doing nothing*.

Just because it was.

Circling

I often wonder how much of my own world I take into the classroom and if the classroom is an extension of kind of therapy group (McNamee et al, 2023). Am I re-enacting a kind of therapy by getting all the students into a group, or a least a circle?

Is a circle a group?

Or a group, a circle?

Does a group need a circle?

Who says so?

It's just ones of those things we do as teachers, educators. Draw learners into our rounded world. More concerned with what Brookfield (2017) calls the pedagogic 'feng shui' (p.29) or the assumptions that educators make about *things being better this way* just because they are.

I understand the circle to mean democracy, equality, visibility, presence, unity, togetherness. But what about Paddy and all the others who do not want to be part of the circle? Do students want to be in a group or is it just the way it is?

Am I unsettling, disturbing, inviting, propositioning when I am circling? or just making assumptions. Am I the therapist or the teacher or both or none? Can I assume that the experience for all students is universal? Or is this a way of harnessing and holding space to allow to be what it is that is to be, just because it is.

Like a lot of what happens in mental health. It just is.

Critically reflecting on my own participation in group as a Doctoral learner allows me a privilege from both inside and outside the circle that is sometimes mental healthcare and sometimes illness. I draw on my experience as a mental health nurse in the comfort that when I first entered the group as a post graduate learner, I knew what *was coming*. I watched, in surveillance mode as the lecturers went about their work decentering themselves as participants blending into the circle. They make it look easy when it is, in fact, not. This was transformative for me because it challenges some of my previously held views about *being circled* and helped me 'make meaning' from my experience, from the learner to the teacher and back again (Mezirow,1991, p.100). I became aware that groups, when done properly were powerful and protective ways of engaging with the world.

From my own experience as an educator, I feel that that learners can flourish when they can feel, be seen and be heard as legitimate in their world (Winnicott (1971, p.2). When we (learners) feel loved, we can begin to realize our humanity through our relationship with others. This is further supported by Honneth (1996, p.78) who agrees that love is foundational in learning, but that love is also belonging and is respect. Self-respect and belonging are considered as love. This belonging can refer to a group and that fear and anxiety that coming to a new group of learners may sometimes bring. In demonstrating care and love, learners can feel self-respected as they are now part of something. When we (learners) feel that we can learn, a change occurs in who we are as learners and therefore in how we see the world.

Formenti and West (2018, p.149) also develop this idea of love and the need for educators (particularly Adult Educators) to appreciate where learners are coming from in terms of their experience of education and life. As a learner that was new to the habitus (Bourdieu, 1977, p.19) of group research supervision the educators invited our group in with care, recognition and love. hooks (2003) further support this by saying that when we feel that we are recognized

we are fully able to recognise others. My sense is that my participation in the research supervision group allowed me to be recognised and therefore able to recognise others.

hooks (2014) in writing about *transgression* wrote that excitement in higher education was viewed as potentially disruptive to the atmosphere of seriousness assumed to be essential to the learning process (p.7). Betty's transgression, Paddy's transgression, my many transgressions could be seen as needing excitement to counter our varying degrees of institutionalization.

Thinking about this and the stories of Paddy, Una and Jan becomes a deeply emotional experience for me in ways that (Holmes, 2010) describes as critical reflexivity, by that I mean that my emotional experiences as entangled within a power structure and power relationships which are often hostile and delegitimatizes my development as a critical mental health nurse educator.

This work for me is *life changing* (Holmes, 2010, p.140) as my practice is slowly changing as a result of what I am learning through this process of critical reflexivity and autoethnography. What I feel at times of high stress and frustration (feeling lesser than, angry, disappointed, binaried thinking, changing, despondent, hopeless) begins to change as I began to learn about the circumstances of my practice. I am trying to mirror a Freirean approch in developing skills of curiosity, listening and tolerance (Freire, 1998). Tolerance being the most challenging for me at times, especially when I think I am *doing things right* (group work, active listening).

By drawing students into a circle am I offering them a metaphorical cigarette to stay and be part of the system that is mental health nurse education, all of which exists within the dominance of the biomedical model and a hierarchical structure with psychiatrists at the top. I am drawing them into this theoretical and cultural space with the assumption that they are now part of the circle. The circle is psychiatry, which is supported by a scientific oriented, banking approach to education that infuses nurse education. I am part of both. I am the institution that legitimizes the medical model of psychiatry instead of challenging it. Because it is a powerful circle framed and layered in powerful medical and diagnostic epistemologies language and discourse and the business of pathologizing human experience.

But

Critical education offers a way into reimagining such structural and systemic problems by thinking as Freire might. Jenkins (2014) proposes that 'consciousness-raising approaches within the profession, collaboratively with other professional groups and with mental health consumers to focus awareness on and critique the injustices that are perpetuated by practices which privilege and maintain a narrow, unbalanced approach to mental health are needed' (p.6). This is further supported by Peplau (1992) and Rodney et al. (2012) who argue that members of the profession have a valuable opportunity to engage in action at a 'political level to address the ethical implications of the politicization of knowledge about mental health and illness' (p.6).

Time to …

Relax

Relate

Communicate

Suzy Bernstein shouted those words to the members of her group therapy class in Bernard Farrell's (1979) play *I do not like thee Dr Fell*, more commonly known as *Dr. Fell*. In the satirical comedy she passionately believed in group therapy so much so that she could not see the irony of her own failures and blamed the group participants for the failure of the group therapy sessions. In some ways my practice as an as educator is not dissimilar in that I am busy doing group because it seems like the right thing to do, and I assume that I am the right person

to do it. Getting students to relax, relate and communicate is my role as an educator but the challenge is also to prepare students to become graduate mental health nurses and to work in the murky waters of reality.

Bringing students into the *circle* may also be a way of bringing them into the realities of clinical practice. The divide between the inner circle (institution) and the outer circle (practice) is an unclear one which they constantly need to negotiate as students and one which I also need to steward as a lecturer but also a mental health nurse. Repper and Perkins (2009, p.85) argue the key challenge is a dichotomy between how mental health nurses are educated and what they find in practice; there is a theory practice gap.

The duality of the theory practice gap in nursing is well documented in nurse education. It is problematized within nurse education by Greenway et al (2019) as 'the gap between the theoretical knowledge and the practical application of nursing, most often expressed as a negative entity, with adverse consequence' (p.2).

I am aware that I bring my own experience to learning. I bring with me my assumptions about the duality of the theory practice gap and how that must exist, especially as I had experienced it, as a form of truth, albeit slant. Such binaried thinking has grown from my own experience as a student nurse and a lecturer in nursing. I may teach students that what I teach in class may not be witnessed by them in clinical practice and offer strategies around how that might be mitigated, suggesting that they may need to share their knowledge with their qualified mentors, like one of Betty's brown bread parcels. Warrender, a mental health nursing lecturer describes this:

> 'Whilst I would never claim that the theory and academic component to nurse education is perfect (it is far from perfect), the problem is that regardless of what I teach, with one sentence from any nurse in practice, it can be dismissed as idealism'
>
> (Warrender, 2022, p.3)

Bainbridge (2018, p.40) describes this/these as *gaps.* The role of teacher as *to mind the gap*. Perhaps I am the bridge.

But the problem is not the gap. The problem is what I am teaching student nurses rests of a medicalised conceptual framework without a social analysis of neoliberalism. While educators and researchers have been concentrating on the gaps between theory and practice the problem of the biomedical model has become more endemic and naturalized within mental healthcare

with Sharfstein (2008) noting that the bio-psycho-social model which traditionally underpinned mental healthcare has been replaced by the 'bio-bio model' (p.2).

However, as I have journeyed through this Doctorate programme, I am beginning to realise that I have my own agentic power to seek opportunities to teach in ways which explore alternatives through problem posing, collaboration and dialogue.

A busy Thursday

Lunch?

Haven't time…but thanks anyway. I'm snowed under here.

Go on Robert … its curry today -you never know, it might be nice?

Is it always this busy?

Sometimes……mostly.

-It's a different kind of busy, one that just keeps going and going. But you will get used to it.

-Think of the holidays.

Yes, looking forward to that. One of the benefits of being in Higher Ed..

True.

Certain times of the year are busier than others, you will get used to it.

How long have you been in Higher Ed?

Too long.

Seen some changes?

Yeah, plenty.

Do you still enjoy it?

Sometimes. I still like the teaching but there is so much to cover these days, because of all the directives. The amount of admin is cruel and getting worse. But you will get used to things.

-Starting a new career is hard and moving into new spaces is harder. I get that.

-It's a tough gig, leaving practice and moving into Higher Ed Robert.

-How about you? Are you settling in?

I like the teaching but it's just so different. I feel a bit useless to be honest. Everyone seems to know what they are doing here.

They are just pretending!, I shouted out.

-Seriously Robert, I understand. I really do. When I moved here I was so lost but some colleagues were nice to me. Some were nicer than others in fact. You will find your tribe, in time.

It's well documented that this transition is tough (Seal, 2017, p.95; Logan et al, 2016, p.596; Duffy, 2013, p.620) *and in the early days of 2002 when undergraduate nursing first started nurse lecturers were seen as different because we were and still are so highly regulated making us seem different* (Fealy, 2005, p.33).

Robert, In any career change, the role transition from practitioner to educator can be 'problematic' (Goodrich, 2014, p.206) *and it's been called a neglected transition for good reason* (Hunter and Hayter, 2019, p.182) *because there is the assumption that nurses can transfer seamlessly from practice without adequate time to assimilate into a very different world*

…It is ironic that many lecturers start new roles in September when there is simply no time to teach them!

You know what I mean Margaret, when you are on the wards and even when you don't know what to do, you still know *what to do*?

In what way?

-Well, if I was working in community care and then moved onto an acute ward, I'd pretty much know something, because I am nurse. Patients don't change, do they? So, I feel that I could help in some way, because I am a nurse.

-Nurses always know what to do, that's how we roll. That's our profession, that's our identity.
-I would instantly know *what to ask, what to look for, how to talk* to patients, what to do and just get on with it.

-Here I feel a bit useless. I miss being useful and knowing what and who I am.

-I worry that I am not a nurse anymore. Margaret and I am worried about the temporary contract and the work precarity (O'Neill, 2015, p.190; Seal, 2017, p.6).

It's a tough move. A big move.

But Robert, you are still a nurse

And now a lecturer

A nurse- lecturer

A lecturer of Nursing!

And anyways mental health nursing has always been moulded by others, so we are well used to adapting so this role transition entails assimilating a new set of values and norms, as well as developing a new identity.[72]

Short silence

Look, I won't pretend that the transition over is smooth, it's not. Really not. It's just different Robert, everyone settles eventually, different language, different processes, different expectations: all of which can make the novice feel overwhelmed and out of their depth (Anderson, 2009, p.205).

[72] In Ireland nurse tutors were previously employed by the Dept of Health were afforded an opportunity to move with their pay and conditions intact for a period of up to two years and return to their previous role as nurse tutor if they wanted to so there was a sense that in the early days the transition was temporary for some

But you will find your own way and settle into it.

Are you sure?

Yes of course I am Robert.

This is well known. There are heaps of literature on it.

You are leaving the familiar and moving into the familiar and this is a tough gig for sure.

But it gets better.

I will help you but meanwhile there is some interesting articles on the experiences of nurses who left practice to move into higher education and who found the transition difficult. Many have felt lost and miss their identity, but you will build another one, which holds space for the two worlds of the theoretical and the clinical but in time you will find a balance between being a clinician and an academic thus 'reconciling…professional identity'(Baldwin et al, 2017, p.20).

I will signpost some good ones and email them to you later.

Now lunch!

before all the curry is gone

Definitely…

Identity (ies)

The transition of nurses from clinical practice to academia can result in a shift in professional identity that is how one sees themselves in the context of their professional milieu. Psychiatric or mental health nursing can be many things to many people and so ‘the profession’ is at the mercy of others. Historically it has been shaped by the needs of service (Connell et al, 2022, p.472) and professionalism within mental healthcare is very difficult to define (Aylott et al, 2019, p.546).

I suggest that psychiatric nurse's role is today in an *identity crisis* and has been for some time. It is accepted that nursing contribution lacks definitional and role clarity generally, but this is especially pronounced in mental health nursing. The continued ambiguity about the scope of the profession is harmful to the discipline's identity and to patients' interests (MacNeela et al, 2010, p.340).

Practitioners in the field, experience challenges in maintaining an ever-increasing demands of professional competence and knowledge of Mental Health legislation, clinical skills, therapeutic interventions, advanced skills of assessment, diagnosis and treatment and service providers want an off the shelf nurse who is both clinically competent and compassionate. Emphasizing the Science and Art aspect of the role is often mediated through accommodating pathology and risk with humanistic and caring and is reflected in how nurses perceive the core elements of their role.

Many lecturers I speak with agree that the variation in nursing roles may affect everyday understandings of what it is to be a mental health nurse (Terry, 2020, p.414). According to a review by Trede, Macklin, and Bridges (2012, p.366, cited in Terry, 2020, p.414), ‘professional identity development focuses mainly on self-identity, structure and agency, a community of practice, situated and experiential learning, reflective practice, critical pedagogy, and grow and develops along the way.’

In the absence of understanding professional identity, a profession may struggle to recruit new members, develop a knowledge base, and demonstrate efficacy and that is clearly evident in psychiatric nursing today.

In the early days of 2007 deciding where to have lunch became a major task as I wanted to return to familiar faces and a university canteen can seem very different to a hospital one, compounding the sense of loss through feelings of isolation; therefore, forging new friendships and alliances is integral to 'belonging' (McDermid et al., 2016, p.30) and my desire to hold my identity as part of a group (Honneth, 1996; Formenti and West, 2018, p.166).

Transitioning from one profession to another is made more complex because, as is evident throughout this contribution, psychiatric nursing itself is in a crisis in terms of its own identity. The identity of psychiatric nursing is in transition from asylum to community, from medical to social, from myth to metaphor, from old, crooked walls to newer bigger walls.

The identity crisis which beleaguers psychiatric nursing is not a new phenomenon. Barker and Buchanan-Barker (2005, p.39) describe *an enduring enquiry* within the professional discipline of mental health nursing. Arguing that psychiatric nurses 'engage in a variety of professional roles' they struggle at times to 'articulate clearly what a mental health nurse does' (Grant, 2001, p.4). This is strikingly evident in Ireland as the professional regulator (NMBI) fails to clearly articulate what a psychiatric nurse does but does so for general nursing (NMBI, 2016) explaining the values psychiatric nursing espouses but not the nature and practice of psychiatric nursing itself.

I agree that the 'consistent dialogue' (Barker, 2006, p.40) or *identity enquiry* (Santangelo et al , 2018, p.267) about psychiatric nursing impacts negatively on nurses, students and lecturers and to position themselves in any place other than one which retains a *psychiatric episteme.* A 'weakly defined professional identity' (Hercelinsky et al, 2014, p.25) is intrinsically linked to the unpopularity of the specialty (Happell & Gaskin, 2013, p.150).

McKenna et al (2004, p.178) articulate that lack of a clearly defined place for psychiatric nursing leaves the profession vulnerable to a form of *role drift* in practice: namely the 'ad hoc' shifting of responsibilities. This is clearly evident in the recent shift within the profession to recovery-based system of care. The *role adrift* is further compounded by the orientation of mental health care towards a social model of care rather than a medical model which nursing as traditionally identified with. If mental health is to be delivered within a social care context and mental illness is to be regarded as a normal function of everyday life, then what is the future for mental health nursing?

Barker and Buchanan-Barker (2005, p.39) were instrumental in developing a model of care which instead of viewing mental illness in pathological terms begins to describe mental illness in terms of recovery possibilities and does so in metaphors. Barkers' assumption is based on a philosophical approach to the discovery of mental health which emphasises helping people reclaim the personal story of mental illness through finding their own voice. The use of personal narrative and metaphors (seeing illness as a tide which ebbs and flows through life) has become popular in contemporary mental healthcare as a way of developing therapeutic alliances with service users, which is regarded as essential to recovery. This is well documented within mental healthcare (Turner, 2014, p.16)

The challenge in attending to any kind of professional commitment is deep seated and rooted in the emergence of the profession itself. Furthermore, the nature of the transition into Higher Education by nurse educators is at the heart of what McNamara (2009, p.1566) describes as interdisciplinary politics.

This is not unique to psychiatric nursing. It is also situated within the role of the nurse and the relationship between knowledge and caring and nursing and knowledge. I think that we cannot separate this 'crisis of identity' from the hierarchical relationship between nursing and medicine. So much of nursing knowledge - much of which is experiential, draws us away from the medical model yet the systems we operate within ensure we cannot turn our backs on it given the dominance of the medical model and the hierarchical relationship of the two professions. Discourses about theory practice gaps and the nature of nursing remain as critical as whether nursing identifies itself primarily as a science or art.

Such discourses also sustain the coexistence of a divide. Nightingale's view of 'nursing proper' cited in Fealy (2005) that nursing could only be taught at the patient's bedside and that lectures and books are but valuable accessories (Fleetwood, 2002, p.1) is a reminder that the challenges to nursing can also arise from within the profession itself. Peplau (1994) stated that 'what nurses or psychiatric nurses do-or learn to do-in any given country has much to do with prevailing definitions of the phenomena called 'mental illness' and of definitions of the nature of the corrective professional work that is needed to put patients in the direction of 'mental health' (p.10).

Who are we?

The HSE, (HSE.ie) name Psychiatric Nursing as a *specialist nursing discipline*, concerned with working with people who are experiencing mental health problems. It describes nurses as those who work with both the person and their families in times of distress to enable them to use theirown inner resources as well as professional resources to promote recovery and wellbeing. As employers it seems to frame nursing in terms of what nurses *do* or rather what it thinks nurses should be doing. In describing their role and functions it is assumes the power to do so and so shapes the identity of the mental health nurse through the lens of the employer.

Nursing's patterns of knowing and subsequent clinical, conceptual, and empirical knowledge require placement in institutions of higher learning that promote both professional competencies and attitudes. Knowledge and appreciation of the virtues of caring, compassion, integrity, honesty, respect, and empathy are a basis for upholding the professional values of nursing and identity as a nurse (NMBI, 2016).

As I have evidenced throughout this research, mental health nursing is about more than thinking and doing. It is about being. Being of ourselves and being with others. It is a relational enterprise. Hildegard Peplau's Theory of Interpersonal Relations (1997) is probably the most significant in terms of offering a theoretical and practical understanding of the importance of the nurse- patient relationship. 'People need relationships with other persons. At their best, relationships confirm self-worth provide a sense of connectedness with others and support self-esteem. Relationships constitute the social fabric of life' (p.165).

Scanlon (2010) studied the profession's perception of what constituted as important in a therapeutic relationship and agreed with Rolfe's (1990) conclusion that Psychiatric nursing can be seen as occupying two care domains as indicated by the role or title; to nurse implies a *doing* activity and psychiatric nursing involves a competence and knowledge of conditions within the spectrum of the study and treatment of mental diseases (p.3).

Thinking about nursing in these terms seems to limit the potential and possibilities of the mental health nurse and I wonder about the need to do that at all. The shift towards an evidence base, the focus on recovery as a primary care philosophy, the involvement of service users and their families lead to a more person centred co-authored undergraduate curriculum. The proliferation of humanistic *Recovery* based approaches to care, which is concerned with social determinants

of mental illness and the subsequent relationship with the nurse has had a major impact on the development of mental health nurse education at higher level since 2012. (HSE, 2012). Perhaps alternatives are now needed. Recovery has somewhat been accepted as 'gospel' in Ireland and now underpins all mental health policy and practice and education without any form of scrutiny. There is no agreed definition of what *recovery* means, instead it is understood not as a linear process but a personal journey that involves a change in attitudes, beliefs, and skills to live a hopeful and meaningful life (Higgins, 2008). Psychiatric nurses have embraced this way of working with service users which offers hope as a way forward. It is a philosophical, policy and practice shift towards a less medicalised way of honouring human experience and now guides mental health nurses (DoHC, 2012) however it remains firmly rooted within an employer context, dominated by a medicalised *deficit/diagnosis* care approach. The impact of this move away from the medical to a more social way of being on the role identity of mental health nurses is yet to be evaluated as traditionally the profession was aligned to medical psychiatry. Gournay (1996, p.9) advocates for a robust evidence based in mental health nursing which includes the proposition of a biological basis for mental illness.

Chambers and Markham (2017, p.802) asserts that mental health nursing does not take place in a vacuum but, rather, in a system influenced by social, political, and professional initiatives and directives. Factors which impact on a personals mental health are not limited to the problematizing of human distress and include housing, access to paid work, finance, access to health and a sense of belonging within society. The recent allocation of just one percent of the Governments annual budget for mental health has been derided as appalling by trade unions.

This, compared to funding for mental health as a percentage of the overall health budget, has fallen from 16% during the 1980s to 6% in 2020 and the 2021 allocation represents a continued under-investment in mental health services. Chambers and Markham (2017), while referring to the UK experience, but is not dissimilar in Ireland, also assert that 'although mental health and illness have greater prominence on the political and social agenda, there is a mismatch between rhetoric and reality with investment in mental health below that for other illnesses' (p.42).

The lack of investment in mental healthcare in Ireland impacts negatively impacts the successful implementation of the recommendations of the *Vision for Change* (2006) and the *Vision for Psychiatric Nursing* (2012) as mental health nurses account for the largest percentage of mental health workforce and are most likely to be impacted, particularly new nurse graduates.

Hope and Hummus

Walking through Parnell Street to meet my friend Hattie (Hat, or H sometimes). She usually calls me M or Margaret when she is trying to make a point. A lifelong friend. I peer through the darkened rain to see if I can catch a glimpse of her through the mid-week evening rush. I am always excited to meet her because she is a great person, great fun, and a very good teacher. An entrepreneur with a taste for travel and adventure. A PhD in Physics aged twenty-eight, she has spent most of her working life in the post-doctoral world of dental research but sometimes teaches.

She *was* late. About thirty minutes, or so.

'Hello Hattie, how are you?'

'You're late!'

' I *did* text. I got held up at a meeting. I *did text*. Look at your phone the odd time M.'

Proceeding to search for it in my bag. 'Oh Yes. Reading the three texts. how's it all going?'

'Great M. Great. '

Inattentively listening to our ritual-mutual *wellbeing* replies, we headed in from the rain into a well-known pub where a huge welcoming fire was burning.

'Usual M?'

'Yep..make it a quick, busy week.

'No argument there, mo chara. Couldn't be any worse than mine.'

Hattie brought the drinks down to our table, ready for a long *un*sobering chat. A small drink to taper the edge off the day, the week and life in Higher Education for us both. As is often the case with friends who work in a similar sector, conversations creep to chats about work and the week we have both had.

'Well...?'

'You first Margaret?'

'Well, Hattie, seems funny now, but wasn't at the time… This morning, I gave the students a lecture about using their mobile phones in class .so much so that, I told them that if I saw *one more person* looking at their phones, I would ask them to hand it over to me…. I think I was a bit tired today and guess what?'

'What?'

'My own mobile went off. In my pocket!'

'What? No way! You?'

'I never bring my phone into class. Never. Can you believe that?'

'Oh, I can,' (sarcastically).

'And then ..one student marched up and requested my phone from me. I had no choice but to give it to him. What could I do? I was so embarrassed, but he was right. Perfectly right. He took my phone and placed it on the desk at the top of the lecture theatre.. They (students) were all laughing, and it taught me a valuable lesson.

Never ask students to do something I would not do myself !

… and every day is a learning day for everyone!

My class was ruined, I lost them, and they lost me. We lost each other and I just couldn't get it back.

Hattie laughs out loud.

'Yeah, now that *WAS* funny Margaret. That will teach you in future.'

'OK, OK OK. Enough now. Your turn.'

Hattie started her confession.

'Do tell.'

'Well, you think *the phone thing* was embarrassing, I marched into the big lecture hall in a mad rush and shouted out an apology for being late.

The class looked bewildered and glared at me …I mean really glared at me …with intent. I thought they were cross I was so late, so I threw my bag and bits onto a chair with a mighty wallop, my lunch box falling onto the floor. Bits of food everywhere.'

'And guess what?'

'What?'

'I was in the wrong room Margaret! With the wrong class!'

'Yeah?' (Laughing).

'Yes'

'I thought it was Tuesday. It's Wednesday today.'

'I know!'

' I didn't notice the lecturer down the back of the room, talking, teaching in full flow.'

'Ooops.'

'I froze, my internal dialogue was like a switchboard. Jumbled.'

'The lecturer, just glared at me and asked *can I help you*?'

'Then to make matters worse ..one of the students repeated it.'

'Can I help you?'

'I couldn't get out of that room fast enough…'

'Hahahahaha..that is funny Hattie.'

'A kind student helped me wipe the hummus off the floor. I was frozen. I mean really was.'

'Like a frozen chip..'

'I am glad you think it was funny. Jeez ..why do we bother eh?'

'Exactly. Not easy.'

'Yeah…people think we have it easy..'

'Do they?'

'Yeah...you know, summer holidays, good jobs, pensions, etc Public Servants ..'

'Seriously. Half the time M, I feel like I am winging it..'

‘Half!???’

‘How are we expected to know it all?’

‘We aren’t ..’

‘But I think they expect we do.’

‘They? You mean the students?’

‘Them yes..everyone, the *Ard* Level. Higher ed.’

‘Really? Do you really believe that Hattie?’

‘Yes, I think that they come to Uni and expect that we know everything and will fill their heads with information and knowledge…*that we know everything*. Sometimes it terrifies me to be honest. The pressure. To know *all there is to know* on what I teach. What do I do? But fill their heads with information and take it all back out and put it back again the next year. Rinse and Repeat.’

‘Empty vessels ..’

‘Yes. I suppose so.’

‘Like Freire?’

‘Not him again!’

‘Yes *him* again. He had ideas about filling students’ heads with knowledge.’

‘Oh that. I don’t agree. As much as its stressful for us at the end of the day, we know more than them and they are here to learn. We are paid to teach and make them learn. Simples. Don’t over complicate it M’!

‘Them?’

‘Yes, the learners. The students. The phone takers and hummus scrapers, M’

A smiling silence warms the chat.

‘True. But it **IS** complicated Hattie, isn’t it?’

‘No, it isn’t. It’s **YOU LOT**, that make it complicated.’

‘Us lot?’

‘Overthinking, complicating, theorizing, no answers, there is never an answer, only questions. Education liberals. Never an answer to anything.’

‘Are there answers? It depends, suppose. I really do not know Hattie.’

‘Well, you are an academic Margaret, you should know what you know. If you don’t know then how you can teach!’

‘It depends, Hattie.’

‘No, it does not depend. On anything. It is not contingent on anything. Either you know your subject, mental health nursing or you don’t. I know physics. I teach people who know nothing about physics, and they learn that from me. I pass it on. Only one way really. Students show up because they want to be there. To learn physics and its application. In real life.’

‘Do you think they know nothing ?’

‘Of course, they don’t. That’s why they come to me. Or I to them. They are empty. I fill them up with facts. Derived from science. I teach them everything they know.’

‘ If you can find them…’(laughing).

‘Seriously M, we shouldn’t devalue ourselves.’

‘No we shouldn’t. I don’t think we do. Intentionally. Except with phones.’

‘What do you think M? Don’t you agree?’

‘OK. I think that you are probably an excellent teacher, but I don’t agree that your students *know nothing*. They arrive knowing something about the world they inhabit. They come with a certain type and kind of knowledge, even when we are teaching the sciences (Frankenstein, 1983, p.315) You then create the conditions in which that can flourish. But I suppose there are different ways of looking at things Hat.’

‘That’s just nonsense*.’*

‘You seem bothered, by this?’

‘Well, I’ve been told that I need to have a teaching qualification. I need to do a Cert of some sort in Teaching and Learning. I’ve been teaching for years !...only been teaching for twenty years. Lots of research, I have published every year and now?

I'm told I must do a course in how to teach and how to be a learner? Who decided this? I feel it's unfair to be honest.'

'That must be so difficult for you (sarcastically)?'

'Yes.'

'I don't like that waffly 'critical education' nonsense. I do not believe in it. I am good at what I do, what do I need a Cert to prove that?'

'Good point H'

'If I can teach and students pass their exams, what more is there? That is how the world rolls. In and out M, does it not?'

But I do not think that critical education is to blame., if there is such a thing.

'Oh there is !'

'Why do you say that? Maybe there is just education. Knowledge. Simple.'

'Imagine thinking that there is no such thing as truth or reality or that what we teach is subjective? Are they going to teach me that on my teaching course?'

'Maybe you need a better attitude.'

Silence

'Sorry.'

M, I don't get it.

'If you turn up to your course with a poor attitude then you are unlikely to learn, are you? Do you know nothing about teaching and learning H?'

'Of course, I do! I've been teaching and learning for the past twenty years.'

'Exactly H! mo chara.'

'If we are not experts in our field of knowledge, then what are we? But that's just a belief, your belief. It has no value. Not Science. Hard Science. Proven Science. I teach dentistry. Future dentists. But this applies to those who teach physicists, or doctors etc. I teach my students knowledge on how to become dentists and rely on facts to do so. Imagine if I interpreted facts and read and taught them in a way that suited myself ..imagine that? I am a

Scientist. What I know is that ‘empirical, factual sciences are the only legitimate form of knowledge’.

‘I don’t disagree. I am not arguing with you. I believe that knowledge is derived from different sources but that in teaching and learning we need to understand how we know what we know and why that is so. If you believe that facts are’ only derived from observation’ or that knowledge is that which ‘can only be verified’ (Bentz and Shapiro, 1998, p.177) then that is the world that you inhabit.’

‘I do. I believe that’

‘I Do not H’.

‘Think about this. Hattie. If you are teaching that group of learners whom you assume know nothing about your subject areaand who’s heads you must fill with new knowledge are you assuming that they are all the same? That they all know the same nothing or are there different forms of nothing? Maybe that nothing knowledge rests in a vacuum or maybe it does not. Maybe that nothing knowledge is owned by one person in a different way than another. They cannot all know the same amount of nothing at the time in the same conditions. You cannot avoid the messy temporality of human learning.’

Hattie, If you hold the position that the fundamental relationship of the knower to reality is essentially a passive or a neutral one, consisting primarily of observing facts or sensory data and then building up knowledge from these observed facts (Bentz and Shapiro, 1998, p.182) then you walk through the knowing world in that way’.

‘Well M, if it’s not about the objective world, then what is it about? ‘

It’s about everything. Relationships mainly.

What do you mean Margaret?

‘Human phenomena can be explained in terms of causal relationships, albeit this causality is assumed to be complex, multiplicity and interactive Knowledge is derived from that’

‘Remember the hummus falling out of your lunch box?’

‘I had just forgotten about that. Thanks for reminding me’ (sarcastic tone)

‘Remember that one student who came to help you clear it up?’

‘Yes, she was a kind student, she could feel my embarrassment, she knew what to do’.

‘How? How did she know how to know what to do and how did she know how to help as she did at that time? ‘

‘Did you ask her? Instruct her?’

‘Of course not’

‘But she knew. She acted because she knew’

‘Maybe she was taught that by her parents?’

‘Maybe. Who knows? My point Hattie is this. There are a million reasons why that student came to your aid. But she did. We will never know exactly what she behaved in that way. She demonstrated empathy, warmth, a knowledge of what was to be done and we can look at that through different lenses, and each will offer its explanation. An explanation. A way of viewing that will depend on what we value as knowledge. As fact. If you saw that students coming over to help you as kindness or compassion then that is what you will view that to be. On the other hand, if you viewed it as a technical- knowing act then that’s how you will construct it. How will you fully know. You won’t? Only a partially objective account of the world can be produced, for all methods of examining such accounts are flawed (Guba and Lincoln, 1994, p.27). You will see what that student did in different ways once you see knowing in different ways’.

Guba and Lincoln (1994) refer to a theoretical perspective as a position from which the world is viewed.

‘So this has something to do with me then? Rather than what actually happened with that student’?

‘Are you not the best person to decide that?’

‘I suppose so.’

‘I am beginning to think of knowledge in terms of how it is perceived, its status and the conditions it lives in.’

‘You mean M, you think that it is inside of us rather than outside?’

‘I am not sure yet H’

I am not sure if its created inside of us our outside of us. Maybe somewhere innate. I do not know, its head wrecking to be honest. Sometimes I think that it is both, but I wonder if that can be ?

'What do you mean?'

'Both of us teach. Different subjects- different worlds, right H?'

'Agreed.'

'But both try to grow and develop the students' 'to become competent, caring, knowledgeable workers',

and maybe if we are lucky we might help them along a professional route.'

'Yes, I think so M'.

V, but what if aspects of what they need to know is inside the student already ? What if the student's reality is determined by their own real-world experiences? We just help them along the way?'

'Really M Most first years know nothing..nothing.'

'Is that true?'

'What do you mean?'

'Let's take physics ?'

' Let's say a lecturer who teaches physics, and an example of this might be walking..so walking operates on traction does it not ? ..a kettle operates on thermodynamics; a phone operates from the concept of electromagnetics ..these are all every day's things and students know how they operate already. So teaching is building on what they already know not filing empty vessels with knowledge, what Freire calls the banking or depository approach to education.'

'Well remember Freire, I told you about him, critical educator and activist from Brazil, well I think a Freirean approach questions the canonical nature of knowledge much more broadly arguing that knowledge is relative and partial, and that the notion of fixed truths should be problematised.'

'I see. How is that practical? But I can't see that working with large groups of students.'

‘The idea that students are students are ‘active participants in their reality and not just passive recorders of it’ (Elkind, 2004, p.306).

‘One of the big dilemmas I have Hattie is that what I teach does not change the status quo. I recall my own training and people I cared for, the man I told you about before, Paddy, who had schizophrenia and what his life experience was like. He had schizophrenia- he got awful side effects from medication and couldn’t function in life, not because of the schizophrenia but the drugs.’

And I am now…… I am teaching the same thing, albeit it different drugs, more potent ones actually in 2023!

‘I really should be teaching about power and privilege, about the social determinants of health, about the wellness industry and how it monetizes human distress and discomfort in a neoliberal world, should this not be what we are teaching them?’

‘But I teach blood pressures? As a way of managing or caring for the side effects of medication.

That is true madness Hattie?’

‘And it’s not just medication, it’s the coercive nature of care, the care planning, the locked wards, the problematization of humans into discreet objectives and goals to be evaluated.’

‘And I am actively contributing to this, this this this, neglect ‘?

‘Seems a bit radical Margaret?’

‘Yes I suppose so Hattie. And the worst think is that Freire expects us to do something about this to take action,’

‘Ok, Margaret, but where would you start ?’

‘Besides it’s not all your responsibility’- the problems of Mental health nurse education, is it Margaret?’

‘No, Hattie it is not but it all starts with me, with my own awareness, communication, and dialogue, I think Freire (1996) said something like:

“Dialogue cannot exist between those who deny others the right to speak their truth and those whose right to speak has been denied to them’’ (p.69)

‘So seeing different perspectives, and multiple ways of knowing and understanding the world and the people in it is being a critical educator …it is above all about human beings!’

‘Agreed.’

‘Let’s go home H, busy day tomorrow.’

‘Agreed Hattie.’

The barman shouts last orders. It is getting late and there are only a few people left in the pub. I began to regret and enjoy the evening, in equal measures.

‘Margaret, I enjoyed the chat tonight; it made me think’

‘You did?’

‘I think you might be right, that people learn from each other. I see that now. I think that students learn by observing and working with their peers collaboratively. They are influenced by their peers. Its about them interacting with each other. The weaker ones often learn from the better students.’

‘I suppose learning is social.’

‘Agreed.’

‘Agreed.’

The night steals our conversation and tiredness creeps in. The reality of tomorrow for us both is beginning to seem real. We finish our drinks and Hattie walks me to the waiting taxi.

I wonder will Hattie enjoy that course, probably not if she feels compelled to do it I thought. I wonder if teaching was becoming more liberal and education more neoliberal. I wonder if she understood that in the way that I did.

Did it mean the same thing to us both?

I could appreciate her 'learning is social and collaborative' stance but she did not articulate why. Maybe the course might help her theorize it a bit better and then we could have a proper argument. I think I might enjoy that.

I am supposed to be teaching Biological Psychiatry to first years.

How might I approach this now? As a Critical Educator?

As I left the company of my friend, I started to think about what I might do in the morning. Maybe I am reflecting. That's it. Reflecting on practice. Reflective practice. But without the circles and systems, and descriptions (Schon, 1984, p.2). In action with myself, mulling, excavating, unearthing, problematizing, framing and making some sort of meaning from all the teachery issues in my head.

Thinking in such depth is sometimes called critical thinking. Kim et al (2014, p.80) argue that critical thinking concerns examining an idea in depth and challenging the obvious or received wisdom. Hughes (2009) asserts that consultation with others is essential for critical reflection. I think critically because deeper thinking makes me think more deeply. But am I thinking critically? and if so does it help me to be a better teacher.

Am I properly reflecting on this ?

Bouncing conversations with arguments and counter arguments inside the walls of my head, offering me temporality of asylum as I try and think about multiple perspectives on teaching practice.

Thursday

I arrive early to get a large coffee from the canteen and head to my office, thinking about what I was about to teach. Not what I was to teach but how and why. It was first years, and I began to think about how I would approach the class.

The students will already have received instruction on the role and functions of neurotransmitters with a special emphasis on Dopamine. The biomedical theory of mental Illness is a term that is used to describe a biological or physical cause of disease and my first class is titled the Biological aetiology of Schizophrenia. The outcome of the class is that students will develop an understanding of the biological basis for schizophrenia. Except there is none. Understanding the cause and pathogenesis of schizophrenia remains one of the great challenges in psychiatry (Owen, O'Donovan et al, 2005).

I decide to take the class and approach it differently, putting emphasis on each individual learner. I started the session, using a problem posing approach, by asking them to think about the topic of *schizophrenia* which felt challenging for me because I felt as if I was somehow betraying the syllabus! It felt stressful at times as I contended with meeting the outcomes and managing my own anxiety. Maybe I was *watching myself*. The session went well and I was surprised at how they seemed to explore the topic, in whatever way they wanted without my usual watchful guidance.

I wonder what it might be like to have schizophrenia.

They worked independently with curiously and energy and for the first time in a long time I enjoyed the class. As the morning was quickly over, I decided to sit and enjoy my lunch in the garden of the large Victorian institution and wondered if the inmates sat in the same place as me. A feeling of sadness came over me thinking about all the people who sat inside those big, bricked walls and wondered what they felt about life in that era of Foucauldian confinement. If times were different maybe some of them may have been my students.

The afternoon approaches and I made my way into a group of final year students and the topic this afternoon is anti-psychiatry. I like the topic because it resonates with me, and the afternoon passes very quickly. After the class I start to think about anti psychiatry and wonder if such a

thing exists – perhaps critical sounds much more respectable, deeper, and more reflective. At least the CPN appears to be engaging in notions of being critical even if it is among their own peer group. What about mental health nursing I ask myself?

I leave the room and walk down the corridor my mind full of thoughts about my teaching and began to wonder if resistance and social activism might support to mental health nursing and education. I began to think about what and how I taught and who's agenda was I serving? I wondered what it might be like to work with students who were socially engaged activist nurses and imagined what that might be like. The possibilities.

Dyson (2018, p.76) argues that 'the goal of critical pedagogy is to challenge conservative, right wing and traditional philosophies and politics. For this reason, critical pedagogy is essential to contemporary nursing practice, in that nurses, while constituting the largest part of the health sector workforce historically, struggle to contribute fully to policymaking around healthcare and to high-level decision-making on health issues' (WHO, 2009).

In mental health care the experiences of individuals which are often pathologized into discreet diagnoses instead of being framed in a way which searches out contradictions in that care. An example of this is the way that regulators create standards which are franchised out to providers to provide independently but take no accountability for creating those standards in the first instance or the way in which students are told that the nursing degree is a four-year undergraduate programme involving incremental learning scaffolded through spiral programme design but yet must complete every single element of it before progressing. Nursing education is littered with such examples and exploring problems dialectically can highlight the contractionary way in which nurse education often occurs. Educators need to see both sides of an issue from both a macro and micro perspective.

I am somewhat shamed that it has taken me to study at this level to critically question my role as a mental health nursing lecturer. Apart from not knowing anything about *Freire, Foucault and Friends* I had not heard of, radical education, or critical education prior to embarking on this personal quest into my professional practice as a lecturer.

Teaching Hopefully

I am hopeful that I can embrace being a critical educator and bring my experience and learning as a result of this Doctoral programme into my everyday educator work. One thing I have come to appreciate is that I have my own agency, my own resources and that the problems/issues of my professional world are not confined to others but are mine too. I am also learning that hope is something I can learn to give myself. I have my own agency, I always had.

Year 5

Newer Beginnings

Monday Morning (Margaret)

It is 8am.

I am upstairs in my office, writing a *good luck* card for my colleague Robert, who is taking over my teaching while I take leave to write up my Doctorate. I am deep in thought. I cannot quite believe that it's been four years already. Five years of Doctoral work, reading writing drafting, labouring on am autoethnographic study about my practice. Reflecting, excavating, unearthing, labouring drowning and swimming, location, growing, developing, interrogating messy work, remembering, learning, growing some more, connecting, reconnecting, relocating, shifting,

Autoethnography seems to have taken root in my mind and in my body. I seem to see the world through Freire and his way of teaching /education seems to have offered me Hope. I have laboured hard to create conditions of *Hope* through reflection dialogue conscientization on this Doctoral journey. In the same way that autoethnography is a way of living or being so too is critical education. The constant inward gaze of refection is both troublesome and revealing.

I was mindful of my need to honour my experience but also the experience of the characters portrayed in the stories. From the outset I wanted to study something that would help me find my voice as an as an author and researcher and to connect with how I was feeling about my work. The notion of mental health work, whether it is practice or educative, was central to my study and I intersected both. Traditional forms of enquiry would not address all three areas and I found myself, with the advice and support of my supervisor, turning to alternative/creative forms of expression to explore ways to regain a sense of agency, inspiration, and relevance.

I felt that these areas were largely absent from my life and that my approach should mirror them. I also wanted to explore my professional practice in an honest and engaging way embodying the process as I worked through complexities.

In writing stories about the present (Robert) and the past (Paddy, the six men, Betty, Una and the others you have met) the line between fiction and non-fiction has become blurred. Such blurred lines or fuzziness (Thackray, 2015) describes the 'contradiction that is at the heart of biographical writing' (p.199) but can also be challenging as I negotiated their *reimaginations* and *reawakenings* from memory. The picture at the beginning of the thesis illustrates that.

Denzin (2010) in writing about the transformational nature of qualitative *research* and its own trajectory describe the importance of moving through various *moments* cite traditional to the modernist, through blurred genres, crisis of representation to an emergence where 'messy uncertain, multi voiced texts, cultural criticism' and the emergence of new ways reflexive intertextual representation and the importance of the humanistic commitment of the researcher to study the perspective of the interacting individual' (p.30).

The continuous back and forth *thinking and rethinking* of positions, perspectives, political, structural, and epistemic underlay is the basis for this work.

Chasing Paddy and finding Hope in a hostile place is about me finding hope, joy and love in my role as a mnetal helath nurse educator. Having arrived at this work in 2019, with feelings disconnection, and lacking hope about the future I have come to appreciate that *Hope* "navigates a way forward between the false certainties of optimism and pessimism and the complacency or passivity that goes with both' (Solnit, 2019, p.4). I also think that while the future of mental health nurse education may be unpredictable and uncertain, I know that my agentic self may be able to write my role into that future space or maybe some of it at least. This autoethnographic work highlights the hope and possibilities not just in writing about my own dilemmas but the dilemmas of others who may share my concerns as I work towards living an *autoethnographic activist life* (Holman Jones, 2019, p.527).

Back again

‘Margaret?’

‘Yes’

‘V, is that you?’

‘V is that you?’

‘V?’

‘Hello?’

‘Who is there?’

‘Is that you V?’

‘Me’

‘Who?’

‘Do you have a smoke?’

‘No no I don’t! I haven’t smoked in years since I was a student’.

‘Who is this PLEASE?’

‘It’s Paddy.’

‘Remember me?’

‘Paddy!’

‘What! Good Grief ..’

‘Paddy, good Heavens is that you Paddy?’

‘Where, how I mean ……. how?’

‘But where is V?’

‘Have you seen her Paddy?’

‘V, your companion you mean Margaret?’

‘Yes, my critical friend, my wisdom, my source of knowing, been with me for years.’

‘I haven’t heard from her in a while’

‘Has she left me?’

‘Forgotten me?’

‘No Margaret.’

‘Then where is she Paddy?’

‘And why are *you* here now?’

‘I was always here Margaret. With you.’

‘Sorry, Paddy what did you say?’

‘I was always here, by your side, Margaret. ‘

‘Showing you the way.’

‘Along the dark lonely corners, when you were lost and couldn’t find a way out, when you struggled, and when others depending on you?’

‘You mean my students Paddy?’

‘Yes them’,

‘Paddy I am confused, where is V?’

‘I am lost without her.’

‘V, was a construct in your mind Margaret.’

‘No, no she WAS real Paddy.’

‘Reality’

‘I heard her every day, her critical voice, advising, telling, showing, teaching, telling, marketing, BANKING!’

‘I don’t know how to cope without her Paddy.’

‘What about the Handouts?’

‘What about those empty vessels in first year?

‘But look at your last class?’

‘You enjoyed it, didn’t you?’

‘Yes, I did, very much, I felt alive, engaged, interested.’

‘ But……’

‘You have been here all this time Paddy?’

‘Yes.’

‘I never left your side.’

‘But in the past life Paddy, I treated you so badly, assumed I had all the knowledge, knew the way to the canteen, knew that group-work was good’

‘That was in the past ..’

‘Before critical pedagogy Margaret!’

‘But now you know better’

‘You know how to be in the world,’

‘How to be better, do better.’

‘Thank you, Paddy. I am sorry’.

‘Will you stay with me Paddy?’

‘No, Margaret.’

‘I am here of you need me, but this is your journey.’

‘Besides you seem to be enjoying what you are doing!’

‘What are your plan now ?

‘What do you mean Paddy’?

‘ What now, after your study, your autoethnography?’

‘Well, firstly I feel better about my work, more connected and have a better sense of what’s going on. But as you know autoethnography speaks to the cultural through the self and for me it was always about surfacing the tensions I had about my practice as a mental health educator, and in so doing hoping that this might be useful to others…’

‘Do you think it might be?’

‘Yes Paddy, I do’

‘I’m much more involved now in policy work, at national level and am working with colleagues in the UK who seem to be a bit more vocal about issues in mental health nursing- I am learning a lot from them. In Ireland we can learn a lot about the future (or not) of mental health nursing and the role of the educator from places like the UK and Australia. I hope to be able to share my work locally and to start a conversation about that..

‘An autoethnographer and an activist Margaret ?’

‘Yes I suppose so, I know I can do this’

‘You can rely on yourself from now on Margaret.’

‘If you need me, just sit in conscientization, and check in with yourself.’

‘I will Paddy.’

‘I need to go now Margaret.’

‘I have others who need my help.’

‘Thank you, Paddy.’

‘Goodbye.’

‘Oh, Paddy before you go, can I ask you something please?’

‘Yes of course, Margaret.’

‘How is Una?’

‘You mean Queen Victoria?’

Margaret smiles and feels energetic and emotional, thinking about V, Paddy, Una, Jan, Jerry, Robert and Camilla and everyone who has helped to shape her as an educator.

But I need to get going now.

Walking away

Biscuits! (can never have enough of them in term one)

He likes coffee, lots of

Some more reference notes for him, he can have my bio..

Yes, yes that's about it

now…. Tidy up, neat and

tidy desk Time to escape ...

Happy to be quiet,

Close the door gently, keys into the secure box

Box full of items, *feminist toolkit*-(Ahmed, 2017) favourite book, nurses' scissors (why),

favourite scarf

Walking and

Step step step lightly, feet earthed to the ground.

Wait…

Is that ..?

Look! in the distance, down the hall, near the front door, by the photocopier……

That photocopier !

Oh yes, that former lifeline, reproducing and reproducing handouts …thousands of them over the years….but I don't seem to need that copier as much these days…and the students seem to be fine with that. I wonder why I needed it so much?

Or thought that I did…….

Is that Robert? Better not interrupt him, he looks a bit busy, very busy

I have left a note anyways.

He will be fine; I should not worry so much about him. He is clever and smart and not as stressed out as I was. But after almost five years of staying close to work, I feel as if I am feeling and seeing the world again, feeling hopeful and a bit happier, as if a light is shining and showing the world to be a bit brighter.

Walking

Head up, straight, intact, feeling light but connected to the world,

But what now?

What happens after autoethnography ?

What do other autoethnographers do?

Am I really an activist ?

'To what end'…..(Gale and Wyatt, 2019, p.566)

..will this work help others …I feel a transformation has taken place within me but is that enough ? for me, my colleagues, my students ? those who require services of mental health nurses ? Will mental health nursing change or stay the same or will nurses be needed in the same way, but it will always be about the self ..maybe it should be about honouring the self and the self of others more, but are nurses the best people to support people with mental health issues, maybe people with lived experience might be better but is the profession ready for that yet ?Is the business of mental health nursing ready for such change? What if there were no more mental health nurses and then there might be no more mental health nurse educators …no more me…

But for now, I am here…

After a long journey of autoethnographing ……

(I know I know ! … its not a real word, but I like it)

But it has

…strengthened my values and principles of mental health nursing…

….And what I do as a mental health educator

…..And I remain….

….Committed to person centred care , Building relationships

…..Caring, kindness, compassion, valuing lived experiences,

……seeing people as just that, people, not pathologies..

…maybe that is love…?

…..maybe mental health education is love?

……..Little acts of transgression …here and there …

……Like Bettys bread…

I wonder what will happen in future ? What will mental health nurse education look like ? for the Roberts of this world and those who follow….the future .. I imagine conversations, lots of conversations…nationally …about mental health and nursing …and education, and identity -and agency …

– which is not the work of another …othered …who see the

Living in the world … as problems …maybe more conversations are the way forward like

the UK colleagues (MHNAUK)– who give voice to each other …forum for shared ideas …

So many ideas….the possibilities……..here is Hoping….

But I am,

Moving…

legs moving, arms moving, fingers, toes, all connected,

Counting,

One , two , three, four, five, six, seven, eight, nine, ten.

Yep,

All there. Busy doing what digits are supposed to do.

Walking away feeling good

Out along the corridor now.

Oh, look! Someone has forgotten to water the Summer plants.

They look lovely, hadn't noticed them before...

Touching Tiles, body intact, smiling, energetic.

But for now,

Lots to do.

Catch up later...

Monday Morning (Robert)

It is 8.30 am on September the 5th 2022, the academic New Year.

There is a sense of all things new and fresh as he parked his car in the car park at the back of the sprawling higher education institution where he has worked for the past four years.

'Don't forget to return those books he reminded himself', adding it to the growing mental list of mundane errands that comes with the start of anything new. He took his sports bag out of the boot of his car with intentions of getting back into football training this semester. He missed the lads and the buzz that comes from being part of a training group. He decided that he would have a better work/life balance this year, taking time to exercise and join a few lunch time runs. Things were looking up.

He was delighted to have got *the call*.

Not for the team, but for the contract.

Nothing was as bad as past four years, he thought -the workload, the long hours, the isolation the constant prepping, teaching at short notice and marking. *First year is a killer* he was told in 2018 but it *gets better after that*. It did ease somewhat and after four years he was now a permanent employee. Starting this new semester, knowing what he was expected to teach and not having to constantly *fill-in* the teaching gaps gave him reassurance and the constant thoughts he had of leaving higher education and going back to practice were now at the back of his mind. Robert was determined to enjoy his first day of term with certainty.

A permanent contract reassured him that he would *be ok* now. This was going to be a good year. He walked over to a colleague and shared a joke about the *All-Ireland* final and felt settled in himself for the first time in a long time.

As he walked up to the changing rooms to put his kit bag into the small locker, he noticed the new locker room layout. Work had started last June, and it was fully finished now. It looked stylish and smart, and he imagined being there, at the *after-work* training sessions. But,

Had it really been five years?

He noticed the time. Almost 8.15 am.

Time to hurry, time to meet the first years.

Up the stairs and into Margaret's office. It was unusually tidy. She was on leave to write up her Doctorate – the one about herself and the job and the hassles in mental health nurse education. She might have a point, he thought reflectively.

Her office was always untidy but was now clean and fresh and she had left coffee and biscuits for him.

'Ah yes, for me' he thought, how nice and she tidied up the place for me,

In her absence it was now *his office*. No more sharing.

'That desk doesn't work there' he said, promising to move it around to face the window and away from the door.

Psych nurses never sit with their backs to the door- everyone knows that.

What's this?

A card for me?

He put the envelope into his pocket and headed upstairs. He would read it later when he had time.

He races upstairs.

Busy day …

Check the room…

yes great …

all good to go

32 expected. Numbers are up this year. Makes a change he thought.

Down the stairs to the office.

Time for a quick coffee? asks a colleague

‘No sorry. Have first years at 9. On my own this year’

‘Oh yes, heard Margaret’s on leave.’

‘Good luck. See you later for the staff meeting Rob’

Quarter to Quarter to…do I have time to?

Ok, run down the stairs, ground floor

To the photocopier,

Morning, almost finished now Robert, how did your summer go? says Mary the admin assistant expertly laying mounds of sheets into an empty box for one of the lecturers.

Great great. Mary thanks. See you later.

Press one...

Start

One copy. Clean. Black and White.

Lovely.

Back up them stairs.

Two at a time, keeping fit..

New class

Into the classroom ..

‘Morning Robert’

‘Morning Tom’, (caretaker) fixing a bolt on the windowsill.

‘Will you be long?’

‘No, almost done.’

‘Good, because I have first years at 9, Tom. First day.’

‘10’

‘No 9’

‘No, its 10. Timetable change’.

The room will be ready at 10’

‘What???’

‘32’

‘I have 32 coming and I have no classroom ……..’

‘You have a room but not until 10’.

‘But I need it now!’ , Robert protests to the old caretaker.

‘But Tom I *have* the room arranged, in circles ready for group work. All prepared specially.’

‘Did you not read the memo Robert?’

‘No, I was on leave until today.’

Robert decides that he cannot wait until 10am and by now is stressed. Damn it! I am always organised and, on the ball, …

Down the stairs again

Look for a room

Look for a room

See what is available

Big enough

32 with chairs

In a circle

Nope

Nope

No, not that one..

He runs up to level four. Lovely new classrooms here…

1, 2, 3, 4, 5, 6,

Too small.

Then… Yes

yes .. This

will do

32

Yes, with chairs

And the circle...

Great.

Goes online onto his phone, into the app and books the room until 1pm

Result!!!

Just press this… all booked.

Put a sign on the door to direct the new students to their new room, Robert.

Downstairs again

Photocopier

Erect a sign …first year's level 4 room 22

Show them where to go...

Need someone to show them the way…….

Hello Robert, how was your holiday, enquires Liz, a colleague from another department

Why don't you use your own copier? a voice inside his head whispers.

Haven't time for small talk, I am in a panic, 32 first years in 5 minutes,

Before he has time to locate the paper, Liz asserts bossily

..'I haven't got too much to do….wont be long Robert', as

she butts in before he could beg her to get ahead of the queue for the copier.

'Please please please……'

She loads the copier as anxiety crept up his body.

Damn it! No point stressing now...his morning was already ruined.

Just don't let this bother you, he thought to himself.

He decided to sit and wait and watch Liz feed the photocopying machine

In and out it went ..

In Double sided delay

Churning around papers and printing and printing.

She talked and talked and did not see that he was in a *panic.*

32 first years who won't know where to go…they need to be shown the way…

He felt tension creep up the back of his neck, separating his head from the rest of his body. Agitation now making his legs heavy and twitch, shaking with temper.

He decided not to listen to her verboseness

Oh what's the point now, he thought in despair. His head started to hurt.

Might as well sit down and wait until she had finished.

Need to survive the hostilities of this place…sick of this

He rested his back against the old, crooked wall of the small room and watched the copier hum and hum as it went about its business...

In and out it spat paper

Keep the Feet on the floor

Take deep breaths..

In and out slowly…

Wish this beginning was less stressful, he thought.

He remembered the card in his jacket pocket

Opens the envelope

Ooh

Something small and round rolled onto the floor …what?

Is that?

What is…?

It's a

a?

A blue Bead!

he laughed loudly holding it aloft between his fore fingers.

He reads the card carefully,

Dear Robert

Wishing you all the Best

You will be great.

Something to remember me by….

See you next year.

Mgt

He smiled as he picked up the little Blue Bead and remembered his very *first day*.

Was that really five years ago?

Liz headed off...

He stood up and walked over to the photocopier and decided that *this September* was going to be his best one yet.

Finger on photocopier.

Print all.

Postscript

This thesis is an autoethnographic exploration of my practice as a mental health nurse educator and represents a long journey of self-discovery, reflection, and critical interrogation of my professional work and occupational milieu within the higher education landscape in Ireland. Although it is a highly personal enterprise, it also reaches out to the wider mental health community. Academic literature suggested that many mental health nurse educators are concerned about the issues I have also documented in this thesis, but that work is internationally focussed and excludes an Irish context. I believe this work to be the first of its kind in Ireland and hope that it will start, albeit in a small way, a conversation about the future of mental health nursing education in Ireland.

Autoethnography research was a way in which I could focus my attention inwards towards my own practice with a view to looking outwards to the practice and experiences of colleagues, service users and others who may be involved to varying degrees in mental health nurse education. I embarked on this research journey in 2018 and since then my confidence has grown in forming new connections with others within my field. The educative dilemmas which previously dogged my practice are now shared with others, through newly forged conversations and professional connections. As an autoethnographer I own the words, the feelings, the descriptions, the questions in this study and this degree of authenticity in which I stand behind every word in this work will allow others to see who I am as a person but also as a nurse, educator, researcher, and activist.

I have become actively involved in promoting parts of that conversation at a national level in work with academic colleagues on behalf of the nursing regulator (NMBI) and with colleagues from another University by sharing common pedagogic experiences. I also have become a member of the MHNAUK (Mental Health Nurse Academics UK), the largest forum for mental health nurse academics. Of greatest interest to me is my work (early stages) with an academic colleague in Scotland from a recently formed organisation, *Mental Health Deserves Better* (#MHDeservesBetter) which describes itself as ‘a grassroots movement born from the frustrations around the dilution of mental health nurse education across the United Kingdom and made up of concerned mental health nurses in academia and clinical practice, as well as students currently studying mental health nursing’.

This *grassroots activism* encapsulates where I see the future development of this important autoethnographic work in the future.

References

Abroms, G. M. (1969) 'Defining Milieu Therapy', *Archives of General Psychiatry*. American Medical Association, 21(5), pp. 553–560.

Adams, T. E. (2008) 'A review of narrative ethics', *Qualitative Inquiry*, 14(2), pp. 175–194.

Adams, T., Boylorn, R. and Tillmann, L. (2021) *Advances in Autoethnography and Narrative Inquiry: Reflections on the Legacy of Carolyn Ellis and Arthur Bochner*. New York: Routledge.

Adams, T. E., Holman Jones, S. L. and Ellis, C. (2014) *Autoethnography*. Oxford: Oxford University Press

Adams, T. E., Holman Jones, S. L. and Ellis, C. (2022) *Handbook of autoethnography*. New York: Routledge.

Adams, T., Jones, S. and Bochner, A. (2021) 'Introduction: Making Sense and Taking Action: Creating a Caring Community of Autoethnographers', in *Handbook of Autoethnography*. London: Routledge.

Ahmed, S. (2016) *feminist killjoys | killing joy as a world making project*, *feminist killjoys blog*. Available at: https://feministkilljoys.com/ (Accessed: 14 February 2023).

Ahmed, S. (2017) *Living a Feminist Life*, *Living a Feminist Life*. Durham: Duke University Press.

Ahmed, S. (2019) 'Sara Ahmed: Dresher conversations '. UMBCtube. Available at: https://www.youtube.com/watch?v=zadqi8Pn0O0 (Accessed: 8 February 2023).

Akpan, V. idaresit *et al.* (2020) 'Social Constructivism: Implications on Teaching and Learning - EA Journals', *British Journal of Education*, 8(8), pp. 49–56.

American Psychiatric Association (2013) *Diagnostic and statistical manual of mental disorders : DSM-5.* 5th ed. Arlington VA ;Washington D.C.: American Psychiatric Association

Anderson, L. (2006) 'Analytic autoethnography', *Journal of Contemporary Ethnography*, 35(4), pp. 373–395.

Anderson, J. K. (2009) 'The work-role transition of expert clinician to novice academic

educator', *Journal of Nursing Education*, 48(4), pp. 203–208.

Andrew, S. (2017) *Searching for an autoethnographic ethic*. New York: Routledge.
Arruzza, C. *et al.* (2019) *Feminism for the 99%: A Manifesto Cinzia Arruzza, Tithi Bhattacharya, and Nancy Fraser Brooklyn, N.Y.: Verso*

Atkinson, P. (2006) 'Rescuing autoethnography', *Journal of Contemporary Ethnography*, 35(4), pp. 400–404.

Aylott, L. *et al.* (2019) 'Defining professionalism for mental health services: A rapid systematic review', *Journal of Mental Health*. Taylor and Francis Ltd, 28(5), pp. 546–565.

Bainbridge, A. (2018) *Psychoanalysis and Education : Minding a Gap*. London: Taylor and Francis.

Baldwin, T. T., Kevin Ford, J. and Blume, B. D. (2017) 'The State of Transfer of Training Research: Moving Toward More Consumer-Centric Inquiry', *Human Resource Development Quarterly*. John Wiley and Sons Inc., 28(1), pp. 17–28.

Bandura, A. (2001) 'Social Cognitive Theory: An Agentic Perspective', *Annual Review of Psychology*. Annual Reviews 52, pp. 1–26.

Barker, P. (2001a) 'The tidal model: developing a person-centered approach to psychiatric and mental health nursing', *Perspectives in psychiatric care*. 37(3), pp. 79–87.

Barker, P. (2001b) 'The tidal model: the lived-experience in person-centred mental health nursing care', *Nursing Philosophy*. Wiley, 2(3), pp. 213–223.

Barker, P. (2017) *Psychiatric and mental health nursing: The craft of caring*. Abingdon: Routledge

Barker, P. and Buchanan-Barker, P. (2005) 'Missing pieces: the mental health nursing review is a wake-up call for a sidelined profession, argue Phil Barker and Poppy Buchanan-Barker', *Nursing Standard*, 19(24), pp.26-27.

Baum, J. B. (2021) 'A provocative dissonance: Evocative academic writing', *Human Affairs*. De Gruyter Open Ltd, 31(3), pp. 290–298

Beals, F., Kidman, J. and Funaki, H. (2020) 'Insider and Outsider Research: Negotiating Self at the Edge of the Emic/Etic Divide', *Qualitative Inquiry*. SAGE Publications Inc., 26(6), pp. 593–601.

Bearskin, M. L. B. (2023) ‘Decolonization the what, why and how: A treaties on Indigenous nursing knowledge’, *Nursing Philosophy*. John Wiley and Sons Inc, 24(2).

Begley, C. M. (2002) ‘“Great fleas have little fleas”: Irish student midwives’ views of the hierarchy in midwifery’, *Journal of Advanced Nursing*, 38(3), pp. 310–317.

Benner, P. (1982) ‘From Novice To Expert ’, *American Journal of Nursing*, 82(3), pp. 402–407.

Bennett, D. and Morris, I. (1983) ‘Deinstitutionalization in the United Kingdom’, *International Journal on Mental Health*, 11(4), pp. 5–23.

Bentz, V. and Shapiro, J. (1998) *Mindful inquiry : putting the person at the center of social research* . London: SAGE.

Blake, W. (1794) *London* , *poets.org*. Available at: https://poets.org/poem/london (Accessed: 20 July 2022).

Blenkinsop, A. *et al.* (1997) *From compliance to concordance-achieving shared goals in medicine taking*. *London: Royal Pharmaceutical Society of Great Britain*

Blumer, H. (1969) ‘The methodological position of symbolic interactionism ’, in *Symbolic Interactionism: Perspective and Method* . Englewood Cliffs, NJ: Prentice Hall

Bochner, A. *et al.* (2018) *At home with grief: Continued bonds with the deceased*. New York: Routledge.

Bochner, A. P. (2012) ‘On first-person narrative scholarship: Autoethnography as acts of meaning’, *Narrative Inquiry*. 22(1), pp. 155–164.

Bochner, A. P. and Ellis, C. (2016) ‘Evocative autoethnography: Writing lives and telling stories’, New York: Routledge

Boling, A. (2003) ‘The professionalization of psychiatric nursing: From doctor’s handmaidens to empowered professionals’, *Journal of Psychosocial Nursing and Mental Health Services*. 41(10), pp. 26–40.

Le Bon, G. (1908) *The crowd : a study of the popular mind*. London: T.F. Unwin.

Bourdieu, P. (1977) ‘Structures and the habitus (R.Nice, Tran)’, *Outline of a theory of practice*. Cambridge University Press, pp. 72–95.

Bourke, J. (2011) *What is means to be human: Historical reflections from the 1800s to the Present*. New York: Counterpoint

Bowers, L., Gournay, K. and Duffy, D. (2000) ‘Suicide and self-harm in inpatient psychiatric units: A national survey of observation policies’, *Journal of Advanced Nursing*., 32(2), pp. 437–444.

Brantmeier, E. (2013) ‘Pedagogy of vulnerability: Definitions, assumptions, and applications’, in *Re-envisioning higher education: Embodied pathways to wisdom and transformation*, pp. 95–106.

Brenton, K. (2002) ‘Rehabilitation Counselling in Physical and Mental Health’, in *Rehabilitation Counselling in Physical and Mental Health*. London: Jessica Kingsley.

Brien, D. and McAllister, M. (2019) ‘Fashioning modernity, myth and the macabre: An examination of the function of nurses’ uniforms on screen’, *Australasian Journal of Popular Culture*, 8(1), pp. 101–118.

Brijnath, B. and Antoniades, J. (2016) ‘“I’m running my depression:” Self-management of depression in neoliberal Australia’, *Social Science and Medicine*, 152, pp. 1–8.

Brimblecombe, N. (2006) ‘Asylum nursing as a career in the United Kingdom, 1890–1910’, *Journal of Advanced Nursing*, 55(6), pp. 770–777.

British Educational Research Association (BERA) (2011) *Ethical guidelines for educational research, London*. London.

Brookfield, S. (2017) *Becoming a critically reflective teacher*. Second. San Francisco: Jossey-Bass.

Buchanan-Barker, P. and Barker, P. (2009) ‘The convenient myth of Thomas Szasz’, *Journal of Psychiatric and Mental Health Nursing*, 16(1), pp. 87–95.

Bullock, A. and Trombley, S. (1999) *The New Fontana dictionary of modern thought* . London: HarperCollins.

Burstow, B. (2015) *Psychiatry and the business of madness: An ethical and epistemologicalaccounting*, New York: Palgrave Macmillan.

Butler, J. (2015) *Notes toward a performative theory of assembly*. Cambridge,Massachusetts:Harvard Univeristy Press.

Caplan, P. J. (1991) 'How do they decide who is normal? The bizarre, but true, tale of the DSM process.', *Canadian Psychology/Psychologie canadienne*. American Psychological Association (APA), 32(2), pp. 162–170.

Carney, T. (2008) 'The mental health service crisis of neoliberalism—An antipodean perspective', *International Jounral of Law and Psychiatry*, 31(2), pp. 101–115.

Chambers, M. and Markham, S. (2017) 'Nursing metrics and mental health nursing', in *Psychiatric and mental health nursing*. Routledge, pp. 799–806.

Chang, H. (2008) *Autoethnography as Method*. Walnut Creek, California: Left Coast Press.

Chang, H. (2016a) *Authoethnography as a Method*, *Paper Knowledge . Toward a Media History of Documents*. London: Routledge.

Chang, H. (2016b) 'Autoethnography in health research: Growing pains?', *Qualitative Health Research*. SAGE Publications Inc., 26(4), pp. 443–451.

Charland, L. (2018) 'Lost in myth, lost in translation: Philippe Pinel's 1809 Medico-Philosophical Treatise on Mental Alienation', *International Journal of Mental Health* . Routledge, 47(3), pp. 245–249.

Charon, J. (2007) *Symbolic interactionism: An introduction, an interpretation, an integration - Search Results*. Upper Saddle River, NJ: Prentice Hall

Chawla, D. and Atay, A. (2018) 'Introduction: Decolonizing Autoethnography', *Cultural Studies - Critical Methodologies*. SAGE Publications Inc., 18(1), pp. 3–8.

Clarke, A. E. *et al.* (2010) '1 / Biomedicalization Technoscientific Transformations of Health, Illness , and U. S. Biomedicine', in *Biomedicalization*. Duke University Press, pp. 47–87.

Cleary, M. (2018) 'Promoting emotional intelligence and resilience in undergraduate nursing students: An integrative review', *Nurse Education Today, 68, pp*. 112-120.

Coffey, M., Pryjmachuk, S. and Duxbury, J. A. (2015) 'The shape of caring review: what does it

mean for mental health nursing?', *Journal of Psychiatric and Mental Health Nursing*. John Wiley & Sons Ltd, 22(9), pp. 738–741.

Coffey, M. *et al.* (2017) 'Ordinary risks and accepted fictions: how contrasting and competingpriorities work in risk assessment and mental health care planning', *Health Expectations*, 20(3), pp. 471–483.

Cohen, B. (2016) *Psychiatric hegemony: A Marxist theory of mental illness*. London: Palgrave Macmillan.

Connell, C. *et al.* (2022) 'Mental health nursing identity: a critical analysis of the UK's Nursing and Midwifery Council's pre-registration syllabus change and subsequent move towards genericism', *Mental Health Review Journal*, 27(4), pp. 472–483.

Conrad, P. (2007) *The medicalization of society : on the transformation of human conditions into treatable disorders*. Baltimore: Johns Hopkins University Press.

Cowen, P. J. and Browning, M. (2015) 'What has serotonin to do with depression?', *World Psychiatry*, 14(2), pp. 158–160..

Cowman, S. (2001) 'Nursing education in Ireland: the end of the beginning and the envy of others in Europe.', *Journal of Advanced Nursing*, 34(4), p. 419.

Craig, T. and Timms, P. W. (2009) 'Out of the wards and onto the streets? Deinstitutionalization and homelessness in Britain', *Journal of Mental Health*. Taylor & Francis, 1(3), pp. 265–275.

Creswell John W and Poth, C. N. (2018) *Qualitative inquiry and research design : choosing among five approaches*. Los Angeles: Sage.

Crowley, F. (Amnesty I. ireland) (2003) *Mental illness: The neglected quarter*. Dublin.

Curtis, E. and Drennan, J. (2013) *Quantitative health research methods issues and methods*. Maidenhead: McGraw-Hill Open University Press.

Cusack, E., Killoury, F. and Nugent, L. E. (2017) 'The professional psychiatric/mental health nurse: skills, competencies and supports required to adopt recovery-orientated policy in practice', *Journal of Psychiatric and Mental Health Nursing*, 24(2–3), pp. 93–104.

Custer, D. (2014) 'Autoethnography as a Transformative Research Method', *The Qualitative Report*. Nova Southeastern University, 19(37), pp. 1–13.

Cutcliffe, J. R. and Goward, P. (2000) 'Mental health nurses and qualitative research methods: A mutual attraction?', *Journal of Advanced Nursing*, 31(3), pp. 590–598.

Davies, B. *et al.* (2004) 'The ambivalent practices of reflexivity', *Qualitative Inquiry*, 10(3), pp. 360–389.

Davies, B. and Gannon, S. (2006) *Doing Collective Biography*. Maidenhead: Open University Press

Davies, J. (2013) *Cracked: The Unhappy Truth about Psychiatry*. London: Icon Books

Davies, J. (2021) *Sedated : how modern capitalism created our mental health crisis* . London: Atlantic Books.

Deacon, B. (2013) 'The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research', *Clinical Psychology Review*, 33(7), pp. 846–861.

Delamont, S. (2009) 'The only honest thing: autoethnography, reflexivity and small crises in fieldwork', *Ethnography and Education*. Informa UK Limited, 4(1), pp. 51–63.

Delgado, C. *et al.* (2021) 'Mental health nurses' psychological well-being, mental distress, and workplace resilience: A cross-sectional survey', *International Journal of Mental Health Nursing*. John Wiley and Sons Inc, 30(5), pp. 1234–1247.

Denshire, S. (2014) 'On auto-ethnography', *Current Sociology*. SAGE Publications Ltd, 62(6), pp. 831–850.

Denzin, N. (2010) 'Moments, mixed methods, and paradigm dialogs', *Qualitative Inquiry*, 16(6), pp. 419–427.

Denzin, N. (2014) *Interpretive autoethnography* . Los Angeles: SAGE.

Denzin, N. K. (1989) 'Selves, stories, and experiences', in *Interpretive Biography*. Newbury Park: Sage, pp. 69–80.

Department of Health (1984) *The psychiatric services - planning for the future: report of a study group on the development of the psychiatric services*, *Department of Health Commission*. Edited by G. Balint et al. Dublin: Stationery Office.

Department of Health (2021) *Short Term Review of Clinical Placement Allowances for Student Nurses and Midwives: Report completed for Minister for Health, Mr Stephen Donnelly T.D.* Department of Health. Dublin: Stationery Office.

Dickens, C. (1844) *The Life and Adventures. Martin Chuzzlewit*. London: Chapman and Hall.

Dickinson, E. (1998) 'Tell all the truth but tell it slant ', in Franklin, R. W. (ed.) *The Poems of Emily Dickinson: Reading Edition*. Cambridge, Mass: Belknap Press of Harvard University.

Duffy, M. (2005) 'Reproducing labor inequalities: Challenges for feminists conceptualizing care at the intersections of gender, race, and class', *Gender & Society*. SAGE Publications Inc., 19(1), pp. 66–82.

Duffy, R. (2013) 'Nurse to educator? Academic roles and the formation of personal academic identities', *Nurse Education Today*. Churchill Livingstone, 33(6), pp. 620–624.

Dunn, B. (1993) 'Use of therapeutic humour by psychiatric nurses.', *British journal of nursing (Mark Allen Publishing)*, 2(9), pp. 468–473.

Dunphy, R. (1997) 'Sexual identities, national identities: The politics of gay law reform in the Republic of Ireland', *Contemporary Politics*, 3(3), pp. 247–265.

Durcan, G. *et al.* (2017) *The future of the mental health workforce* , *The Future*. Available at: https://www.centreformentalhealth.org.uk/publications/future-mental-health-workforce (Accessed: 13 October 2022).

Dyson, S. (2018) *Critical pedagogy in nursing : transformational approaches to nurse education in a globalized world*. London: Palmgrave Macmillan.

Edwards, J. (2021) 'Ethical autoethnography: Is it possible?', *International Journal of Qualitative Methods*, 20, pp. 1-6 .

Elkind, D. (2004) 'The Problem with Constructivism', *The Educational Forum*. Taylor & Francis Group , 68(4), pp. 306–312.

Elkind, D. (2008) 'The Power of Play: Learning What Comes Naturally', *American Journal of Play, 2008*, 1(1), pp. 1–6.

Ellingson, L. and Ellis, C. (2008) 'Autoethnography as constructionist project', in *Handbook of constructionist research*, New York: Guilford Press.

Ellis, C. (1995) ‘Emotional and ethical quagmires in returning to the field’, *Journal of Contemporary Ethnography*, 24(1), pp. 68–98.

Ellis, C. (1997) ‘Evocative autoethnography: Writing emotionally about our lives’, in *Representation and the text:Reframing the narrative voice*. New York: SUNY Press, pp. 115–139.

Ellis, C. (2004) *Ethnographic Alternatives : Ethnographic I : A Methodological Novel about Autoethnography (13th Edition)*. Walnut Creek, California: AltaMira Press.

Ellis, C. (2007) ‘Telling secrets, revealing lives: Relational ethics in research with intimate others’, *Qualitative Inquiry*, 13(1), pp. 3–29.

Ellis, C. (2009) ‘Fighting back or moving on: An autoethnographic response to critics’, *International Review of Qualitative Research*. SAGE Publications, 2(3), pp. 371–378.

Ellis, C. (2011) ‘Jumping On and Off the Runaway Train of Success: Stress and Committed Intensity in an Academic Life’, *Symbolic Interaction*. Wiley, 34(2), pp. 158–172.

Ellis, C. (2012) ‘Crossing the Rabbit Hole: Autoethnographic Life Review’, *Qualitative Inquiry*. SAGE Publications CA: Los Angeles, CA, 19(1), pp. 35–45.

Ellis, C. (2017) ‘Manifesting Compassionate Autoethnographic Research’, *International Review of Qualitative Research*, 10(1), pp. 54–61.

Ellis, C., Adams, T. and Bochner, A. (2011) ‘Autoethnography: an overview’, *Historical Social Research*, pp. 273–290

Ellis, C. and Bochner, A. P. (1996) *Composing ethnography : alternative forms of qualitative writing*. London: SAGE.

Esposito, L. and Perez, F. (2014) ‘Neoliberalism and the commodification of mental health’, *Humanity and Society*. SAGE Publications, 38(4), pp. 414–442.

Etherington, K. (2004) *Becoming a reflexive researcher using our selves in research*. London , Birmingham AL USA: Jessica Kingsley Publishers

Etherington, K. (2007) ‘Ethical research in reflexive relationships’, *Qualitative Inquiry*, 13(5), pp. 599–616.

European Union Agency For Fundamental Rights (2007) *Article 15 - Freedom to choose an occupation and right to engage in work | European Union Agency for Fundamental Rights*, *EU Charter of Fundamental Rights*.

Farrell, B. (1979) *I do not like thee, Doctor Fell*. Dublin: Co-op Books.

Farrell, L. *et al.* (2015) 'Autoethnography: Introducing "I" into medical education research', *Medical Education*, 49(10), pp. 974–982.

Fawcett, B., Weber, Z. and Bannister, H. (2020) *The Medicalisation of Everyday Life: A Critical Perspective*. London: Macmillan Education.

Fealy, G. M. (2005), *A History of Apprenticeship Nurse Training in Ireland*. London:Routledge.

Feucht, F. C., Lunn Brownlee, J. and Schraw, G. (2017) 'Moving Beyond Reflection: Reflexivity and Epistemic Cognition in Teaching and Teacher Education', *Educational Psychologist*. Routledge, 52(4), pp. 234–241.

Finnane, M. (1985) 'Asylums, families and the state', *History Workshop Journal*, 20, pp. 134–148.

Finnerty, S. (2019) *Rehabilitation And Recovery Mental Health Services In Ireland 2018/2019 | Mental Health Commission*. Dublin. Available at: https://www.mhcirl.ie/publications/rehabilitation-and-recovery-mental-health-services- ireland 2018/2019 (Accessed: 19 March 2023).

Fitzsimons, C. (2017) *Community education and neoliberalism : philosophies, practices and policies in Ireland*. Cham, Switzerland: Palgrave Macmillan.Fitzsimons, C. (2021) *Repealed:Ireland's unfinished fight for reproductive rights*. London: Pluto Press.

Fixsen, A. (2021) '"Communitas in crisis": An autoethnography of psychosis under lockdown', *Qualitative Health Research*. SAGE Publications Inc., 31(12), pp. 2340–2350.

Fleetwood, J. (2002) 'The noble art that is nursing', Dublin: *Irish Medical News*.

Formenti, L. and West, L. (2018) *Transforming perspectives in lifelong learning and adult education : a dialogue*, *Transforming Perspectives in Lifelong Learning and Adult Education: A Dialogue*. Cham, Switzerland: Palgrave Macmillan.

Foster, E. (2017) ‘Academic labor in the age of anxiety: Autoethnography matters’, Cultural Studies <--> Critical Methdologies ,17(4), pp. 320-326.

Foucault, M. (1967) *Madness and civilization : a history of insanity in the Age of Reason*. London: Tavistock.

Foucault, M. (1980) *Power/knowledge. a selected interviews and other writings 1972-77*. New York: Pantheon Books.

Foucault, M. *et al.* (1988) *Technologies of the self : a seminar with Michel Foucault*. Amherst: University of Massachusetts Press.

Foucault, M. (1995) *Discipline and Punish: The Birth of the Prison (A.Sheridan trans)*. New York: Vintage Books.

Foucault, M. (1997) *Society must be defended at all costs (trans. D Macey)*. New York: Picador.

Foucault, M. (2005) *The Order of Things*. New York: Routledge.

Foucault, M. (2007) *Security, territory, population: lectures at the Collège de France, 1977-78*, Basingstoke: Palgrave Macmillan.

Foucault, M. and Sheridan, A. (1977) ‘Discipline and punish : the birth of the prison’, London: Penguin.

Frankenstein, M. (1983) ‘Critical mathematics education: An application of Paulo Freire’s epistemology’, *Journal of Education*, pp. 315–339.

Frederiksen, K., Lomborg, K. and Beedholm, K. (2015) ‘Foucault’s notion of problematization: A methodological discussion of the application of Foucault’s later work to nursing research’, *Nursing Inquiry*, 22(3), pp. 202–209.

Freire, P. (1972) *Pedagogy of the oppressed*. Harmondsworth, Middlesex: Penguin Education.

Freire, P. (1978) ‘Pedagogy of the oppressed’, in *Toward a Sociology of Education*. 1st edn. New York: Routledge.

Freire, P. (1987) ‘Letter to North American Teachers’, in *Freire for the classrom: A sourcebook for*

lieratory teaching. Portsmouth, New Hampshire: Heinemann Educational Books, Inc.

Freire, P. (1994) *Pedagogy of Hope: Reliving Pedagogy of the Oppressed*.New York: Continuum

Freire, P. (1997) *e prática da libertação: uma introdução ao pensamento de Paulo Freire. [Conscientization: theory and practice of liberation. An introduction to Paulo Freire's thought] Translated by Kátia de Mello e Silva.* São Paulo :Cortez & Moraes.

Freire, P. (2000) *Education for Critical Consciousness*, New York: Continuum.

Freire, P. (2005a) *Education for critical consciousness.* London ; New York: Continuum.

Freire, P. (2005b) *Teachers as cultural workers : letters to those who dare teach*. New York: Routledge.

Freire, P. and Macedo, D. (2005) *Literacy: Reading the word and the world*, New York: Routledge.

Freshwater, D. (2008) 'On the constitution and status of "evidence" in the health sciences',*Journal of Research in Nursing*, 13(4), p. 281.

Gabrielsson, S., Sävenstedt, S. and Olsson, M. (2016) 'Taking personal responsibility: Nurses' and assistant nurses' experiences of good nursing practice in psychiatric inpatient care', *International Journal of Mental Health Nursing*. Blackwell Publishing, 25(5), pp. 434–443.

Gale, K. and Wyatt, J. (2019) 'Autoethnography and activism: Movement, intensity, and potential', *Qualitative inquiry*. SAGE Publications Inc., 25(6), pp. 566–568.

Gannon, S. (2017) 'Autoethnography', *Oxford Research Encyclopedia of Education*. Oxford University Press.

Gastaldo, D. and Holmes, D. (1999) 'Foucault and nursing: A history of the present', *Nursing Inquiry*, 6(4), pp. 231–240.

Gazza, E. (2006) 'The experience of being a full-time nursing faculty member in a baccalaureate nursing education program', *Journal of Professional Nursing*, 25(4), pp. 218–226.

Giroux, H. A. (2011) *On Critical Pedagogy (Critical Pedagogy Today)*. Edited by S. R. Steinberg and A. M. A. Frieire. New York: Continuum.

Goffman, E. (1963) *Stigma : notes on the management of spoiled identity*. Englewood Cliffs N.J.: Prentice-Hall.

Goodall, H. L. (2016) *Writing qualitative inquiry : self, stories, and academic life*. Walnut Creek, Ca: Left Coast Press.

Gooding, P. (2016) 'From deinstitutionalisation to consumer empowerment: Mental health policy, neoliberal restructuring and the closure of the Big bins in Victoria', *Health Sociology Review*. Routledge, 25(1), pp. 33–47.

Goodrich, R. S. (2014) 'Transition to Academic Nurse Educator: A Survey Exploring Readiness, Confidence, and Locus of Control', *Journal of Professional Nursing*. W.B. Saunders, 30(3), pp. 203–212.

Gournay, K. (1996) 'Schizophrenia: A review of the contemporary literature and implications for mental health nursing theory, practice and education', *Journal of Psychiatric and Mental Health Nursing*. Blackwell Publishing Ltd, 3(1), pp. 7–12.

Gournay, K. (2020) 'No Title', in *Mental Health Nursing: from the outside, looking in*. Cheshire: White Winstanley.

Graf, Eve-Maria (2014) *Discourses of Helping Professions*. Edited by Eva-Maria Graf, M. Sator, and T. Spranz-Fogasy. Amsterdam: John Benjamins Publishing Company.

Graneheim, U. H. *et al.* (2014) 'Contradictions between ideals and reality: Swedish registered nurses' experiences of dialogues with inpatients in psychiatric care', *Issues in Mental Health Nursing*. Informa Healthcare, 35(5), pp. 395–402.

Grant, A. (2010) 'Writing the reflexive self: an autoethnography of alcoholism and the impact of psychotherapy culture', *Journal of Psychiatric and Mental Health Nursing*. John Wiley & Sons, Ltd, 17(7), pp. 577–582.

Grant, A. J. (2016) 'Living my narrative: storying dishonesty and deception in mental health nursing', *Nursing Philosophy*. John Wiley & Sons, Ltd, 17(3), pp. 194–201.

Grant, A., Leigh-Phippard, H. and Short, N. P. (2015) 'Re-storying narrative identity: A dialogical study of mental health recovery and survival', *Journal of Psychiatric and Mental Health Nursing*, 22(4), pp. 278–286.

Green, M. (2014) 'On the inside looking in: Methodological insights and challenges in conducting qualitative insider research', *The qualitative report*, 19(29), pp. 1–13.

Greenway, K. *et al.* (2019) 'What is a theory-practice gap? An exploration of the concept', *Nurse educaton in practice*, *Nurse education in practice*, *34*, pp.1-6. Greer, G. (1971) *The female eunuch*. London: Paladin.

Greer, G. (1987) *The madwoman's underclothes : essays and occasional writings, 1968-85*. London: Picador.

Greer, G. (1999) *The whole woman*. London: Doubleday.

Grey, F. (2016) 'Benevolent othering: Speaking positively about mental health service users', *Philosophy, Psychiatry, & Psychology*, 23(3), pp. 241–251.

Guba, E. G. and Lincoln, Y. S. (1994) 'Competing paradigms in qualitative research', in Denzin, N. and Lincoln, Y. (eds) *Handbook of Qualitative Research*. New York: Sage Publications, pp. 105–117.

Halter, M. J. (2008) 'Perceived characteristics of psychiatric nurses: stigma by association', *Archives of psychiatric nursing*. Arch Psychiatr Nurs, 22(1), pp. 20–26.

Hamilton, B. E. and Manias, E. (2007) 'Rethinking nurses' observations: Psychiatric Nursing skills and invisibility in an acute inpatient setting', *Social Science & Medicine*. Pergamon, 65(2), pp. 331–343.

Happell, B. *et al.* (2014) 'It's the anxiety: Facilitators and inhibitors to nursing students' career interests in mental health nursing', *Issues in Mental Health Nursing*. Informa Healthcare, 35(1), pp.50–57.

Happell, B. *et al.* (2022) '"It is much more real when it comes from them": The role of experts by experience in the integration of mental health nursing theory and practice', *Perspectives in Psychiatric Care*. John Wiley & Sons, Inc., 56(4), pp. 811–819.

Happell, B. and Gaskin, C. J. (2013) 'The attitudes of undergraduate nursing students towards mental health nursing: a systematic review', *Journal of Clinical Nursing*. John Wiley & Sons, Ltd, 22(1–2), pp. 148–158.

Harmon, R. B. and Hills, R. L. (2015) 'Transforming psychiatric mental health nursing education with team based learning', *Archives of psychiatric nursing*. Arch Psychiatr Nurs, 29(6), pp. 413–418.

Harrison, C. A., Hauck, Y. and Ashby, R. (2017) 'Breaking down the stigma of mental health nursing: A qualitative study reflecting opinions from western australian nurses', *Journal of*

Psychiatric and Mental Health Nursing. John Wiley & Sons, Ltd, 24(7), pp. 513–522.

Hayano, D. (1979) 'Auto-Ethnography: Paradigms, Problems, and Prospects', *Human Organization*. Allen Press, 38(1), pp. 99–104.

Health Education England (2014) *'Raising the Bar: Share of Caring. A Review of the Future of Education and Training of Registered Nurses and Care Assistants'. HEE, London.*

Hemingway, S., Clifton, A. and Edward, K. L. (2016) 'The future of mental health nursing education in the United Kingdom: reflections on the Australian and New Zealand experience', *Journal of Psychiatric and Mental Health Nursing*. Blackwell Publishing Ltd, 23(5), pp. 331–337.

Hercelinskyj, G. *et al.* (2014) 'Perceptions from the front line: Professional identity in mental health nursing', *International Journal of Mental Health Nursing*. John Wiley & Sons, Ltd, 23(1), pp. 24–32.

Holman Jones, S. (2016) 'Living Bodies of Thought: The "Critical" in Critical Autoethnography', *Qualitative Inquiry*, 22(4), pp. 228–237.

Holman Jones, S. (2019) 'Living an Autoethnographic Activist Life', *Qualitative Inquiry*, 25(6), pp. 527–528.

Holmes, C. A. (2006) 'The slow death of psychiatric nursing: What next?', *Journal of Psychiatric and Mental Health Nursing*, 13(4), pp. 401–415.

Holmes, M. (2010) 'The Emotionalization of Reflexivity', *Sociology*, 44(1), pp. 139–154.

Honey, A. *et al.* (2019) 'Using systematic collaborative reflection to enhance consumer-led mental health research', *British Journal of Occupational Therapy*. SAGE Publications Inc., 82(11), pp. 666–674.

Honneth, A. (1996) *The Struggle for Recognition The Moral Grammar of Social Conflicts Cambridge, Ma: MIT Press.*

hooks, bell (2013) 'Teaching Critical Thinking : Practical Wisdom'. New York: Routledge.

hooks, bell (2014) *Teaching to transgress : education as the practice of freedom*. New York: Routledge.

hooks, bell (2000) *Where we stand : class matters*. New York: Routledge.

hooks, bell (2003) *Teaching community : a pedagogy of hope*. New York: Routledge.

Hopton, J. (1996) 'Reconceptualizing the theory-practice gap in mental health nursing', *Nurse Education Today*. Churchill Livingstone, 16(3), pp. 227–232.

Horwitz, A. V. (2002) *Creating mental illness*. Chicago: University of Chcago Press.

HSE (2006) *Vision for Change :Report of the expert group on Mental Health policy.* Dublin: Stationery Office.

HSE (2019) *HSE Employment Report 2019*. Dublin.

HSE (2020) *Sharing the Vision - A Mental Health Policy for Everyone*, *Mental Health Policy*.Dublin: Stationery Office.

Hughes, G. (2009) 'Talking to oneself: using autobiographical internal dialogue to critique everyday and professional practice', *Relfective Practice: International and Multidiscilinary Perspectives*. Routledge , 10(4), pp. 451–463.

Hughes, S. and Pennington, J. (2016) *Autoethnography: Process, product, and possibility for critical social research*. London: Sage Pubications.

Hunter, J. and Hayter, M. (2019) 'A neglected transition in nursing: The need to support the move from clinician to academic properly', *Journal of Advanced Nursing*. John Wiley & Sons, Ltd, 75(9), pp. 1820–1822.

Hutchinson, J. R. and Huberman, M. (1994) 'Knowledge dissemination and use in science and mathematics education: A literature review', *Journal of Science Education and Technology 1994 3:1*. Springer, 3(1), pp. 27–47.

Illich, I. (1975) *Medical nemesis : the expropriation of health*. London: Calder & Boyars.
International Council of Nurses, . (2021) *The ICN code of Ethics for Nurses.*, *The ICN code of Ethics for Nurses.*

Irish Statute Book (1945) *Mental Treatment Act, 1945*.
Irish Statute Book (2001) *Mental Health Act, 2001*

Jackson, A. Y. and Mazzei, L. A. (2022) *Thinking with theory in qualitative research* . New York: Routledge.

Jenkins, E. K. (2014) 'The politics of knowledge: Implications for understanding and addressing mental health and illness', *Nursing Inquiry*, 21(1), pp. 3–10.

Kafar, M. (2021) 'Traveling with Carolyn Ellis and Art Bochner, or how I became harmonized with the autoethnographic life: An autoformative story', *Advances in Autoethnography and Narrative Inquiry: Reflections on the Legacy of Carolyn Ellis and Arthur Bochner*. Taylor and Francis, pp. 48–63.

Kameg, K. *et al.* (2009) 'Communication and human patient simulation in psychiatric nursing', *Issues in Mental Health Nursing*, 30(8), pp. 503–508.

Keles, U. (2022) 'Writing a "Good" Autoethnography in Educational Research: A Modest Proposal.', *Qualitative Report*, 27(9), p.2026-2045.

Kellehear, K. J. (2014) 'The theory-practice gap: Well and truly alive in mental health nursing', *Nursing and Health Sciences*. Blackwell Publishing, 16(2), pp. 141–142.

Kelly, B. D. (2016) *Hearing voices : the history of psychiatry in Ireland*. Newbridge, Co. Kildare, Ireland: Irish Academic Press.

Kelly, B. D. (2019) 'The Great Irish Famine (1845–52) and the Irish asylum system: remembering, forgetting, and remembering again', *Irish Journal of Medical Science (1971 -) 2019 188:3*. Springer, 188(3), pp. 953–958.

Kelly, S. H. (2020) 'The hidden curriculum: Undergraduate nursing students' perspectives of socialization and professionalism', *Nursing Ethics*. SAGE Publications Ltd, 27(5), pp. 1250–1260.

Kim, D. *et al.* (2014) 'Nursing students' critical thinking disposition according to academic level and satisfaction with nursing', *Nurse Education Today*, pp. 78–82.

Knapp, M. and Wong, G. (2020) 'Economics and mental health: the current scenario', *World Psychiatry*. Blackwell Publishing Ltd, 19(1), pp. 3–14.

Laing, R. (1963) in 'Schizophrenia as a Human Process: By Harry Stack Sullivan. With Introduction and Commentaries by Helen Swick Perry.New York', *International Journal of Psycho-Analysis*, 44, pp. 376–378.

Lakeman, R. and Hurley, J. (2021) 'What mental health nurses have to say about themselves: A discourse analysis', *International Journal of Mental Health Nursing*. John Wiley & Sons, Ltd,

30(1), pp. 126–135.

Lakritz, K. (2009) ‘Michel Foucault’s Madness and Civilization: A History of Insanity in the Age of Reason’, *Psychiatric Times*, 26(6).

Lambert, S. and Mahon, A. (2021) ‘An exploration of the wellbeing of nurses and midwives in Ireland’, *Irish Nurses and MIdwives Association*.

Lapadat, J. C. (2017) ‘Ethics in Autoethnography and Collaborative Autoethnography’, *Qualitative Inquiry*. SAGE Publications Inc., 23(8), pp. 589–603.

Lasky, S. (2005) ‘A sociocultural approach to understanding teacher identity, agency and professional vulnerability in a context of secondary school reform’, *Teaching and Teacher Education*. Pergamon, 21(8), pp. 899–916.

Leavy, P. (2020) *Method meets art: Arts-based research practice*. New York: Guilford

LeBlanc, M., Bryanton, J. and Wood, K. (2019) ‘Male patients’ gender preferences for hospital nurses. ’, *Journal of Nursing Education and Practice* , 9(9), pp. 115–122.

Lebowitz, M. S. and Appelbaum, P. S. (2019) ‘Biomedical Explanations of Psychopathology and Their Implications forAttitudes and Beliefs About Mental Disorders’, *Annual review of clinical psychology*. NIH Public Access, 15, p. 555.

Leff, J. (2001) ‘Why is care in the community perceived as a failure?’, *The British Journal of Psychiatry*, 179(NOV.), pp. 381–383.

Leigh, J. and Brown, N. (2021) ‘Researcher experiences in practice-based interdisciplinary research’, *Research Evaluation*, 30(4), pp. 421–430.

Logan, P. A., Gallimore, D. and Jordan, S. E. (2016) ‘Transition from clinician to academic: an interview study of the experiences of UK and Australian Registered Nurses’, *Journal of Advanced Nursing*. John Wiley & Sons, Ltd, 72(3), pp. 593–604.

Loh, J. (2013) ‘Inquiry into issues of trustworthiness and quality in narrative studies: A perspective.’, *Qualitative Report*, 18(33), pp. 1–15.

MacNeela, P. *et al.* (2010) ‘Seen as core: a Delphi consensus study of essential elements of mental health nursing care in Ireland’, *Archives of psychiatric nursing*, 24(5), pp. 339–348.

Malachowski, C. K. *et al.* (2016) 'The "Work" of Workplace Mental Health: An Institutional Ethnography', *Society and Mental Health*. SAGE Publications Inc., 6(3), pp. 207–222.

Manderius, C. *et al.* (2023) 'The psychiatric mental health nurse's ethical considerations regarding the use of coercive measures – a qualitative interview study', *BMC Nursing*. BioMed Central Ltd, 22(1)

Martin, T. and Street, A. F. (2003) 'Exploring evidence of the therapeutic relationship in forensic psychiatric nursing', *Journal of psychiatric and mental health nursing*. 10(5), pp. 543–551.

Martinez, A. and Andreatta, M. (2014) '"It's my body and my life" A dialogued collaborative autoethnography', *Critical Methodologies*. SAGE Publications Inc., 15(3), pp. 224–232.

Martyr, P. (2010) 'A Lesson in Vigilance? Mental Health Nursing Training in Western Australia, 1903–1958', *Issues in Mental Health Nursing*. Taylor & Francis, 31(11), pp. 723–730.

Maslow, A. H. (1943) 'A theory of human motivation', *Psychological Review*, 50(4), pp. 370–396.

Mauger, A. (2017) *The cost of insanity in nineteenth-century Ireland: public, voluntary and private asylum care*. Basingstoke: Springer Nature.

Maynooth University. (2020) *Maynooth University Research Ethics Policy*.

Mccann, J. (2016) 'Is Mental Illness Socially Constructed?', *Journal of Applied Psychology and Social Science*, 2(1), pp. 1–11.

McCormack, D. (2014) 'Trína chéile: Reflections on journaling in the border country of doctoral research', *Studies in the Education of Adults*. Taylor and Francis Ltd., 46(2), pp. 163–176.

McCormack, D. (2015) 'A Poem Points, a Thesis Explains: Pedagogic Epiphany and Liminal Disposition in Adult Education.', *Adult Learner: The Irish Journal of Adult and Community Education*, 75, p. 87

McCormack, D. (2018) 'Evocative autoethnography: writing lives and telling stories', *British Journal of Guidance and Counselling*. Routledge, 46(2), pp. 267–268.

McDermid, F. *et al.* (2016) 'Developing resilience: Stories from novice nurse academics', *Nurse education today*. Nurse Educ Today, 38, pp. 29–35.

McDermott, J. and McDermott, P. (1999) *St. Mary's Hospital Castlebar*. Galway: Western Health Board.

McGregor, S. (2001) 'Neoliberalism and health care', *International Journal of Consumer Studies*, 25(2), pp. 82–89.

McKenna, H. P., Ashton, S. and Keeney, S. (2004) 'Barriers to evidence-based practice in primary care', *Journal of Advanced Nursing*. John Wiley & Sons, Ltd, 45(2), pp. 178–189.

McKeown, M. (2023) 'Resisting genericization: Towards the renewal of mental health nursing', *Journal of Advanced Nursing*. John Wiley and Sons Inc.

McKeown, M., Malihi-Shoja, L. and Downe, S. (2011) *Service user and carer involvement in education for health and social care: Promoting partnership for health*.Chichester: John Wiley and Sons.

McKeown, M. and White, J. (2015) 'The future of mental health nursing: are we barking up the wrong tree?', *Journal of Psychiatric and Mental Health Nursing*, (22), pp. 724–730.

Mckeown, M., Wright, K. and Mercer, D. (2017) 'Care planning: a neoliberal three card trick', *Journal of Psychiatric and Mental Health Nursing*, 24(6), pp. 451–460.

McLoone, S. C. (2012) 'On Using Fuzzy Logic for Grading Highly Subjective Assessment Material - a Case Study', in *IET Irish Signals and Systems Conference (ISSC 2012)*. Institution of Engineering and Technology, pp. 9–9.

Mcmahon, R. (2020) *The silenced manifesto an autoethnography of living with Schizoaffective Disorder*. University of Wollongon

Mcmahon A and McCurry C (2020) *Ireland's mental health system is 'out of date and not fit for purpose' - Belfast Telegraph*.

Mcnamara, M. (2009) 'Nursing academics' languages of legitimation: A discourse analysis', *International Journal of Nursing*, 46(12), pp. 1566–1579.

McNamee, S., Rasera, E. and Martins, P. (2023) *Practicing therapy as social construction* . Los

Angeles: SAGE Publications.

Mehan, S. and Morris, J. (2018) 'A literature review of breathworks and mindfulness intervention', *British Journal of Health Care Management*. MA Healthcare Ltd, 24(5), pp. 235–241.

Meissner, J. E. (1986) 'Nurses: are we eating our young?', *Nursing*, 16(3), pp. 51–53. Melville, H. (1851) *Moby-Dick; Or, the Whale* . New York: Harper and Brothers.

Mental Health Commission (2019) *Rehabilitation And Recovery Mental Health Services In Ireland 2018/2019*.

Merriam, S. B. *et al.* (2001) 'Power and positionality: Negotiating insider/outsider status within and across cultures', *International Journal of Lifelong Education*, 20(5), pp. 405–416.

Mezirow, J. (1991) *Transformative dimensions of adult learning*, *Transformative dimensions of adult learning*. San Fransisco Calif.: Jossey-Bass.

Mezirow, J. (2000) *Learning as Transformation: Critical Perspectives on a Theory in Progress.* San Francisco Calif.: Jossey-Bass

Mezirow, J. (2008) 'An overview on transformative learning', in Sutherland, P. and Crowther, J. (eds) *Lifelong Learning*. 1st edn. Routledge, pp. 40–54.

MHNAUK (2023) *PUBLICATIONS/POSITION PAPERS — MHNAUK*, *Publications/Position Papers*. Available at: https://mhnauk.org/publications (Accessed: 27 April 2023).

Middleton, H. and Moncrieff, J. (2019) 'Critical psychiatry: a brief overview', *BJPsych Advances*. Cambridge University Press, 25(1), pp. 47–54.

Miklowitz, D. J. *et al.* (2021) 'Adjunctive Psychotherapy for Bipolar Disorder: A Systematic Review and Component Network Meta-analysis', *JAMA Psychiatry*. American Medical Association, 78(2), pp. 141–150.

Miller-McLemore, B. (2016) 'The Theory-Practice Binary and the Politics of Practical Knowledge', *Conundrums in Practical Theology*. BRILL, pp. 190–218.

Miller, K. I. and Considine, J. R. (2009) 'Communication in the helping professions',

Routledge Handbook of Applied Communication Research. Taylor and Francis, pp. 405–428.

Mizzi, R. (2010) 'Unraveling Researcher Subjectivity through Multivocality in Autoethnography.', *Journal of research Practice*, 6(1).

Monbiot, G. (2016) *How did we get into this mess? : politics, equality, nature*. London: Verso Books.

Moncreiff, J. (2020) *Psychiatry and the Human Condition: Joanna Moncrieff, MD*, *Psychiatric Tmes*.

Moncrieff, J. (2016) 'Ten books', *The British Journal of Psychiatry*. Cambridge University Press, 209(5), pp. 437–439.

Moncrieff, J. (2018) *Limits to Medicine: re-visiting Ivan Illich* , *Critical Psychiatry*.

Moncrieff, J. *et al.* (2022) 'The serotonin theory of depression: a systematic umbrella review of the evidence', *Molecular Psychiatry 2022*. Nature Publishing Group, pp. 1–14.

Muncey, T. (2010) *Creating autoethnographies* . London: Sage.

Myers, M. D. (2008) *Qualitative research in business & management*, *Qualitative Research in Business and Management*. London: Sage.

Nadler–Moodie, M. and Loucks, J. (2011) 'The implementation of a new-graduate nurse residency training program directly into psychiatric–mental health nursing', *Archives of Psychiatric Nursing*, 25(6), pp. 479–484.

National Institute for Health and Care Excellence (2014) 'Overview | Bipolar disorder: assessment and management. NICE Guidance. NICE.

National Institute for Health and Care Excellence (2018) 'Clinical Guidance Document CG1798', *NICE Guidance*. NICE.

National Nursing and Midwifery Council (2022) *Enabling professionalism in nursing and midwifery practice.*

Nightingale, F. (1969) 'Notes on Nursing: What It Is and What It Is Not'. New York: Dover Publications Inc.

NMBI (2016) *Standards and Requirements for Nurse Registration Programmes*, *NMBI Standards and Requirements*.

Noddings, N. (2003) *Happiness and Education*. Cambridge: Cambridge University Press.

Nolan, P. (2003) 'Celebrating our history of care.', *Journal of Psychiatric and Mental Health Nursing*, 10(6), pp. 637–639.

Nolan, P. (2020) 'Views in the rear mirror', in *Mental Health Nursing: from the outside, looking in*. White Winstanley.

Norman, I. and Ryrie, I. (2018) *Art and science of mental health nursing principles and practice.* London: Open University Press.

Norris, J. and Saudelli, M. (2018) 'Heating up online learning: Insights from a collaboration employing arts based research/pedagogy for an adult education, online, community outreach undergraduate course', *Social Sciences*, 7(7), p. 104.

Nursing and Midwifery Board of Ireland (2014) 'Code of Professional Conduct and Ethics', *NMBI Standards and Guidance*. Dublin.

Nursing and Midwifery Board of Ireland (2015) *NMBI Ethical Conduct in Research: Professional Guidance 2015*. Dublin.

Nursing and MIdwifery Board of Ireland (2016) *Psychiatric Nurse Post-registration Programme: NMBI*, *Psychiatric Nursing Post- Registration programme standards and requirements*.

O'Donnell, H. (2003) 'The future of mental health nursing in Northern Ireland: does anyone really care? Hugh O'Donnell explores the state of mental health nursing in Northern Ireland and', *Mental Health Practice*, 7(3), pp. 30–34.

O'Neill, J (2015) *Ar lorg na slí*. National University of Ireland, Maynooth.

O'Neill, Jerry (2015) 'Ar lorg na slí', *Mural -Maynooth University Research Archive Library*.

O'Neill, J. and Fitzsimons, C. (2020) 'Precarious professionality: graduate outcomes and experiences from an Initial Teacher (Further) Education programme in Ireland', *Research in Post Compulsory Education* . Routledge, 25(1), pp. 1–22.

O'Sullivan, E. and O'Donnell, I. (2007) 'Coercive confinement in the Republic of Ireland: The waning of a culture of control', *Punishment & Society*, 9(1), pp. 27–48.

Office of the Nursing and Midwifery Services Director (HSE) (2012) *Vision for Psychiatric and Mental Health Nursing*. Dublin: Stationery Office.

Owen, M. J., O'donovan, M. C. and Harrison, P. J. (2005) 'Schizophrenia: a genetic disorder of the synapse?: Glutamatergic synapses might be the site of primary abnormalities', *BMJ : British Medical Journal*. BMJ Publishing Group, 330(7484), p. 158.

Palmer, P. J. (1998) 'The courage to teach : exploring the inner landscape of a teacher's life'. San Francisco,Ca.: Jossey-Bass

Palmer, P. J., Jackson, M. and Tucker, E. (2017) *COURAGE TO TEACH : exploring the inner landscape of a teacher's life - 20th anniversary edition.* San Franciso, Ca.: Jossey-Bass.

Pelias, R. J. (2004) *A methodology of the heart : evoking academic and daily life*. Walnut Creek, CA: Alta Mira Press.

Pelias, R. (2019) 'Deploying the Self: Autoethnography', *The Creative Qualitative Researcher*, pp. 19–44.

Pelias, R. J. (2019) *The creative qualitative researcher : writing that makes readers want to read*. New York: Routledge.

Penn, B., Wilson, L. and Rosseter, R. (2008) 'Transitioning from nursing practice to a teaching role', *Online Journal of Issues in Nursing*, 13(3).

Peplau, H. (1978) 'Psychiatric nursing: role of nurses and psychiatric nurses', *International Nursing Review*. Palgrave, London, 25(2), pp. 41–47.

Peplau, H. (1988) *Interpersonal Relations in Nursing : a Conceptual Frame of Reference for Psychodynamic Nursing* . New York: Springer Publishing Company.

Peplau, H. E. (1952) *International relations in nursing ; a conceptual frame of reference for psychodynamic nursing*. New York: Putnam's Sons.

Peplau, H. E. (1992) 'Interpersonal Relations: A Theoretical Framework for Application in Nursing Practice', *Nursing Science Quarterly*, 5(1), pp. 13–18.

Peplau, H. E. (1994) ‘Quality of Life: An Interpersonal Perspective’, *Nursing Science Quarterly*. Sage Publications: Thousand Oaks, CA, 7(1), pp. 10–15.

Peplau, H. E. (1997) ‘Peplau’s theory of interpersonal relations’, *Nursing science quarterly*. 10(4), pp. 162–167.

Perry, A., Lawrence, V. and Henderson, C. (2020) ‘Stigmatisation of those with mental health conditions in the acute general hospital setting. A qualitative framework synthesis’, *Social Science and Medicine*, 255

Piper, H. and Sikes, P. (2010) ‘All teachers are vulnerable but especially gay teachers: using composite fictions to protect research participants in pupil—teacher sex-related research’, *Qualitative Inquiry*, 16(7), pp. 566–574.

Pollock, D. (2006) ‘Part 1: Introduction: Performance Trouble’, in *The SAGE Handbook of Performance Studies*. Thousand Oaks, Ca.: SAGE Publishing.

Poulos, C. N. (2008) ‘Accidental dialogue’, *Communication Theory*, 18(1), pp. 117–138.

Poulos, C. N. (2018) ‘Accidental ethnography: An inquiry into family secrecy, classic edition’, *Accidental Ethnography: An Inquiry into Family Secrecy, Classic Edition*. Taylor and Francis, pp. 1–168.

Pratt, J. H. (1907) ‘The Organization of Tuberculosis Classes’, *Boston Medical and Surgical Journal*. Massachusetts Medical Society, 157(9), pp. 285–291.

du Preez, J. (2008) ‘Locating the researcher in the research: personal narrative and reflective practice’, *Reflective Practice*. Informa UK Limited, 9(4), pp. 509–519.

Du Preez, P. (2012) ‘The Human Right to Education, the Ethical Responsibility of Curriculum, and the Irony in “Safe Spaces”’, *Safe Spaces*. Sense Publishers, Rotterdam, pp. 51–62.

Proctor, G. (2006) ‘ Therapy: opium for the masses or help for those who least need it’, in *Politicizing the person-centred approach: An agenda for social change*. Ross-on-Wye, UK: PCCS Books, pp. 66–79.

Puras, D. and Gooding, P. (2019) ‘Mental health and human rights in the 21st century’, *World psychiatry : official journal of the World Psychiatric Association (WPA)*. World Psychiatry, 18(1), pp. 42–43.

Raabe, P. B. (2010) ‘Mental Illness’: Ontology, Etiology and Philosophy as“Cure’””’, *Haser*. Universidad de Sevilla, 1, pp. 13–41.

Rahmani, N., Mohammadi, E. and Fallahi-Khoshknab, M. (2021) ‘Nurses’ experiences of the causes of their lack of interest in working in psychiatric wards: a qualitative study’, *BMC Nursing*. BioMed Central Ltd, 20(1).

Randall, W. (2014) *The Stories We Are: An Essay on Self-Creation*. 2nd edn. Toronto: University of Toronto Press.

Redknap, R. *et al.* (2015) ‘Nursing practice environment: A strategy for mental health nurse retention?’, *International Journal of Mental Health Nursing*, 24(3), pp. 262–271.

Reed-Danahay, D. (2009) ‘Anthropologists, education, and autoethnography’, *Reviews in Anthropology*, 38(1), pp. 28–47.

Repper, J. and Perkins, R. (2009) *Social inclusion and recovery : a model for mental health practice*. Reprinted. Edinburgh: Baillière Tindall.

Richardson, L. (1997) ‘Trash on the corner: Ethics and ethnography’, in *Fields of play: Constructing an academic life*. New Brunswick, NJ: Rutgers University Press.

Richardson, L. and St. Pierre, E. (2005) ‘Writing: A Method of Inquiry’, in *The Sage Handbook of Qualitative Research*. Sage, pp. 959–978.

Robins, J. (1986) *Fools and mad : a history of the insane in Ireland*. Dublin: Institute of Public Administration.

Rodgers, M. *et al.* (2018) ‘Integrated Care to Address the Physical Health Needs of People with Severe Mental Illness: A Mapping Review of the Recent Evidence on Barriers, Facilitators and Evaluations’, *International Journal of Integrated Care*. Ubiquity Press, 18(1).

Rogers, C. (1950) ‘A Current Formulation of Client-Centered Therapy’, *Social Service Review*. University of Chicago Press, 24(4), pp. 442–450.

Rogers, C. (1961) *On becoming a person: A therapist’s view of psychotherapy*. New York: Houghton Mifflin Harcourt.

Rogers, C. (1979) ‘The foundations of the person-centered approach’, *Education*, 100(2), pp. 98–107.

Rolfe, G. (1990) ‘The assessment of therapeutic attitudes in the psychiatric setting’, *Journal of Advanced Nursing*, 15(5), pp. 564–570.

Rolling, J. H. (2004) ‘Searching Self-Image: Identities To Be Self-Evident’:, *Qualitative Inquiry*. Sage PublicationsSage CA: Thousand Oaks, CA, 10(6), pp. 869–884.

Roper, N., Logan, W. and Tierney, A. (1996) *The elements of nursing : a model for nursing based on a model of living*. 4th edn. London: Churchill Livingstone.

Roper, N., Logan, W. W. and Tierney, A. J. (1990) *The elements of nursing : a model for nursing based on a model of living*. 3rd Editio. Edinburgh: Churchill Livingstone.

Rose, D. and Kalathil, J. (2019) ‘Power, Privilege and Knowledge: the Untenable Promise of Co-production in Mental “Health”’, *Frontiers in Sociology*. Frontiers Media S.A., 4.

Le Roux, C. S. (2017) ‘Exploring rigour in autoethnographic research’, *International Journal of Social Research Methodology*. Routledge, 20(2), pp. 195–207.

Ryan, A. and Walsh, T. (2018) *Reflexivity and Critical Pedagogy*. Leiden, Netherlands: BRILL.

Sadler, M. (2022) ‘Crisis in mental health services blamed on underfunding and consultant shortages’, *Irish Examiner*, 8 February. Available at: https://www.irishexaminer.com/news/arid40803114.html (Accessed: 24 July 2022).

Salzmann-Erikson, M. and Eriksson, H. (2012) ‘Panoptic power and mental health nursing- space and surveillance in relation to staff, patients, and neutral places’, *Issues in Mental Health Nursing*, 33(8), pp. 500–504.

Santangelo, P., Procter, N. and Fassett, D. (2018) ‘Seeking and defining the “special” in specialist mental health nursing: A theoretical construct’, *International Journal of Mental Health Nursing*. John Wiley & Sons, Ltd, 27(1), pp. 267–275.

Sapouna, L. and Gijbels, H. (2016) ‘Social movements in mental health: the case of the Critical Voices Network Ireland’, *Critical and Radical Social Work*. Policy Press, 4(3), pp. 397 402.

Sarvimäki, A. (1995) ‘Aspects of Moral Knowledge in Nursing’, *Scholarly Inquiry for Nursing Practice*. Springer, 9(4), pp. 343–353.

Scanlon, A. (2010) *Psychiatric nurses perceptions of the constituents of the therapeutic relationship*. New York: Nova Science.

Schomerus, G. *et al.* (2012) 'Evolution of public attitudes about mental illness: A systematic review and meta-analysis', *Acta Psychiatrica Scandinavica*, 125(6), pp. 440–452.

Schon, D. A. (1984) 'The architectural studio as an exemplar of education for reflection-in-action', *Journal of Architectural Education*, 38(1), pp. 2–9.

Schrag, Z. M. (2011) 'The Case against Ethics Review in the Social Sciences', *Research Ethics*. SAGE Publications: London, England, 7(4), pp. 120–131.

Schultz, K. (2014) 'What Does It Mean to Be an Activist Scholar? Re-Imagining Our Responses as Anthropologists of Education to Contemporary Challenges', *Anthropology & Education Quarterly*. John Wiley & Sons, Ltd, 45(3), pp. 219–230.

Scott, S. (2017) 'A Sociology of Nothing: Understanding the Unmarked':, *Sociology*. Sage Publications : London, England, 52(1), pp. 3–19.

Scull, A. T. (1977) 'Madness and Segregative Control: The Rise of the Insane Asylum', *Social Problems*. Oxford Academic, 24(3), pp. 337–351.

Seal, J. (2017) 'Multiple professional identities: A personal exploration of the transition from nurse to lecturer', *Journal of Health Visiting*. Mark Allen Group, 5(2), pp. 94–99.

Sercu, C., Ayala, R. A. and Bracke, P. (2015) 'How does stigma influence mental health nursing identities? An ethnographic study of the meaning of stigma for nursing role identities in two Belgian psychiatric hospitals', *International journal of nursing studies*, 52(1), pp. 307–316.

Sharfstein, S. (2008) 'Big pharma and American psychiatry', *The Journal of nervous and mental disease*, 196(4), pp. 265–266.

Sheridan, A. J. (2006) 'The impact of political transition on psychiatric nursing — a case study of twentieth-century Ireland', *Nursing Inquiry*. John Wiley & Sons, Ltd, 13(4), pp. 289–299.

Shoham, N. *et al.* (2021) 'Temporal trends in psychotic symptoms: repeated cross-sectional surveys of the population in England 2000–14', *Schizophrenia Research*, 228, pp. 97–102.

Shore, E. M. (1979) 'Virginia Woolf, Proust, and Orlando', *Comparative Literature*, pp. 232–

245.

De Silva, P. (2017) ‘How to improve psychiatric services: A perspective from critical psychiatry’, *British Journal of Hospital Medicine*. MA Healthcare Ltd, 78(9), pp. 503–507.

Singh, C. *et al.* (2021) ‘Work experiences of Nurse Academics: A qualitative study’, *Nurse Education Today*, 1(106),

Singh, C., Cross, W. and Munro, I. (2020) ‘Occupational stress facing nurse academics—A mixed-methods systematic review’, *Journal of clinical nursing*. Blackwell Publishing Ltd, 29(5–6), pp. 720–735.

Smith, D. E. (2005) *Institutional ethnography : a sociology for people*. Walnut Creek, CA: Alta Mira Press.

Sparkes, A. C. (2000) ‘Autoethnography and Narratives of Self: Reflections on Criteria in Action’, *Sociology of Sport Journal*. Human Kinetics, Inc., 17(1), pp. 21–43.

Speedy, J. and Porter, S. (2014) ‘Introduction to ’creative practitioner inquiry in the helping professions’, in *Creative Practitioner Inquiry in the Helping Professions*. Sense Publishers, pp. 1–6.

Spry, T. (2001) ‘Performing Autoethnography: An Embodied Methodological Praxis’, *Qualitative Inquiry*, 7(6), pp. 706–732.

Steiner, S. F. (2000) *Freirean pedagogy, praxis, and possibilities : projects for the new millennium*. New York: Falmer Press.

Stewart, D. S. (1876) ‘Obstacles to the advancement in Ireland of psychological medicine’, Asylum Journal of Mental Science, 21, p. 383.

Stoyanov, D. *et al.* (2021) *International Perspectives in Values-Based Mental Health Practice*, *International Perspectives in Values-Based Mental Health Practice*. Springer Nature.

Szasz, T. (1960) ‘The myth of mental illness.’, *American Psychologist*, 15(2), p. 113.

Szasz, T. (1972) *The myth of mental illness: foundations of a theory of personal conduct*. London: Paladin.

Szasz, T. (2011) ‘The myth of mental illness: 50 years later’, *The Psychiatrist*, 35(5), pp. 179–

182.

Teresa-Morales, C. *et al.* (2022) 'Current stereotypes associated with nursing and nursing professionals: An integrative review', *International journal of environmental research and public health*, 19(13).

Terry, J. (2020) '"In the middle": A qualitative study of talk about mental health nursing roles and work', *International Journal of Mental Health Nursing*. John Wiley & Sons, Ltd, 29(3), pp. 414 426.

Thackray, J. (2015) 'In search of nirvana: Why nirvana: The true story could never be "true"', *Popular Music and Society*. Routledge, 38(2), pp. 194–207.

Thomas, P. (2014) *Psychiatry in context : Experience, meaning & communities*, *The British Journal of Psychiatry*. Manchester: PCCS Books.

Thomas, S. P., Shattell, M. and Martin, T. (2002) 'What's therapeutic about the therapeutic milieu?', *Archives of Psychiatric Nursing*. Elsevier, 16(3), pp. 99–107.

Tiffany, R. and Sparrow, S. (1987) 'The uniform question: the case for; the case against.', *Nursing Times*, 83(15), pp. 40–41.

Tischler, V. (2010) *Mental health, psychiatry and the arts : a teaching handbook.* Abingdon: Radcliffe Publishing Ltd.

Tolich, M. (2010) 'A critique of current practice: Ten foundational guidelines for autoethnographers', *Qualitative Health Research*, 20(12), pp. 1599–1610.

Tollison, A. C. (2018) 'Stereotype threat in male nurse–patient interactions', *Journal of Nursing Education*. Slack Incorporated, 57(10), pp. 614–619.

Totman, J. *et al.* (2011) 'Factors affecting staff morale on inpatient mental health wards in England: A qualitative investigation', *BMC Psychiatry*, 11, pp. 1–10.

Trede, F., Macklin, R. and Bridges, D. (2012) 'Professional identity development: A review of the higher education literature', *Studies in Higher Education*, 37(3), pp. 365–384.

Treinen, K. P., Abbott-Anderson, K. and Kuechle, L. (2022) 'Paolo Freire's Pedagogy of the Oppressed: A Way Past Oppression for the Nursing Profession', *Creative Nursing*. Springer Publishing Company, 28(3), pp. 161–166.

Turner, J. (2014) ‘Metaphors and therapeutic encounters in mental health nursing’, *Mental Health Nursing*, 34(3).

University of Southampton (1998) *Nurse education and training evaluation in Ireland: independent external evaluation: final report*. Southampton.

Walford, G. (2021) ‘What is worthwhile auto-ethnography? Research in the age of the selfie’, *Ethnography and Education*. Routledge, 16(1), pp. 31–43.

Walker, C. and Gleaves, A. (2016) ‘Constructing the caring higher education teacher: A theoretical framework’, *Teaching and Teacher Education*. Elsevier Ltd, 54, pp. 65–76.

Wall, S. (2008) ‘Easier Said than Done: Writing an Autoethnography’, *International Journal of Qualitative Methods*. SAGE Publications, 7(1), pp. 38–53.

Walsh, K. (2015) ‘Perspectives: Nursing, ethics, human rights and asylum seekers: An Antipodean perspective on 2015’, *Journal of Research in Nursing*. SAGE Publications Ltd, 20(8), pp. 741–745.

Walsh, O. (1999) ‘Lunatic and Criminal Alliances in Nineteenth-Century Ireland’, in *Outside the Walls of the Asylum: Historical Perspectives on Care in the Community in Modern Britain and Ireland*. London: Athlone Press, pp. 132–152.

Walsh, O. (2005) ‘Tales from the big house: the Connacht District Lunatic Asylum in the late nineteenth century’, *History Ireland*, 13(6), pp. 21–25.

Ward, M. (2011) ‘Educational preparation for nurses working with the mentally ill: The case of Cyprus’, *Horatio, European Psychiatric Nurses*.

Warner, J., Slade, R. and Barnes, T. (1995) ‘Change in neuroleptic prescribing practice’, *Psychiatric Bulletin*. Royal College of Psychiatrists, 19(4), pp. 237–239.

Warrender, D. (2022) ‘Mental health nursing and the theory-practice gap: Civil war and intellectual self-injury’, *Journal of Psychiatric and Mental Health Nursing*. John Wiley & Sons, Ltd, 29(2), pp. 171–173.

Weems, M. E. (2021) ‘Loss and found’, *International Journal of Qualitative Studies in Education*. Routledge, 34(6), pp. 486–495.

White, C. and Brooker E (2020) *Mental Health Nursing : from the outside looking in*. Cheshire: White Winstanley.

Willis, G. (2015) *Raising the Bar-Shape of Caring: a Review of the Future Education and Training of Registered Nurses and Care Assistants.* Health Education England.

Willis, R. (2019) 'The use of composite narratives to present interview findings', *Qualitative Research*. SAGE Publications Ltd, 19(4), pp. 471–480.

Winnicott, D. W. (Donald W. (1971) *Playing and reality*. London: Tavistock.

Winslow, L. F. (1877) *Handbook for attendants on the insane (1877 edition)* . London: Balliere, Tindall and Cox.

Wolff-Michael, R. (2009) 'Auto/ethnography and the question of ethics', *Qualitative Social Research*, 10(1).

World Health Organisation (2009) *Global standards for the initial education of professional nurses and midwives*, *Nursing & Midwifery Human Resources for Health*.

World Health Organisation (2015) *WHO global strategy on people-centred and integrated health services: interim report*.

World Health Organisation (2019) *Delivered by women, led by men: A gender and equity analysis of the global health and social workforce*.

World Health Organization (2020) *State of the World's Nursing Report: investing in education, jobs and leadership*, *State of the World's Nursing*.

Young, C. and Calloway, S. (2021) 'Assessing mental health stigma: Nurse practitioners' attitudes regarding managing patients with mental health disorders', *Journal of the American Association of Nurse Practitioners*, 33(4), pp. 278–282