



ORIGINAL ARTICLE

How we say what we do and why it is important: An idiosyncratic analysis of mental health nursing identity on social media

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ABSTRACT: *This paper is the culmination of a qualitative research project into mental health nursing (MHN) identity via exploration of a social media campaign organized in 2018 by the UK Mental Health Nurses Association. Through engagement with this campaign and a multimethod approach, this paper proposes a new and novel heuristic framework for exploring MHN identity holistically, through what is termed the 6Ps of MHN identity. The 6Ps – encompassing the professional, personal, practical, proximal, philosophical, and political aspects of identity – were previously shared with members of the MHN research community at both the 2019 and 2020 proceedings of the International Mental Health Nursing Research Conference. To examine the identity expressed in the social media campaign, all contributions by nurses were amalgamated into one ‘text’ for analysis. When this text was examined, the focus was the particular language used by MHNs. This granular analysis concentrated on word choice, form, and frequency as the constituent aspects of meaning. Even when it was necessary to examine larger grammatical units, the key nouns – grammatical objects and subjects – were the primary focus of analysis. Following this, the author – a mental health nurse themselves – applied their personal understanding of the field of practice to the text to arrive at an understanding of its contents. This approach is the first in the field of MHN identity research to examine the profession’s identity as expressed by members on social media, as well as the linguistic form of that expression.*

KEY WORDS: *hermeneutics, language, mental health, mental health nursing, social media.*

INTRODUCTION

In 2018, the British trade union Unite’s Mental Health Nurses Association (MHNA) organized an online

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promotional campaign for mental health nursing ((MHN) (@MHnursingFuture)/Twitter 2018). The goal was to celebrate the profession within the United Kingdom and raise awareness of the different roles MHN fulfil within health and education systems. The campaign was promoted and accessed exclusively via the social media platform Twitter.

The campaign produced 83 memes, or images, containing both visual and textual information related to MHN. Each meme was unique but adhered to a uniform aesthetic signifying their place within a series. 73 of the produced memes (88%) were gathered from MHN themselves, all of whom gave descriptions of their career and shared their feelings about being MHN alongside a picture of themselves. The other contributors were either MH activists or professionals outside of nursing.

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Each nurse contributor participated voluntarily. Their text and picture were submitted via email to the Lead Professional Officer within MHNA. Their contributions received no editing other than to reduce word count if required. The text and picture were then combined in a single image and posted to, and thus hosted on, the campaign's Twitter page.

All nurse contributors were based in the United Kingdom and represented a range of career stages: pre- and post-registration, manager, teacher, researcher, lecturer, and retired. They also represented a cross-section of clinical and non-clinical areas: community, inpatient adult, older adult, dementia, forensics, CAMHs, suicide prevention, psychosis, policy, research, and education.

This paper represents the culmination of a qualitative research project into MHN identity as expressed by MHN on social media. The overarching goal was to analyse and describe MHN identity via the creation of a novel framework derived from, and applied to, the expressions of MHN – their particular language-use – within a social media campaign.

BACKGROUND

Existing research

MHN identity has received research attention in the United Kingdom (Crawford *et al.* 2008; Hurley & Lakeman, 2011), Australia (Hercelinskyj *et al.* 2014), United States (White & Kudless, 2008), and Europe (Landeweer *et al.* 2010; Sercu *et al.* 2015), as well as across borders (Rasmussen *et al.* 2017).

This study began in 2018 and was initially informed by a number of papers, including Hurley *et al.* (2009), Hurley (2009a), Hurley (2009b) and McCrae *et al.* (2014) through other studies on the topic have been produced since, including Browne and Hurley (2018), Santangelo *et al.* (2018) Hurley *et al.* (2020) and Hurley and Lakeman (2021).

An apparent consensus across these studies is that MHN identity is problematic to describe. McCrae *et al.* (2014, p. 768) observe 'a complex and fluid phenomenon [...] formed not only by design of the profession, but also by organizational forces, and the personal attributes of its members'. Hercelinskyj *et al.* (2014, p. 25) argues that 'no single theoretical perspective [...] could account for the complexity of how MHN understand and experience their role and therefore their professional identity'.

Existing literature finds MHN identity to be multi-faceted, and that this complexity produces

disagreement about what MHN both do and should do (Cleary 2004; Hurley *et al.* 2014). This is captured by Hurley (2009, p. 385) where an interviewee uses the phrase 'generic specialist' to capture the dual demand for MHNs to meet both definite and infinite, niche and holistic, needs of people, services, and systems across various social contexts.

The 6Ps of MHN identity

Taking the problem of MHN identity as its point of departure, this paper proposes a novel heuristic framework for exploring it in a holistic manner, through what is termed the 6Ps of MHN Identity.

The 6Ps framework attempts to capture, via exploration of the representation of the experience of being and doing MHN found in the social media campaign, the aspects of MHN identity detailed by MHN themselves. It is offered as a 'porous' conceptual device comprised of elements that should not be understood as separate compartmentalized domains, but rather as overlapping and in dialogue with each other (Bryson 2014, p. 9).

Although there is overlap between the six aspects, their classification is non-arbitrary. Each has a specific definition (thematic content) and was examined through specific linguistic phenomena (lexical-semantic content) that pertain to that meaning. Potential categories of understanding emerged during data analysis and settled into a framework during interpretation. A somewhat analogous device can be found in the work of Grundy and colleagues who articulate the 10Cs of user-involved care planning (Grundy *et al.* 2016).

Here MHN identity is broken down into the following inter-related categories or aspects.

- *Professional* identity refers to the occupational roles and spaces MHNs picture themselves alongside and within. This is explored via nouns indicating role, activity, and service.
- *Personal* identity refers to both the feelings MHNs have about their role and their therapeutic use of self. This is explored via nouns, noun phrases (NPs), and adjectives expressing personal traits and feelings.
- *Practical* identity refers to the actual doing of the job. This is explored via verb choice, specifically the present participle ending (-ing form).
- *Proximal* identity refers to other (non-professional) identities in the care system MHNs use to define themselves. This is explored via the isolation of nouns, pronouns, and pivots (definition provided in the findings section) indicating such identities.

- *Philosophical* identity refers to both the underlying scientific and therapeutic ideologies that animate and inform the work of MHNs. This is explored via noun phrases indicating such influences as well as prepositions and verbs used immediately before a noun indicating a service-user.
- *Political* identity refers to policy or governance frameworks as well as the quality of care provided. This is explored via noun phrases indicating these influences and outcomes.
- What do MHNs say when they describe their identity?
- How do MHNs describe their identity?
- What do MHNs not say when they describe their identity?

This framework was previously shared with members of the MHN research community at both the 2019 and 2020 International Mental Health Nursing Research Conference (RCN, MHNAUK and ISPN 2019; Hannigan 2020).

Other factors affecting MHN Identity

The 6Ps framework also acknowledges material and institutional phenomena pertinent to MHN (and nursing more widely) that are often absent from professional identity construction within both.

First, recruitment and retention of nurses are widely recognized problems for sufficient and safe delivery of health services presently and into the future (Aiken *et al.* 2014). These systemic issues dramatically impact the resilience, caregiving capacity, and overall job satisfaction of individual nurses and nursing teams (Ray *et al.* 2013; Walker & Clendon 2018). Moreover, there is a case to be made that some of the phenomenological challenges recurrent within MHN – proximity to suicide, violence, trauma, and poverty – also contribute to these difficulties within our field (Takahashi *et al.* 2011; Targari *et al.* 2019).

Second, critical perspectives within mental health professional and service-user literature (Bull *et al.* 2018; Gadsby & McKeown 2021; Poursanidou 2017) draw our moral attention to ongoing practices that contradict or transgress our supposed professional ethics. Thus, a fundamental tenet of the 6Ps holistic formulation of MHN identity is a recognition of these socio-economic and political realities, even if they are not stated.

The 6Ps framework, therefore, observes three sources of meaning: what is said, how it is said, and what is not said.

Research aims and questions

These three sources of meaning correlate to the following research questions:

Limitations of using social media for such a project will be discussed. The ways in which research into MHN identity is relevant to clinical practice are offered in concluding comments via answers to the secondary question:

- Why is MHN identity important?

METHODS

The overall approach taken here is described as ‘idiosyncratic’, which can be understood as synonymous with the ‘synergistic’ (Collins 2015, p. 240) tenets of multimethod research. As is outlined below, the construction and application of the 6Ps heuristic emerge from intersections of ‘multiple methods, purposes, kinds of data, and levels of analysis’ (Hesse-Biber & Johnson 2013, p. 103). Such idiosyncrasy can be deemed necessary by researchers in response to multi-dimensional research questions (Teddle & Tashakkori 2012).

Data selection

This paper takes as its object of analysis a social media campaign (MHnursingFuture (@MHnursingFuture)/Twitter 2018), which was devised, managed, and projected into the public domain via the social media platform Twitter prior to and independently of these research interests.

Data analysis

To examine the identity expressed in the campaign, all contributions were amalgamated into one ‘text’ for analysis. This was done via typed transcription of the text as it appeared in the memes into a single word processing document (Appendix S1). All contributor details were removed from the text in this process.

Next, the language of this text was categorized via linguistic annotation of every word, clause, and sentence (the process of identifying the linguistic phenomena used by each contributor, such as nouns, adjectives, verb endings, and prepositions). The intention was to focus on meaning generated at the level of

the word, rather than the phrase, clause, or sentence. This granular analysis, what amounts to a rudimentary take on lexical semantics (Sueren 1988), concentrated on word choice, form, and frequency as the constituent aspects of meaning. The philosophical and political aspects of meaning necessitate examination of larger grammatical units, but even here the key nouns – grammatical objects and subjects – are the primary focus.

To carry out this annotation effectively, word-finding software and functionality within Windows (PowerGREP and Control+F) were used to identify and isolate the desired linguistic phenomena, with foundational texts such as Dixon (2009) used to define those features accurately and consistently.

It is worth stating that the 6Ps were not an *a priori* construction assembled ahead of the examination of the data. Other than an initial intention for a framework of some kind to become extant, the nature of that framework lacked all form and meaning until the research began. If the process were to be mapped, the form and content of the heuristic framework emerged between the stages of annotating the data (analysis) and attempting to understand it (interpretation), con-stellating into its final form over time.

Interpretation

The six aspects of the 6Ps framework attempt to capture MHN identity holistically. However, given their development and application by a particular MHN, they cannot be separated from the author's personal understanding of MHN and how this influences their identity. Consequently, both the framework and its application can be described as products of a hermeneutic process (Lindseth & Norberg 2004). Hermeneutics has a rich history, but can be broadly understood as the art, study, or philosophy of interpretation (George 2021).

Within the last decade, a growth of interest in applying the tenets of modern hermeneutics within nursing has been noted, with the work of influential 20th century philosopher Hans-Georg Gadamer drawing particular interest (Austgard 2012).

According to Gadamer, interpretation necessarily involves the person doing the interpreting, an act which is informed by that person's interactions with the world (Gadamer 2004). Understanding, interpretation, and application are 'fused' as essential aspects of the interpreter's interpretation (Austgard 2012, p. 833). They are employed in a circular process of trial and error with the focus moving from 'the entirety of the text to

its parts back to the entirety' and so on (Austgard 2012, p. 831; Grondin 2015). Although the initial interpretation is considered to yield a naïve level of understanding, repeat cycles of interpretation, in which the researcher's personal reflections are continually applied, produce new understandings that are considered more robust or refined (Lindseth & Norberg 2004).

So in this case, the author, as a mental health nurse, transparently applies their phenomenological understanding of the field of practice – knowledge, observations, feelings, intuitions, and insights derived from lived-experience – to a chosen text to achieve an understanding of the meaning of its contents (Fagerberg & Norberg 2009).

Any understanding derived from the hermeneutic method is discrete to the researcher (interpreter) in question. Therefore, an MHN with different experiences, a non-MHN, a service-user, any other individual could have engaged with this data and, with their different experiences, arrived at different (or similar) interpretations.

That said, a strength of this approach, when applied in a particular field, is the relevance of the newly produced knowledge to those encountering it. As a process, hermeneutics relies on what is called 'fore-understanding' – all that is already thought, known, and felt by both researcher and audience – or, put more simply, a shared concern in the same subject (Austgard 2012). By staying conscious of this, the interpreter has a sharp sense, a developed sensitivity, of how to stay within boundaries of salience and authenticity when engaging in the repeated cycles of interpretation, understanding, and application. As a result, hermeneutics can be understood as a means of achieving good judgement (Makkreel 2016).

Permissions and ethics

The idea to examine a social media campaign was the author's own. It received explicit encouragement from the appropriate members of Unite's MHNA, notably the Lead Professional Officer who was primarily responsible for the campaign.

The content for all memes was voluntarily submitted with foreknowledge of their publishing and searchability on Twitter, a free-to-access site in the public domain, meaning gaining permission from each individual contributor was not deemed necessary.

Permission was not sought from Twitter as this would be redundant under the relevant jurisdiction. Section 230 of the United States Communication

Decency Act (1996) considers users of social media, not the social media companies themselves, to be the publishers of content on such platforms (Kosseff 2019).

Moreover, according to Annette Markham, a specialist in the ethics of internet research, the approach taken here paper could be justified as ethical ‘fabrication’ (Markham 2012). Defined as ‘creative [...] transfiguration of original data into composite accounts or representational interactions’ (Markham 2012, p. 334), fabrication is a practical and ethical *solution* in circumstances where research takes place in ‘public, archivable, searchable and traceable spaces’ and ‘vulnerability or potential harm is not easily determined’ (Markham 2012, p. 336). Given that all contributors to the campaign were aware of the nature of Twitter by virtue of being users themselves, and that no service-users or places of work are mentioned in the memes, both criteria are met here.

FINDINGS

Professional

The professional aspect of identity refers to the occupational roles and spaces MHNs picture themselves alongside and within. To explore this, all nouns indicating role, activity, and service-user were isolated.

Upon examination of Table 1, it appears MHN is not one thing. It is a diverse community of practice, that no matter how different their role, members see no conflict or interference with their primary identification as MHNs.

Noting the frequency of ‘mental health nurses’ ($n = 74$) and ‘mental health nursing’ ($n = 41$), this data suggests that MHNs describe their practice as distinct from other types of nursing. What also comes through strongly is the value placed on the next generation ($n = 12$), suggesting the profession is future-focused and places a great value on education in professional formation.

Of note is the total absence of medical professions and the word ‘hospital’ ($n = 0$). References to specific MH services ($n = 9$) also outnumber references to the NHS in general ($n = 4$). These findings suggest that MHNs see themselves as neither dependent upon nor constituted by hospitals or medics. This suggests MHN possesses and proliferates a non-institutional identity.

Personal

The personal aspect of identity denotes both the feelings MHNs have about their role and their therapeutic

TABLE 1 The occupational roles and spaces MHNs picture themselves alongside and within, which are indicated via nouns acting as role, activity, or service markers

Role nouns	Incidence	Activity nouns	Incidence
Mental health nurse/s	74	Mental health nursing	41
Nurse/s	13	Nursing	4
Student, student nurse/MH nurse, Next generation of nurses/MH nurses, future nurse	12	Teaching	2
University lecturer, nurse lecturer, lecturer	5	Clinical research/research	2
Clinicians	3	Older person’s nursing	1
Mental health professionals	2	Education	1
Mentor/s	2	Clinical Practice	1
Researcher	2	Policy	1
Policymaker	1	Leadership	1
LD nursing	1	Service nouns	Incidence
CBT therapist	1	The NHS	4
Multi-professional staff	1	Adult mental health	2
Advocate	1	Dementia	1
Healthcare assistant	1	Forensic	1
Adult nurse	1	Inpatient	1
Nurse prescriber	1	Community	1
Project manager	1	Older people	1
Nurse manager	1	Suicide prevention	1
Practice staff	1	CAMHs	1
		Quality assurance	1
		Non-NHS setting	1
		University	1

use of self. This is displayed in Table 2a and b, which capture the nouns, adjectives, and phrases that express personal traits and feelings.

One finding within Table 2a is that, contrary to popular value-based formulations of nursing such as the 6Cs (Bostock-Cox 2013; Stephenson 2014) the notion of skills is mentioned more frequently ($n = 7$) than any one value trait (compassion is the most frequent, $n = 6$). This emphasis on skills may indicate a need to reformulate MHN, if not nursing more broadly, as capacity-based rather than value-based. Arguably MHN is presented here as a profession in which its members consider compassion, empathy, and non-judgement as low-visibility (Brown & Fowler 1972) non-technical skills, not simply values.

We also find allusions to the therapeutic use of self in phrases like ‘self-aware’, ‘human connection’, ‘good communicator’, and ‘present’. The skills and traits MHNs see themselves as having are located within the

TABLE 2 (a) *The feelings MHNs have about their role and their therapeutic use of self, which is indicated here by nouns expressing personal traits.* (b) *The feelings MHNs have about their role and their therapeutic use of self, which is indicated here by nouns, adjectives, and/or noun phrases which express personal feelings*

Trait/s	Incidence	Trait/s	Incidence
(a)			
Skills/ed	7	Sensitive	1
Passion/ate	7	Considerate	1
Compassion/ate	6	Respectful	1
Hopeful/agent of hope	4	Warm	1
Non-judgemental	3	Honest	1
Human connection	3	Enthusiasm	1
Self-aware	3	Open-heart/ed	1
Curious/ity	3	Proud	1
Caring	2	Positive	1
Kindness	2	Fun	1
Good communicator	2	Tough	1
Commitment	2	Authentic	1
Optimism	2	Leadership	1
Ability	2	Listener	1
Values	2	Personality	1
Creative/ity	2	Education	1
Knowledge	2	Energy	1
Empathic/empathy	2	Courage	1
Unique	2	Strength	1
Understanding	2	Resilience	1
Genuine	2	Insight	1
Presence/t	2	Extra mile	1
		Good people	1
		People skills	1
		Great in a crisis	1
		Belief in others	1
		Deepest of hearts	1
		Thickest of skins	1
		Emotionally sophisticated	1
Feeling	Incidence	Feeling	Incidence
(b)			
Privilege/d	20	Amazing	1
Pride/Proud	14	Different	1
Rewarding	11	Incredible	1
Exciting	5	Personal	1
My honour/honoured	4	Responsibility	1
Joy	3	Frustration	1
Lucky	3	Gratifying	1
Passionate	3	Humbling	1
The best job/decision	3	Inspirational	1
Unique	2	Emotional	1
Grateful	2	Fortunate	1
Fantastic	2	Perfect fit	1
Special	2	Life choice	1
		True vocation	1

(Continued)

TABLE 2 (Continued)

Feeling	Incidence	Feeling	Incidence
		Generous opportunity	1
		Never a dull moment	1
		Nothing quite like it	1
		Stood me in good stead	1
		Infinite sense of unconditional altruism	1

personality of the nurse themselves. They manifest in what they can do, tolerate and accept ('open-hearted' and 'understanding') but also what they do not do ('judge').

Belief in the healing capacity of self may indicate the continued influence of psychoanalytically influenced, foundational psychiatric nursing theorists such as Peplau (1991) despite the reconfiguration and rebranding of psychiatric nursing as 'mental health' nursing, a change not universally championed by those who identified with the former title (Altschul 1997).

The personal aspect of identity can also be found when the nurses express how they feel about the fact that they are MHNs. A clear finding here is that MHNs feel 'privileged' to be MHNs.

As seen in Table 2b, the word 'privilege' was used repeatedly ($n = 20$) and conveys a strong sense of duty towards a social good located outside of oneself. There are, however, other words that undermine the assumption that this privilege is derived from self-less duty. Despite the one mention of an 'unconditional altruism', other signifiers such as 'rewarding' ($n = 11$) suggest MHNs thrive on feeling positive about the work they do, which in turn functions as a key motivation for doing it. MHN appears to be an occupation fuelled by validation and is thus revealed as an un-altruistic pursuit.

Practical

The practical aspect of identity refers to the actual doing of the job, and thus verbs – 'doing words' – become the linguistic focus. In grammatical terms, where nouns function as subjects and objects verbs are known as predicates: they predicate the action or activity of a clause or sentence.

Table 3a and b offer a breakdown of all of the verb forms used by tense, ending, and whether or not they are preceded by an auxiliary or helping verb such as be, can, could, do, and have.

TABLE 3 (a) A breakdown of all verb forms by tense, ending and whether or not they are preceded by an auxiliary or helping verb. (b) All of the verbs used with past-participle (*ing*) ending, including gerunds

Tense	Form	Incidence	w/Auxiliary
(a)			
Present	Simple	388	49 (12.6%)
	Infinitive (<i>to...</i>)	156	1 (0.6%)
Past	Simple	64	–
Present	Participle (<i>ing</i>)	172 [†]	13 (7.5%)
Past	Participle (<i>ed</i>)	117	117 (100%) [‡]
Present participle	Incidence	Present participle	Incidence
(b)			
Being	44	Combatting	1
Supporting	7	Gaining	1
Working	7	Telling	1
Helping	6	Embracing	1
Challenging	5	Making	1
Learning	5	Contributing	1
Looking	4	Wanting	1
Seeing	4	Opening	1
Recognizing	3	Going	1
Improving	3	Covering	1
Experiencing	3	Teaching	1
Caring	3	Preparing	1
Knowing	2	Building	1
Using	2	Critiquing	1
Holding	2	Asking	1
Providing	2	Appreciating	1
Going	2	Training	1
Celebrating	2	Trying	1
Becoming	2	Expressing	1
Doing	2	Existing	1
Guiding	2	Allowing	1
Finding	2	Growing	1
Listening	2	Putting	1
Having	2	Moving	1
Beginning	2	Keeping	1
Staying	2	Developing	1
Struggling	1	Valuing	1
Drawing	1	Promoting	1
Living	1	Intervening	1
Empowering	1	Depending	1
Fostering	1	Publishing	1
Showing	1	Forming	1
Connecting	1	Understanding	1
Advocating	1	Standing	1
Campaigning	1	Loving	1

[†]Many phrases containing present participle were gerunds.

[‡]Auxiliary verb is always present for past participle ending.

Verbs with present participle ending (*-ing* form) were examined. Words with this verb form express what is called continuous activity, or activity without an intrinsic terminus (*-ed* form) and are thus located in

the present not past tense. This felt appropriate for examining the practical aspect of a contemporary occupational identity.

Focusing on this verb form reveals the utility of the social media campaign as an identity document. The present participle form of the verb that relates most directly to identity – the activity of *being* – appears almost 700% more frequently than any other ($n = 44$).

An additional function of the present participle can be to signify the beginning of a verb phrase that functions as a noun, what is commonly described as a gerund (Maekelberghe *et al.* 2015; De Smet & Heyvaert 2011). The gerunds of this type that appear are introduced by many different verbs. Such variety shows why it can be so unsatisfactory to describe what it is MHNs do in simple terms. Any of the following descriptions outline an aspect of MHN: ‘caring for those who suffer mental distress’; ‘combating stigma and discrimination’; ‘advocating for service users’; ‘empowering people and fostering hope’ and ‘providing direct support and enabling self-support’. These are all different but seemingly essential processes for MHN.

Notably, the processes referred to are, in a modern sense of the word, non-technical; they require skills but not those necessarily involving or requiring or mediated by specific tools, equipment, or space. In a sense, MHNs evoke the meaning of the older Greek word *techne*, meaning craft or art. This brings us back to the debate, discussed by Peplau (1988), about whether MHN is an art or science or both.

Proximal

The proximal aspect of identity refers to other (non-professional) identities in the care system MHNs use to define themselves. In this case, this was overwhelmingly the patient or service-user.

Table 4a lists every noun, pronoun, or pivot used to identify a service-user.

Pivots are a common feature of English grammar. When grammar dictates, a pivot operates as a referent for a previously established topic – the core argument, or theme, of a succession of clauses (Dixon 2009). This argument is often established by a principal subject (a noun or noun phrase) to which a number of other words (verbs, nouns, and adjectives) then refer, detailing the activity of that subject. A pivot, in the form of a pronoun (them, their, and you) or generic noun (people, individuals) allows the speaker to elaborate on the action of that subject without having to repeat the name of the principle noun (Dixon 2009). There are a number of these in the text.

TABLE 4 (a) Other identities to which MHNs consider themselves close, which is indicated via nouns and pronouns indicating service-users and their experiences. (b) Problems experienced by service-users, indicated via nouns or noun phrases

Nouns	Incidence		
(a)			
People			47
Someone			13
Person/s			11
Other			9
Service-user/s			7
Individual			6
Those			6
Carers			6
Family/ies			5
You			5
Patient/s			3
Client/s			2
User-movement			1
Noun/noun phrase	Incidence	Noun/noun phrase	Incidence
(b)			
Distress/distressing experience/mental distress	10	Anxious	1
Mental health/mental health difficulties/issues	9	Altered reality	1
Vulnerable/most vulnerable	7	Isolated	1
Dark/darkest times/darkest of moments	5	Dementia	1
Challenges/challenging problems	4	Unique problems	1
Stigma/stigmatizing beliefs/negative attitudes	4	At their lowest	1
Difficulties/difficult times	4	Barriers	1
Ups and downs	3	Struggles	1
Mental illness/ill health	3	Discrimination	1
Mental health problems	3	Illness	1
Impact of/human experiences	3	Fight demons	1
Need/In need/need it most	3	Lost all hope	1
Psychosis/psychotic breakdown	3	ADHD	1
Diagnoses	2	Autistic spectrum	1
Hopeless	1	Inequality	1
Worthless	1		

A clear finding here is that MHNs refer to patients as people ($n = 47$). Moreover, according to this sample, MHNs make more references to systemic recipients of care (families and carers $n = 11$) than to individuals as service-users ($n = 7$), patients ($n = 3$), or clients ($n = 2$). By doing so, MHN arguably eschews the terminology of both healthcare and capitalism when

speaking of people. This demonstrates both divestments from the ‘us/them’ distinction (Helmus *et al.* 2019) as well as a self-characterization that defies description as a commodity for consumption. One possible explanation for this is that the material and experiential facts of mental distress, well known by MHN, undermine the application of, for example, rational choice theory to describe unwell individuals. For instance, how is a suicidal individual a consumer? How is a multi-stage early intervention in psychosis a product?

That is not to say, however, that people experiencing mental distress should instead be understood solely by the psychiatric diagnostic categories for that distress.

As can be seen in Table 4b, the MHNs appear to avoid such an equivocation. They use broader, non-medical, non-psychiatric terms such as ‘dark times’, ‘challenges’, and ‘ups and downs’ to describe the experiences of the people they work with. This supports a view of MHNs as professionals trying to overcome the ‘us/them’ distinction (Helmus *et al.* 2019). This finding could have implications for research into stigma by suggesting positively that MHN differentiate between individuals and their diagnostic label.

One additional finding that has potential ramifications for the identity of the profession as a whole, is the ambiguous use of the phrase ‘mental health’ itself. Reflecting usage in the wider public, the term ‘mental health’ is used by some MHNs here to denote the full spectrum of psychological wellness, from happy flourishing to severe ill-health and acute distress. Others use it to refer only to the latter. Put bluntly, this suggests MHNs do not agree on what their job title means. This problem could emerge amongst the existential challenges facing MHN as it fights to keep itself distinct, relevant, and effectual (Gabrielsson *et al.* 2021).

Philosophical

This refers to both the underlying scientific and therapeutic ideologies that animate and inform the work of MHNs.

Table 5a displays philosophical influences found in the sample, such as trauma-informed care ($n = 2$) and, perhaps challenging the earlier finding of MHN as craftwork, a rather strong emphasis on evidence and scientifically tested practice ($n = 5$). However, there was one recurrent idea so prevalent it needed a table of its own: that of recovery.

Table 5b displays all instances in which ‘recovery’, or what were deemed synonymous phrases, such as ‘journey’, were explicitly evoked ($n = 18$). Given the prevalence of recovery paradigms in NHS services, this is understandable but not unproblematic.

The problems with the recovery paradigm are articulated forcefully by service-user groups such as Recovery in the Bin (Edwards *et al.* 2019), one fundamental critique being that the meaning and function of the term ‘recovery’ has shifted dramatically to become principally defined and measured by institutions and closely associated with work and economic productivity. Indeed, if recovery does not belong to the people undergoing it, is it actually recovery?

MHNs may well be charged as being naïve or lacking reflexivity on this point; of using the term in exponentially different contexts without thinking about the material impact of this on the lives of service-users. However, if statements such as ‘changing from a dun-to to a dun with culture’ are considered, the language used here depicts MHNs as companions rather than controllers. This can be seen most evidently in their choice of prepositions.

Table 5c lists all of the prepositions and verbs used immediately before a noun indicating a service-user. Those suggesting that we care *with* ($n = 14$) and *for* ($n = 11$) people rather than do things *to* them ($n = 6$) are in the majority.

Political

The word political can be imbued with many different meanings depending on your location within or without the psychiatric system, which makes arriving at a singular definition difficult.

The term is used herein a macro sense to capture all references to policy or governance frameworks as well as the quality of care provided, as this was judged as the most prevalent ‘political’ content in the text.

The quality of care can be considered political in that it is directly related to decisions taken at a supra-clinical level, often by individuals within government, the civil service, or service-management, that materially affect the superstructure within which care occurs, such as budget, staffing, and bed capacity.

However, as can be seen in Table 6, there are very few statements to this effect. The NMC, the regulatory body, is mentioned only indirectly in conjunction with ‘the future nurse standards of proficiency’. Moreover, there is a total absence of any direct reference to outcomes. This could be seen as problematic in that

TABLE 5 (a) *The underlying scientific and therapeutic ideologies that animate and inform the work of MHNs, which is indicated by various phrases.* (b) *All phrases including the word recovery or indicating a recovery journey*

Category	Indicating phrases
(a)	
Person-centred thinking, caring, decision making	To move from a ‘dun-to’ [sic] to a ‘dun with’ [sic] culture Embrace, rather than react to, user-movement ideas The person is the centre of our decision-making Putting the person and the people they love and are loved by first rather than the needs of the system Working alongside family members, carers, or significant others and valuing them as partners in care
Evidence-based practice	New knowledge and new practices Contributing to the evidence base Develop the evidence base Create an evidence base Implement evidence-based care
Holism; anti-mind/body dualism	The entirety of a person, mind, body, and spirit Supporting physical and mental well-being in a psychologically way Promoting both physical and mental well-being
Solidarity	There is no ‘us’ and ‘them’ We all have mental health Mental health is essential as the air we breathe
Trauma-informed	Trauma-informed care ($n = 2$) ‘What has happened to you?’ rather than ‘What’s wrong with you?’
Category	Indicating phrases
(b)	
Recovery	The road to recovery/well-being The chance to support recovery Journey of recovery and mutual growth Celebrating recovery All stages of life and recovery Not just about recovery [...] but more so about discovery A person and a family’s recovery journey Individual recovery in all its guises The starting point of recovery Recovery journey/s Unique recovery journey Their journey/a person’s journey Their journey through some of the darkest times to some of the best Each journey is different People’s stories, struggles, and achievements Looking to the future Achieve your goals Live their life the way that before they could only dream about

TABLE 6 Policy or governance frameworks and comments on the quality of care provided

Political statement	Incidence
'The future nurse standards of proficiency'	1
'Improve service quality'	1
'World-class mental health treatments and care'	1
'Care which is safe, effective, and of high quality'	1
'The best possible care'	1
Outcome/s	0
Power	0

MHNs may appear unconcerned by their effectiveness, which, in terms of their political capital, would weaken them in a world of evidence-based commissioning.

On the contrary, there are clear statements referring to the quality of care, a phrase synonymous with positive outcomes. Therefore, although outcomes are not mentioned explicitly, better outcomes are implied.

What has no such counter-point, however, is the total absence of references to power. Power is a fundamental question for MHN for many reasons, not least because it is a profession invested with legal powers to facilitate involuntary detention, impose treatment, and transgress privacy without consent, albeit in the name of safety. It could be argued that the data set as a whole implies MHN use their personal and professional capacities for good, but this claim would be disputed by members of survivor groups and critical perspectives within the profession who find such practices at odds with, not just the value base of nursing, but deeper normative frameworks of human rights (Bull *et al.* 2018; Gadsby & McKeown, 2021).

STRENGTHS AND WEAKNESSES

Sample Size

When the country of origin, sample population, and research question are considered, three studies conducted in the United Kingdom in the past 15 years bear similarities to this research.

Rungapadiachy *et al.* (2006) conducted follow-up interviews of 14 student mental health nurses in Leeds 6 months after their registration. McCrae *et al.* (2014) conducted semi-structured qualitative interviews with a sample of 10 mental health nurses who had completed the postgraduate diploma in mental health nursing at Kings College, London. Hurley (2009) conducted a phenomenological interview study of 25 mental health nurses working in the United Kingdom. In comparison

to these studies, a strength of this social media campaign (of the data set) is the size of its sample. Although restricted by necessity to a few statements or paragraphs per person, it combines the voices of 73 nurses, which is nearly 300% greater than the largest study mentioned.

That said, this is a tiny fraction of the contemporary MHN workforce in the United Kingdom, which in 2017 was estimated to be around 96,000 across NHS and private providers (Health Education England 2017).

Moreover, as a social media campaign, the experiences of nurses not using Twitter are necessarily absent. This means both the campaign and any framework derived from it only represent the views of MHN who knew about or were invited to participate in the campaign, have higher levels of digital literacy and are inclined to engage via social media. Many nurses do not use social media, at least not in their professional capacity, and so these nurses are also not represented.

Exclusion of negative experiences and critical perspectives

As a promotional campaign, all contributions will by definition contain positive and motivating messages. The views of disillusioned, burnt-out nurses are unavoidably entirely absent. Capturing the experience of these nurses is critical to any proposed formulation of MHN identity.

Furthermore, the nurses who did participate may have presented, for a number of possible reasons, an idealized view of the profession. Restrictive and coercive aspects of MHN practice such as the MHA, restraint, and enforced treatment – established motifs of critical perspectives within the profession (Gadsby & McKeown 2021) – are never explicitly stated or even hinted at. This may lead to the charge that our identity has blind spots, not featuring the practices we may find unethical or feel uneasy about or contending with the instrumentalization of MHN by the existing system of detention and diagnostic psychiatry (Hurley *et al.* 2020; Hurley & Lakeman 2021).

Despite this absence, however, the text is the text; it contains what was said, how it was said, not why what was said was said, and interpretation cannot access the motives of the contributors. Arguably the account of MHN presented by the text is best categorized not as idealized but rather aspirational. The claim is not that MHN is *always* like this, but rather that MHN *can* be, feel and look like this. What is presented is a hopeful

vision for the future embedded within pockets of past and present personal experience.

Idiosyncratic approach

The above two points relate to limitations of the data for the purposes of the study, not the approach taken within the study itself. An idiosyncratic approach involving mixed methods is vulnerable to errors in the application of its various aspects, as well as open to established criticism of those various aspects, which in this instance include limitations of rudimentary linguistic analysis, the hermeneutic method, and the creation of novel frameworks.

For example, on this latter point, it could be argued that the 6Ps risks undermining itself as a heuristic device for understanding the holistic identity of a particular occupational group when the professional aspect of that identity is presented as a subcategory of the framework rather than the outcome of its application, which is of course also the case.

On the other hand, the benefits of each of these aspects, including the interdisciplinary, creative, and personal, are used to produce findings of interest to the relevant professional group.

CONCLUSION

The importance of a healthcare professional's identity to the quality of their patient care may not be immediately apparent. Despite its weaknesses, there are a number of reasons why models such as the 6Ps have value for MHN and mental health service-users.

If we are consistent with our stated values, and truly prioritize peers and service-users, we need a strong sense of our identity for the very reason it legitimates critique, both that of frustrated and aspirational colleagues, but also service-users who have had negative or traumatizing experiences. Without an identity to counter, it is harder to recognize shortfalls between what we think we stand for and what we actually represent. Without this awareness, we cannot take decisive steps forward or consider ourselves genuinely honest.

Such progress, however, would not be easily negotiated. It may depend on the proliferation of a critical consciousness which does not accept status-quo practices, leadership discourse, and change methodologies as sufficiently evolutionary. Whilst these may have value in 'expanding the floor of the cage' (Herod 1999) there remain deeply existential, necessarily confrontational debates to be had about how MHNs can successfully

close the gaps between certain values and practices whilst not undermining their ability to exist at all.

A modern identity may be of use here. It would allow for effective differentiation from past forms of mental health care, which in turn could provide ethical confidence in the best of our present efforts whilst articulating simultaneously a demand for further, the faster movement towards less restrictive practices and a maximalist vision of care-giving (McKenna Lawson & Watmough 2021).

RELEVANCE FOR CLINICAL PRACTICE

It is clear from campaigns such as the one examined here, that MHNs feel a great many positive things about their work; some contradictory, most complimentary. The vision of a highly skilled, interpersonal agent of therapy and healing is present in the self-concept of these MHNs, yet continues to be absent from policy conceptions and job descriptions that dictate real-life roles and responsibilities for MHN.

Another absence that is evident here is that of the particular and peculiar difficulties of MHN as a profession, those downstream of our proximity to suicide, violence, trauma, and poverty. These are facts of the work. There may be benefits for recruitment, retention, and development, and thus a more stable workforce, in creating a more-rounded identity discourse which includes both the positive and painful; one that not just acknowledges but is, to some extent, constructed explicitly upon recognition of the skill it takes to work therapeutically with and within such conditions.

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SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article at the publisher’s website:

Appendix S1. Hand-typed anonymised transcript of all 73 Nurse Contributions to #MHNFuture.