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Professional identity in community mental health nursing: A thematic analysis

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Abstract

Aim: The study aimed to explore how community mental health nurses (CMHNs) UK perceived their working lives. This was subdivided into questions related to:

- How do nurses perceive their professional status in terms of public image compared with their understanding of their working lives?
- How does the relationship between professional aspirations and experiences of working life affect their feelings about their work and their self image?

Background: In a rapidly changing organizational context CMHNs face the challenge of achieving a coherent professional identity.
Method: An interview study was conducted and analyzed using semi-structured interviews and a thematic analysis to identify categories and themes in 34 CMHN's accounts of their working lives.
Findings: The data were classified into four major themes: (i) The client focus: the public service identity of the profession; (ii) Not being a profession: skepticism, doubt and uncertainty; (iii) Growing out of the role: professional development as exit strategy; (iv) Waiting to be discovered: the search for recognition.
Conclusions: The metaphor of nurses searching for recognition has demonstrated its usefulness as a means of illuminating the quest undertaken by CMHNs to establish the legitimacy of their work, and achieve acknowledgment and appreciation. This underlies the search for professional identity in community mental health nursing.

Keywords: Community psychiatric nursing; Qualitative research; Professional identity

What is already known about this topic?

- Nursing is perceived by the public as a practical, feminine, mundane occupation that is subordinate to medicine.

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- Nursing strives for an enhanced professional identity.
- Professional identity in nursing remains a contested area of knowledge.

What this paper adds

- Extends and reformulates the exploration of what professional identity means to mental health nurses working in community settings.
- Provides an account of practitioner talk as a particular kind of 'identity-work' in that it constructs and implicates professional identity.
- Identifies a quest for recognition among community mental health nurses.

1. Introduction

The identity of nursing and the identities of people as nurses has increasingly presented challenges, not least for those working in community mental health. At the same time this occupation has benefitted from innovations in training, improvements in pay and changes in organisational structure to enable nurses to undertake more leadership roles. In this paper, we investigate the occupational experience of a group of community mental health nurses (CMHNs) in the UK Midlands as they establish their professional identity. These issues resonate throughout nursing, across a variety of specialisms in many nations. As Thupayagale and Dithole, (2005, p. 142) put it:

> Nursing has for many years struggled with an inner hunger, a deep need for professional congruency and effectiveness. The perception by many people, except those aligned to nursing, see nursing as an inferior and inadequate undertaking to be regarded as a ''profession''.

With substantial and ongoing changes under a modernisation agenda in the UK NHS (Department of Health, 1998, 1999a, 2000, 2001a) and multiple policies, frameworks and practice guidelines directing mental health services and influencing their cultures (Department of Health, 1999b,c, 2001b, 2002a,b,c, 2003a,b, 2005, 2006a,b) it is important to investigate the reflexive account community mental health nurses have of their collective identity. In light of determined efforts to professionalise the role, exploring how they negotiate the challenges associated with their vocation might yield important insights.

Defining professional identity, of course, is not straightforward. It invites thorny questions of what it means to be a nurse and the strength of nursing's claim to be a profession, which has historically been more difficult in mental health nursing than in other specialisms (Nolan, 1993). In the nursing literature as a whole there are many concerns about nursing's lack of recognition and the possible reasons for this. Fawcett (2003) points to an erosion of professional identity in nursing in its move away from 'hands-on' care, while Anderson (2000, p. 53) marks it as a 'doing' culture that 'values or at least tolerates being oppressed'. Salvage (2006, p. 260) argues that it is perceived as 'dirty work' for 'softies'. Rafferty (1996) concludes that the possibilities of nursing achieving professional status are limited as a result of its association in popular ideology with 'tea and sympathy' that is seen as women's work. Indeed, according to Salvage (2006, p. 260) it is as if, where public representations of the role are concerned, nursing has 'virtually vanished'.

Nursing staff in mental health care itself are equally responsive to concerns about professional identity, yet they do not appear to have the confidence in performing their roles that one would normally expect for professional groups (Gerrish et al., 2003). Public perceptions of community mental health nurses are that they engage in ordinary or everyday work, subordinate to medical control (Takase et al., 2006), and even a generation ago it was noted that practitioners shared a hunger for prestige (Freidson, 1970). Indeed, attempts to construct professional identity in community mental health nursing are often intimately connected with morale boosting drives to gain a sense of empowerment, autonomy and job satisfaction (O'Brien-Pallas et al., 2006).

As with many fields of nursing, historically the identity of psychiatric nurses was most clear when restricted to working within traditional secondary or inpatient services as a supportive and often feminised care provider. With the shift of health services to community settings, the professional identity of the CMHN has become more diverse and blurred with other occupations (Brown et al., 2000), bringing high levels of stress (Edwards et al., 2000, 2001) and burnout (Hannigan et al., 2000)—something that clinical supervision has not succeeded in reducing (Edwards et al., 2006).

Community mental health nursing has changed with the times and practitioners have continually reinvented themselves as counsellors, therapists and befrienders to 'validate their existence' and respond to the changing mental health needs of the public and calls for evidence-based practice (Colley, 2003; Hurley et al., 2006). They are, as Sheppard (1991) described them, the 'artful dodgers' of the mental health world, expanding the scope of their work by 'stealing roles' previously belonging to other occupations. In this sense, CMHNs are viewed as dependent on higher status professions in their drive to achieve recognition for their work.

CMHNs spend a good deal of their working day visiting clients, attending GP practices and hospital clinics, and all this makes it even more difficult for a

fixed, coherent occupational or professional identity to emerge (Morrall, 1998). It also provides them with unique challenges in achieving professional recognition and a sense of self-confident legitimacy.

In the current study, we adopt an approach broadly informed by thematic analysis and phenomenology to consider the discourse through which individuals define themselves and their work. This represents a form of what Tracy and Naughton (2000) call 'identity-work', in that it constructs and promotes a particular kind of professional identity. It is through this 'occupational rhetoric' that 'workers justify and explain to themselves and their public why what they do is admirable and or necessary' (Fine, 1996, p. 90). According to Miller (1998), such 'identification accounts' characterise the process of achieving professional identity.

The current study therefore provides a valuable opportunity to extend this exploration of what professional identity means to CMHNs. It further serves to highlight the similarities and differences in how they perceive and construct their professional identity.

2. The study

2.1. Aims

The aim of the study was to explore the question of how CMHNs perceived their working lives. Specifically, in the course of the study the following research questions were devised:

- How do nurses perceive their professional status in terms of public image compared with their understanding of their working lives?
- How does the gap between professional aspirations and experiences of working life affect their feelings about their work and their self-image?

2.2. Design/methodology

The empirical work for this paper was informed by an approach based in thematic analysis (Braun and Clarke, 2006) and to a lesser extent grounded theory. In-depth, semi-structured interviews were conducted with a view to capturing narratives of professional identity (Charmaz, 2002). Explorations based on participants' own understanding and the themes to which they allude is believed to be particularly valuable for nursing research (McCann and Clarke, 2003) especially under conditions of uncertainty such as are unfolding in the UK. We examined:

(a) the fine grain or detail of what CMHNs think of their jobs, both in terms of the everyday practice and the image of the occupation;
(b) the nature of how nurses identify the central tasks of their occupation;
(c) the steps that CMHNs have taken to professionalise themselves.

With the analytic strategy of thematic analysis, data exploration and theory-construction are combined. In addition, theoretical developments are made in a 'bottom up' manner so as to be anchored to the data (Braun and Clarke, 2006; Glaser and Strauss, 1967; Strauss and Corbin, 1998).

The strength of this approach is illustrated by the way that existing theoretical presuppositions about the 'profession' were challenged by the data, in that there appear to be broader issues at stake. For example, as we shall see, the idea that the role is a 'self-effacing' one, and that even with a degree and further professional training there is little opportunity in terms of promotion, and that in order to progress one must leave nursing and become a different kind of worker was unanticipated at the outset.

2.3. Sample/participants

In the study 34 CMHNs who worked with adults aged 18–65 were recruited in the UK Midlands. They worked from various occupational bases, such that 30 were exclusively in practice and four undertook some teaching at higher educational establishments in the region as well as spending a substantial part of their time in practice. Participants comprised 26 females and eight males. Of those exclusively in practice 19 were at G grade and 11 at E grade at the time of the study on the UK's Whitley Council scales.

2.4. Data collection

Interview data were collected over a period commensurate with the third author's PhD and represent a recursive revisiting of the issues with interested personnel from 2003 to 2006. After consent had been agreed and participants had been informed of their rights, semi-structured interviews were allowed to evolve as a dialogue between the CMHN and the researcher in which jointly they focused and explored the meaning of being a CMHN. Whilst not a nurse herself the researcher worked with nurses at a number of sites in the UK conducting fieldwork concerned with occupational identity and stress for several years and was conversant with many of the issues they faced. As the fieldwork progressed, ideas and topics suggested by earlier participants, particularly those relating to professional identity, were prominent and these were used as a basis for further prompts in subsequent interviews to open fresh insights about identity construction.

2.5. Ethical considerations

Participants were briefed about the study and informed of their right to withdraw participation or data at any time. Also, in line with the conditions necessary for local research ethics committee (in this case the relevant NHS LREC) approval, they were advised of the confidentiality and anonymity of their responses and availability of support if the interview were to prove stressful. Whilst the details of participants' lives are reported as they were given, every effort was made to exclude details which would enable them to be identified.

2.6. Data analysis

Following transcription of the interview material, analysis in the study focused on what the participants expressed about their job roles, and was extended into a close reading to extract themes relating to:

(a) accounts of what the participants do in their jobs and the nature of professional identity;
(b) their similarities and differences from other occupations;
(c) their interest in further study and obtaining additional academic qualifications;
(d) the possibilities for career advancement as a result of qualifications.

2.7. Validity, reliability and rigour

Whittemore et al. (2001) and Jorgensen (2006) advocate credibility, authenticity, criticality and integrity as primary criteria for evaluating qualitative research. Credibility (Lincoln and Guba, 1985), relates to whether the results of the research reflect the experience of the participants in a believable way. Themes extracted were discussed subsequently with selected participants who had previously indicated a willingness to be involved in further inquiry. This enabled us to refine them in the light of feedback, thus addressing the challenge 'of preserving participants' definitions of reality' (Daly, 1997, p. 350) through a process of participant validation. Authenticity was addressed by retaining a reflective awareness of our preconceptions and retaining also the possibility of being surprised by findings. The criteria of criticality and integrity relate to the potential for many different interpretations that can be made, dependant on the assumptions and knowledge background of the investigators. To address this, two groups of nurse researchers were convened at the authors' host institutions to review the emerging themes and to establish their credibility, plausibility and their resonance with experiences beyond the confines of the original study (Horsburgh, 2003). Thus the resulting organisation of data is both plausible and rigorously defensible in terms not only of the authors' interpretation but that of participants and fellow researchers.

3. Results and discussion

The key themes then derived from the data were as follows:

- *The client focus*: The public service identity of the profession.
- *Not being a profession*: Skepticism, doubt and uncertainty.
- *Growing out of the role*: Professional development as exit strategy.
- *Waiting to be discovered*: The search for recognition.

3.1. The client focus: the public service identity of the profession

This theme concerns the CMHNs' perception of their identity as rooted in the client's well-being. At the same time a sense of self-effacement through and in work is apparent in some of the participants' quotes:

> 019(S): Professional identity? I find that quite difficult to answer. What my exact role is. I tend to say that I am kind for a living. I help people to help themselves. I try to enable people, empower people. Encourage people to be independent to be able to get a good quality of life… .

Here, the participant is drawing upon folk categories to characterise what she does, such as being 'kind', or by seeking a justification in terms of the ends to which her efforts are directed, such as through clients having a better quality of life. This pattern in representing nursing work has been noted elsewhere (Liaschenko, 1998; Liaschenko and Fisher, 1999), and is often described as contributing to the 'invisibility of nursing' (Falk-Rafael, 1996; Latimer, 2000). In this sense it represents a clue as to how the striving for recognition comes about. Here, a participant discussed the value of finding something you could do for the client:

> 002(S): I suppose, whoever you see, you're always thinking how can I help this person, and some of them are really wretched, and you know they haven't been looking after themselves but there's always something you might be able to do even if it isn't very much.

And later, new ways of working were judged in a similar way:

> 002(S): … as long as everything is beneficial to the client

This tendency of caring professionals to foreground the client, especially in the face of ambiguity has been noted elsewhere (Brown et al., 2000) and is similar to Naughton's (1996) account of nurses, like the method actor, providing evidence that they are 'living' their 'commitment'. Similarly, our CMHN participant is doing identity-work in keeping with a principle of client/user focused care, and at the same time, subtly pushing her own identity into the background.

Again, we see 'identity-work' around being client-focused when another participant contrasts herself with someone who resists the contemporary trend toward role blurring:

> 003(S): …from a patient's perspective I think the overlap of roles might be better. It might cut out them having to tell their story to too many people that maybe within one individual they have the skills and mental framework to be able deal with their needs. I am not one of these resistors of blurring of roles. I'm OK with that as long as it's client focused.

The three quotations selected here foreground the client focus, and represent a broader trend in our own study's data and that of others. The performance of CMHNs is formulated so as to emphasise the way they serve the public (Tolson, 2001) and thus achieve 'moral credibility'.

Yet at the same time, the willingness to formulate one's work in colloquial terms (019), become a jack of all trades (002) or allow roles to blur (003) we can see how this very client focus and willingness to be flexible might be at odds with developing a clear cut professional identity.

This kind of self-effacement also featured in the next theme where participants emphasised the flexibility inherent in their role. At the same time, as Turner (2006, p. 154) says, this valorises an 'intrinsic ordinariness' that grants authenticity to their performance.

3.2. Not being a profession: skepticism, doubt and uncertainty

Mirroring the uncertainty expressed elsewhere, a number of the CMHNs in this study expressed doubt about their career being a profession.

> 001(S): we just don't have the clout…We answer to everybody…A social worker and a doctor can compulsorily admit someone to hospital, a Community Mental Health Nurse can't, yet who goes out and sorts it all out when it falls apart? The nurses. If we're supposedly mental health specialists why isn't our opinion sought?

Thus, in line with the concerns expressed in the literature about subservience (Lewis and Urmston, 2000) the participant characterises the role as not being granted importance. As Liaschenko and Peter (2004) note, in health care, the 'crisis' issues readily achieve 'the status of the serious', whereas the routine, everyday 'housekeeping' issues related to 'sorting it all out' that constitute much health care work are largely ignored or invisible (Warren, 1989, p. 78).

This invisibility was compounded by the hard-to-define subject matter of community mental health nursing:

> 019(S): …people don't recognise it. They don't recognise mental health problems. They think people should pull themselves together. So perhaps that's why they don't recognise mental health nurses as being professionals because it's not a real illness.

The nature of the clients that one sees and the problems that one deals with as a CMHN provide a further source of difficulty in defining oneself as a profession, especially when this is at odds with what the commonly accepted role of a nurse involves, as one of the participants who had done some teaching identifies:

> 033(S): it's like with my students or anybody else, when I say I'm a nurse they think about what they see on Casualty or something, and some of them think it's all crises but most of what you do is just looking after people really.

The occupational self-effacement identified in the earlier of the two quotes from 019(S), where the nurse herself was eclipsed by the empowerment of the client is echoed here. This very flexibility effaces both the technologies of change and the occupational identity of the practitioner. The occupational space is one where skilled workers are neither visible nor fully credited for the work they do.

A further issue which was seen to work against being a full profession was the feminisation of nursing itself—something that resonates with the gender inequalities elsewhere in society as noted by White (2002). As one participant commented:

> 007(S): Nurses are not willing to support each other. The reason for that, not being pc is that it's female dominated. Traditionally it's been that women tend to be less assertive, tolerate more for want of a better word crap than men will…It's seen as a female role, it's nurturing, it's caring. … It's a badly paid job…So it's low pay and men won't do it, and if they do it's at the management level, away from nursing.

As well as the widely discussed factors relating to pay and gender stereotypes, there is an allusion here to the humiliations piled upon the novice and the way that their needs are subordinated to particular performance formats (Turner, 2006). In addition, the emphasis on

how the caring, nurturing side of nursing detracts from the professional status of the role was also apparent as other participants attempted to reformulate what they saw to be the skills involved. On the one hand, CMHNs are functionaries because by virtue of being nurses they are bossed around and answerable to everybody (O'Neill, 1999). On the other hand however, they are people who pride themselves on this flexible, resourceful approach and even develop themselves in order to perform those functions more effectively.

3.3. Growing out of the role: professional development as exit strategy

Several participants have undertaken further training in a variety of other disciplines such as counseling courses, cognitive behaviour therapy, family therapy, dramatherapy and art therapy. CMHNs are getting additional skills from outside of their discipline in an attempt to make themselves more professional as nurses. The participants sometimes appeared to be in a double bind inasmuch as being a good nurse was also about becoming proficient in other fields too.

> 021(S): … the role has lots and lots of subtle growths within it.… I use a lot of counseling principles because I felt I needed some skills development so I went off and did two counseling courses … Because I started to feel the need that … we had to start being accountable and saying what we did was evidence based… I just felt as a CPN I wanted to preserve some sort of integrity as our profession. And possibly my own personal feelings. I don't want to feel put down either.

This then highlights the contradiction at the heart of the participants' problems in achieving recognition. Like the successful actor, the more professionalised they become in terms of the skills and qualifications acquired, the more deeply they slip into what O'Neill (1999) terms a 'functionary' role. On the one hand, they were keen to gain knowledge and skills of the kind that secure social position and yield access to certain resources. If they were to lack such resources they might consequently have to cope with more uncertainties, anxieties, and hazards (Beck, 2000). These cultural resources gained through education usually enable individuals to create 'status shields' (Hochschild, 1983, pp. 174–175) that protect them from demands and impositions that are made by more powerful individuals and institutions involved in service work settings (Weaver, 2005). On the other hand, this drive for continuing education is not a simple gateway to enhanced status as professionals. Indeed, many of them were disillusioned regarding the potential of education and training to facilitate such development.

> 001(S): … the way that CPNs have gone with this doing degrees. They wanted everyone to be degree level nurses. But that was it. You got a degree and that was it. There was no fundamental change in what you did except that it looked good on the organisation … you didn't get your clinical grading looked at again, you couldn't change the way you worked.

Thus, the addition of qualifications and skills does not necessarily secure career advancement. Pursuing the metaphor of searching for recognition a little further, so far it has not enabled their professional worth to be 'discovered' and has even seemed to make it more likely that nurses will be overlooked in the scramble for status, prestige or esteem. It has meant that they are concerned or preoccupied with issues around acceptance, collective professional self-esteem and occupational visibility. Furthermore, their strategies for recognition do not seem to be working.

3.4. Waiting to be discovered: the search for recognition

Notable in the present study was the sense of waiting to be discovered, perhaps even more acutely felt than in previous accounts of the working lives of nurses. In one case this concerned a hunger for recognition:

> 0034(S): It's like everyone wants to be famous these days, and I get the impression us nurses are like that, waiting to be discovered, as if someone will come along and recognise our talents, and I'm like 'don't hold your breath darling'.

Equally, the sense of uncertainty which the need for recognition brings is further compounded by a great many other factors:

> 0031(S): so much of feeling good about your work and your self when it comes down to it depends on whether other people appreciate it, like when the patients say thank you or if your manager does, if that ever was to happen which seems pretty unlikely, but at the end of the day you're just so dependent on the approval of other people.

Thus, a number of participants saw their role as inexorably intertwined with a need for recognition, appreciation and the sense that one's efforts will lead to one being 'discovered' (Tolson, 2001). The expressive acts of one's work, and the social interactions that result from them, have their therapeutic value validated by being recognised. Equally, there is the fear of not being recognised:

> 007(S): I think in this place, perhaps because we're out [seeing clients in their homes] you could be here for years and no one would notice, in fact if you

weren't here at all, they wouldn't know either and the patients would just be going quietly mad at home and I still think no one would twig.

We can see then across all four themes a pervasive sense of invisibility in the CMHN's role, the infrequency of recognition and the precariousness of being valued. The puzzle is how practitioners with training, experience, a career structure and a role in the health service should find themselves struggling for recognition in this way. In the case of CMHNs, identification with the service and vocational aspects of the role has been connected with conflict between working life and home life (Majomi et al., 2003) and an increasing desperation about inadequate management support in meeting the needs of clients (Brown and Crawford, 2003).

These difficulties in relationships are made worse by multiple relationships between care providers and patients, fragmentation of services and tension between the goals of organisations and their workers (Liaschenko and Peter, 2004). There is also an increasing lack of agreement about what constitutes expert knowledge and which individuals or disciplines are responsible for applying such knowledge within organisations (Liaschenko and Peter, 2004).

4. Conclusions

The sample ($n = 34$) studied here is small, and represents only one facet of the whole field of nursing. Moreover, our focus has been on individuals and has not afforded an analysis of the broader social-structural factors that have consigned nursing to a handmaid role over the last century and a half. Nevertheless, we would claim a broader relevance for the study inasmuch as its findings are consistent with larger studies conducted over the last two decades (Edwards et al., 2000, 2001, 2006). Added to these, the present decade has witnessed a sustained upheaval in the organisation of the NHS in which nursing in general and community mental health nursing in particular bear the scars of many transitions. Practitioners are increasingly cast as 'solitary' managers of their own evidence-based performance in a process which has been termed the 'clinical governance of the soul' (Brown and Crawford, 2003). The NHS provides a management structure where the occupational groups are continually auditioning for status and resources and which seems to encourage uncertainty and introspection as to whether one is worthy of professional rewards. Whilst the Healthcare Commission's (2007) surveys suggest that 73% of staff in mental health care were 'more satisfied than dissatisfied' with their jobs, a different story emerges from press reports and other research. Elsewhere, other authors have noted that morale is unrelentingly low around the world (Callaghan, 2003; Hsu and Kernohan, 2006) and a significant proportion wish to leave nursing (Ball and Pike, 2004). Thus it is clear that differing stories emerge from health service workers depending on who is asking, and how the questions are formulated. Perhaps the satisfaction of working with patients is distinct from dissatisfaction at the perceived lack of status and recognition.

The individuated status of the practitioner is welded to a culture of self-questioning and self-monitoring. Participants are locked into a cycle of gaining skills, responding to the demands of clients and other professional groups and adapting to organisational change. Their very willingness to adapt to the parameters of a role defined elsewhere makes it difficult to effectively challenge the dominant stereotypical conceptions of the nurse. Virtues such as being self-sacrificing, obedient, loyal and above all devoted (Hallam, 2000), being there for the client, and addressing the client's needs are emphasised. The CMHNs have shown that their 'profession' is not static, and is something towards which they are constantly struggling. However, as is equally clear from participants' accounts this is not necessarily associated with any greater subjective sense of success in becoming a profession. They are not able to present their diverse contribution in a way that makes them easily identified and visible; they do not achieve the status of professionals who can provide a more decisive profile. Thus they struggle to achieve the kind of self-advertisement and justification required in the contemporary health service.

Professional identity has, paradoxically, become the kind of burden which makes the likelihood of securing professional status all the more difficult. CMHNs partake in 'identity-work' around being client-centred and offering therapeutic communication. They are caught up in a frustrating and potentially counterproductive quest as they embark on additional courses and training that seem to render them skilled and diligent yet invisible. Alternatively, it takes them away from nursing itself into other spheres of expertise as they repackage themselves as managers, counsellors, dramatherapists and so forth, questing for recognition elsewhere. Yet as Forchuk et al. (2000) contend, the centrality of the relationship with clients remains important whatever role nurses find themselves taking on.

Community mental health nurses (CMHNs), like many employees in service-oriented workplaces can be conceptualised as 'performers' whose performances are 'consumed' by managers, policymakers, other professional groups as well as clients and their caregivers. This performative or 'theatrical' dimension of interactive service work is associated with self-presentation, display, and interpersonal communication. As performers, CMHNs can influence or shape their own 'show', but not necessarily the conditions or direction under which they perform. We would enter a plea for researchers to

develop a sense of the political economy of performance (Weaver, 2005). We need to understand what it is that means nurses' efforts to assist clients flexibly and resourcefully make them less and less visible. The 'identity accounts' and 'occupational rhetorics' that are most attractive are ironically the ones that are sometimes the most self-effacing. The next puzzle is to find a way of making nursing's contribution more prominent. Otherwise the best advice for nurses who merely 'wait to be discovered' is, in the words of our informant above, 'don't hold your breath darling'.

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