

Becoming a Psychiatric/Mental Health Nurse in the UK: A Qualitative Study Exploring Processes of Identity Formation

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Identity studies are well established across the social science literature with mental health nursing beginning to offer evidenced insights into what may, or may not, constitute key identity performances. For mental health nursing these performances remain contested, both from within the profession and from international contexts that favour generic constructions of mental health. This paper offers findings from a qualitative study that focused upon the process of how mental health nursing identity development is influenced, rather than what that identity may or may not be. These findings highlight that mental health nurses (MHNs) not only form their identity around service user centred education and training, but that many also use the education as a means to leave the profession. Through highlighting the impact of informal education (i.e., through work), formal education, and training upon the formation of mental health nursing identity, nurses are potentially alerted to the importance of clinically focussed mental health being prominent within curricula, rewarding mental health nursing skills specialisation, and the importance of the role of the service user in mental health nurse education and, hence, identity formation.

In the not too distant past becoming a “psychiatric nurse,” “mental health nurse,” or some variation of nurse identified as being qualified to work with people diagnosed with mental health problems, was relatively uncomplicated. Would-be nurses or students undertook a course of study and upon completing a prescribed amount of time working largely in a hospital, having attended classes and successfully passed examinations, received a title or endorsement from a regulatory body stating they were a particular kind of nurse (Chatterton, 2004). Presumably the neophyte came to incorporate not only the notion of being a nurse, but the idea of being a specialist nurse as they completed their training and enculturation into the profession and workplace. Such a process is more complicated now, as in many parts of the world (but notably Australia, New Zealand, and parts of North America) undergraduate stu-

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dents undertake so-called comprehensive programmes of study leading to a generic qualification (Robinson & Griffiths, 2007). The proportion of such programmes given over to psychiatric or mental health nursing theory or practice can be negligible (Wynaden, 2010). North America has the Advanced Practice Registered Nurse, which has within its Masters-level framework a psychiatric/mental health nurse speciality. However, only 13% of all nurses in America have masters qualifications (US Department of Health and Human Services, 2010) leaving few with advanced mental health nursing training and titles. In Europe, despite some attempts at standardising broad parameters relating to the preparation of nurses, countries vary enormously in their requirements for nurses’ length of training, level of education, and degree of specialization; countries also vary as to how nursing is administered and regulated. Thus, how nurses come to view themselves as being psychiatric or mental health nurses (if at all) is a process that is not only interesting but also may be critical to the survival of psychiatric or mental health nursing as a distinct specialty (Hurley & Ramsay, 2008).

This paper presents findings from a qualitative study undertaken in Scotland and England. It sought to better understand the process by which mental health nurses (MHNs) reached their current identities, both personally and professionally. In these countries, specialist undergraduate educational programmes have been retained, although the composition of that training is only prescribed in broad terms. In recent years, the UK has committed to standardising the minimum length of programmes (3 years or 4600 hours), the level (Bachelors level), and post-registration requirements for mandatory preceptorship (Nursing and Midwifery Council, 2009). Arguably, those that identify as psychiatric or mental health nurses elected to pursue this field from the outset, but they also have been, and increasingly will be, exposed to much in the way of generic content. Highlighting, their process of identity formulation may offer seeds for discussion on how to strengthen generically trained nurses’ identification with mental health nursing.

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DOES IDENTITY MATTER?

There has been considerable debate, interest, and commentary regarding the concept of “mental health” nursing and how it might be associated or different from “psychiatric” nursing. Indeed Cutcliffe and Ward (2006) placed consideration of the name as the first of a series of key debates in psychiatric/mental health nursing. Mental health nursing appears to signify something different than psychiatric nursing. However, there is considerable geographical variation of nursing titles and being registered under a particular title does not necessarily lead to identification with that title. For example, in the Republic of Ireland, nurses may become registered psychiatric nurses, but at least some identify as mental health nurses as illustrated by MacNeela et al. (2010) who discuss essential elements of mental health nursing care in Ireland. The debate about the proper title of the specialty is unlikely to be resolved any time soon as it is tied to tradition, aspiration, or political expediency. For the purposes of this study the term mental health nursing is used as a signifier of identification with the specialty, whatever so named.

Happell (2006) has frequently contributed commentary and editorials highly critical of the comprehensive undergraduate training in Australia (which has been part of the landscape for over 20 years) in respect of its usefulness to prepare students to work in mental health services. Like others (see Wynaden, 2011) she has promoted the Australian College of Mental Health Nurses (ACMHN) credentialing programme (with a reasonably high bar of postgraduate qualifications, experience, referee checks, and evidence of ongoing professional development) as the pathway to recognition as a mental health nurse. Graduates in Australia are repeatedly informed by professional leaders that they are ill-prepared and have not earned the right to be called a mental health nurse. Paradoxically, however, the majority of nurses who work in public mental health services do not hold the ACMHN’s credentials. Many others are likely to work in the highly generic role of case manager, which forms the mainstay of community care and is typically open to any of the core professions (King et al., 2002). Some commentators such as Holmes (2006) have argued that in the face of chronic shortages, the demoralisation of care providers across all traditional professions, and accounts of the mental health system in most English-speaking countries being in crisis, the best solution (albeit one that is likely to be opposed by the professions themselves) would be to adopt a post-disciplinary stance and develop a generic mental health practitioner specialty. Identity discussions inevitably involve complex social forces (Foucault, 1988). A key consideration for a practice-based activity, such as mental health nursing, is whether such a discussion might somehow improve how service is delivered. Indeed, there is likely to be a close relationship between the experience of competence and identity formation. Thus, when education and training enhance the nurse’s capacity to be an effective helper, and service users are demonstrably helped, this is likely to strengthen identity as a mental health nurse. Additionally, given the close physical

proximity service users have with MHNs, often over extended periods of time, any role the service user may play in the identity formation may be pivotal.

METHOD

A direct phenomenological approach was assumed for this study. Direct phenomenology is centrally concerned with seeking shared meanings that can then be generalised into types of subjective experiences (Titchen & Hobson, 2005). By comparison, indirect phenomenology is more concerned with the analysis of everyday social actions embodied in intuitive non-verbal knowing. Strengths of this direct phenomenological approach are that it incorporates lifeworld determinants, rational understandings, and subjective meanings as well as social action. The study sought to attain dependability and trustworthiness through establishing congruence among the adopted research methods and techniques (Harreveld, 2002). This congruent relationship between the qualitative approach in this study and the adopted paradigm is reinforced through understanding that, by studies being placed in natural settings, qualitative approaches make sense of phenomena through exploring the meanings that people attribute to them (Denzin & Lincoln, 2005).

Sampling

A purposeful sample of 24 MHNs in both England and Scotland were recruited for the study. Participants were invited to take part in the study through an invitation distributed via e-mail in three National Health Service mental health trusts and two universities chosen for convenience. Participants had to be qualified mental health nurses who were engaged in the delivery of talk-based therapies. Hence this sample sought MHNs who, through being qualified, had already undertaken their identity journeys as professionals. Table 1 displays the demographic breakdown of the participants, who had a breadth of nursing experiences and lengths of service.

Ethics

The study was conducted with the ethics approval of the Tayside Committee for Medical Ethics.

Data Collection

Data were collected through semi-structured interviews typically lasting around an hour. The majority of participants were interviewed within their work environments.

Data Analysis

Texts of recorded transcripts were repeatedly read in a search for distinctive meaning units relating to the study’s aims. This requires both manifest and latent analysis to ensure an understanding beyond the surface level. Everyday language is transformed and synthesised, reflecting the essence of each meaning unit into the most general meaning of the phenomenon (O’Donoghue &

TABLE 1
Demographics of Participants

| | | <i>n</i> |
|-----------------------|----------------------|----------|
| MHN Experience | 0–10 years | 5 |
| | 10–20 years | 10 |
| | 20+ years | 9 |
| Gender | Female | 13 |
| | Male | 11 |
| Research Site | England based | 7 |
| | Scotland based A | 9 |
| | Scotland based B | 8 |
| Academic Level | Diploma | 4 |
| | Degree | 10 |
| | Masters | 10 |
| Therapy Qualification | None | 4 |
| | Short course | 11 |
| | Formal qualification | 9 |
| Core Role | Academic | 4 |
| | Managerial | 3 |
| | Clinical | 17 |

Punch, 2003). This phenomenological reduction seeks to lead back to the core of the phenomenon by peeling back layers of taken-for-granted assumptions (McLeod, 2001). This requires paying attention to the interpretive practices and the self- and reality-constructions within each individual narrative and then across the separate narratives. Data are constantly compared and tested for negative case examples and the consistency of information with plausible alternative explanations are sought and justified. Consequently, all emerging themes and patterns are challenged. Commonalities across participants' experiences of the phenomena are then sought and are justified as to why they fit with the topic under investigation (Giorgi, 1985). This process, which was undertaken in the study, was enhanced by the use of NVivo qualitative software.

RESULTS

Four themes encapsulated the social processes associated with becoming a MHN: (1) Identity journeys through direct and vicarious work-based experiences with service users, (2) Identity journeys through non-work-based education and training, (3) Identity journeys through assuming new job titles and roles, and (4) Exit journeys

Identity Journeys through Direct and Vicarious Work-Based Experiences with Service Users

Nearly all participants identified their mental health clinical work with service users as being central to their mental health nursing identity formation. Participants learnt mental health nurse roles, behaviours, and capabilities, as well as knowledge through influences such as working directly with service users, watching experienced clinicians work with service users, and

through socialisation. This focus on effective care provision was the most powerful process identified by participants in forming and maintaining their mental health nurse identity, as well as being the most influential means by which they learnt key aspects of mental health nursing.

I think things like role modeling and coaching, exposure to good clinicians, getting a chance to hear these good clinicians talk out loud about what they do, why they did it and what skills they tapped into. What—you know, potentially, what in the past would have been intuitive skills and now people have become much better at describing their intuitive skills. I think working with people and getting feedback has helped. I think one of them is, is especially in mental health . . . It's probably led from people being with inpatients 24 hours a day. (Research Participant 12 [RP12])

I think it's fascinating and it [mental health nursing] makes you grow and it's not just the bizarre realities; it's the everyday realities, it's what people need out of life . . . part of me, quite a big chunk of me, not all of me because I've got my family, but a big chunk of me is the patients that I saw. (RP2)

Identity Journeys through Non-Work-Based Education and Training

Nearly all participants spoke of the significant influence that education and training, regardless of its duration, conducted away from the workplace had upon their professional identity performances. This theme is inclusive of mental health related education and training that may or may not lead to an academic award. This theme is linked to Theme 1 by having a service user focus, despite being undertaken away from direct interaction with patients. Clinical participants undertaking non-work-based education used stories of service users and their clinical experiences as a means of andragogically embedding their theory-based learning. The non-work-based education and training most valued by the participants, and constructed by them as being most influential on their mental health nurse identity formation, was that which enhanced their capabilities to intervene with service users more effectively. For many of the participants, formal education and training culminated in a strengthened sense of professional worth. Although Scottish participants had a weaker focus upon non-work-based education and training than their English counterparts, this remained a strong theme across all the participants. Academic participants placed the most emphasis upon this as a mechanism for identity formation with managerial participants placing the least emphasis on this. For many of the clinician participants, their engagement with formal education and training advanced their clinical practice beyond what informal work-based experiences could provide.

I think it [a training course in CBT therapies] allowed my practice to become more structured, and what I've found is I'll work and do a much, much fuller assessment than I ever did before. You know what nurses are like and your care plans . . . , and I think it was almost like the assessment that you had to get it over with as quickly as possible. Whereas actually if you look at how psychology works, they actually take a lot of time to do an assessment. (RP23)

I can make a difference by using these sorts [psychological therapy] of approaches; you know, I believe that some people are very lucky early on, some don't get exposed to these sorts of opportunities, some do. You then want to focus more on the counselling aspect of the mental health nursing role, that's because that is where you see yourself most effective. (RP3)

Identity Journeys through Assuming New Job Titles and Roles

A significant majority of participants spoke of how varied job titles within the nursing profession and their expanding roles in talk-based therapies impacted upon their professional identity. The influence of a title upon identity formation was evident within this theme. RP17, quoted below, is an example of how mental health nurse participants view identity when undertaking education from non-MHN sources, and assuming traditionally, non-MHN roles.

I'm not really too sure about that [professional identity] at the moment, because my title here is CBT therapist. I'm not a nurse therapist; I'm a CBT therapist . . . and in some way I know I'm still a registered mental health nurse. (RP17)

RP16 offers an insight into the internal divisions and hierarchies of worth that exist within the mental health nursing profession:

When I was training I referred to myself as a nurse and when . . . I got the job, now I refer to myself as a CPN, so I'm definitely a Community Psychiatric Nurse (CPN). It is almost like I want to distance myself to the other side [the inpatient side]. (RP16)

This third theme of identity journeys closely reflects the central pillars of identity theory as proposed by Giddens (1997), specifically that one of the most important markers of an individual's identity is her or his name, with naming and titles also being centrally important to group identity. Also evident was that participants assumed multiple identities within their mental health nursing roles, identities that were both personal and professional. Participants, such as RP17, who had trained in specialised fields, reported experiences of ambivalences toward their identities, as well as tensions between them. These participants also reported that while their new titles and roles, at times, created uncertainty from other mental health nurses and other professionals, the titles also generated a valued and distinctive difference from those around them. Academic participants and clinician participants with established careers were the most evident categories of participant MHNs to undertake such identity journeys.

Exit Journeys

Linked with the theme of identity journeys through assuming new titles and new roles, just over half of the participants spoke of how mental health nurses effectively left the profession through new roles or non-nursing titles, or through identifying with another profession. Findings arising from within the participant categories showed that emphasis on exit journeys rose with career experience, and that those with formal training in

talk-based therapies had the highest emphasis on exit journeys. Later career, post-graduate, qualified clinicians, academics, and managers were the notable categories of participants to construct this theme.

I was offered either to go into the community mental health team as a MHN or come up here and do Cognitive Behavioural Therapy, and I came here and did CBT. It's been—it's been really good, actually, because my interest always lay in those sort of specific—you know, doing sort of this kind of psychological work, rather than being a more kind of generic based nurse role. (RP17)

And, in discussion with another participant:

Researcher: You obviously did training in CBT.

RP22: Yeah, my experience has been to, kind of, almost, to metamorphose into something that isn't a MHN.

RP17 articulates a tension point between the genericism associated with mental health nursing and the specialism and greater perceived worth inherent within talk-based therapies, generally, and CBT in particular, while RP22 constructs a clear journey between professional identities through CBT training.

RP 8 encapsulates these issues when discussing new MHN roles:

[MHNs are] leaving the profession and they are aligning themselves elsewhere. Almost as if they . . . at some subconscious level have hit at an idea that they need to latch onto a different profession because this one is going, and the others [professions] have got more clout, don't they? (RP8)

DISCUSSION

Identity journeys through mental health work-based experiences have been previously examined within nursing literature. Palmer et al. (2005) described the role of experienced nursing staff in identity formation through passing on knowledge and modelling behaviour to novice or student nurses. Similarly, Deppoliti (2008) studied nurse identity formation over the first three years following qualification. She suggested learning in the workplace, particularly involvement with service users and their families, is central to identity formation. It is of note that participant mental health nurses in this study also identified service users as being pivotal in adding to their professional knowledge and understanding. Peplau (1952), in keeping with a psychodynamic view of nursing, stated that the service user's identification with the nurse as a helping agent was crucial to effective interpersonal help. A reciprocal process may be identification by the nurse with the patient and an internalisation of the role of effective helper. In psychodynamic terms, identification as a mental health nurse arises from projective identification.

Within the categories of participants, those working for prolonged periods with service users constructed the strongest ties and attachment toward the mental health nursing profession, suggesting that service user-based relating is a powerful correlate of mental health nurse identity formation. Such roles for service users also offer opportunity to enhance their own

perceived worth and empowerment by making positive contributions to themselves and the development of others. This has been described in the self-help literature as the “helper therapy” principle (Riessman, 1965). The role of the service user in aiding this learning and identity forming process also reinforces the relationship between service user and mental health nurse as being mutually beneficial.

Mental health nurse academics and managers are somewhat removed from the service users or, at least, have different or indirect roles in relation to them. Simultaneously, mental health nurses in academic and managerial roles exert significant influence on the politics, formation, and delivery of mental health nursing education, in itself a powerful factor in the identity formation of the mental health nurse. Such a potential tension highlights the importance of mental health nurses across clinical, academic, and managerial roles forging effective links with each other to promote a greater semblance of heterogeneity toward mental health nurse identity formation and development.

The importance of enhancing such linking is highlighted further in the findings through the subtheme of identity journeys through role modelling. Again, the service user is a pivotal character within the mental health nurses’ identity journeys through their interactions with experienced clinicians; this appears to be a key process of identity formation. The importance of experienced staff role modelling nursing behaviours with service users and its impact on nurse identity formation has been identified in other studies, such as those by Dutoit (1995), Fagerberg and Kihlgren (2001), and Gregg and Magilvy (2001). Of interest is that this bonding to the profession through role modelling transcended pedagogical approaches, culture and nationality, and other demographic indicators. In this study, participants articulated that the way in which experienced staff conducted themselves within service user-focussed activities acted as a major learning influence upon the formation of their own professional behaviours, values, attitudes, and sense of self as a helping agent.

Non-work-based learning was also, clearly, of importance to the identity formation of participants. Indeed, for many participants it was this type of learning that was most transformational, in the sense of expanding their practice and impacting positively upon their sense of self-worth and confidence. This echoes MacIntosh (2003) who studied the identity formation of nurses across a similar career lifespan to this study and found that formal education and training influenced identity formation. As articulated by RP23, mental health nurses undertaking formal education and training will often glean methods, approaches, and knowledge from other disciplines to bring back into the mental health nursing profession. This not only impacts upon the wider understandings and, hence, identities of the profession (Barker, 2001), but also expands the repertoire of interventions mental health nurses have to offer service users.

Other participants spoke of how formal education and training allowed them to validate their practice. This was an important subtheme with many participants gaining new knowledge

through formal courses, but also having their established clinical practices reflected within the evidenced-based courses they undertook. This validation of practice importantly connects work-based learning and formal education with the service user being the focus of that linking. Confidence, rather than fear and professional doubt, then becomes an identity characteristic of the mental health nurse with formal education being the mechanism to achieve this vital shift. For other participants, the shifting of education and training out of the workplace also offered an opportunity for reflection, for taking time out and thinking about why they do what they do. A focus on completing the tasks of nursing at the cost of reflecting upon those tasks has been previously reported by other authors such as Lynch and Happell (2008) and Mullarkey and Playle (2001).

The third theme of roles and titles emphasises the social arena as being central to the construction, dismantling, and reconstruction of identity—highlighting the importance of the context of mental health nurse identity constructions being linked to title and name (Eisenberg, 2001). Presumably, the kind of projective identification with mental health nursing proposed previously can only take place when there is a shared conception of “mental health nursing” in the collective social imagination. Identity theory (Giddens, 1984) would suggest that generically trained nurses, who enter a nursing course taught predominantly by general nurses and who exit with a generic nursing qualification are likely to identify firstly with generic nursing, as distinct from the specialised mental health nursing. Arguably, initiatives, such as the Credential for Practice Programme in Australia (where no specialist endorsement exists for mental health nursing on the national register), that offer a mental health nursing credential for Australian nurses with mental health experience or qualifications offer a goal and source of collective identity. However, sociopolitical expediency may be more of a motivator to pursue credentialing than wishing to identify as a mental health nurse. A considerable proportion of those whom have sought credentials to date are working in primary care in association with general practitioners, a non-traditional setting, but one which requires this endorsement to ensure an income from the federally funded Mental Health Incentive Programme (Happell & Palmer, 2010; Happell, Palmer, & Tennent, 2010).

As nurses extend their practice into non-traditional or new areas of practice, pursue training in talk-based therapies, or prescribe medications the processes influencing identity formation may well increase the potential for an additional fracturing of mental health nurses’ professional identity. Given that the MHN profession has survived and, arguably, even evolved over many years without widespread internal agreement on a professional title, or scope of practice, such fracturing may not be fatal. However, having a weak internal mental health nursing identity potentially risks eroding the profession.

Interestingly, research participants from management roles placed the least emphasis on identity journeys through new work roles and titles, implying that role expansion and education and training are valued from their perspective as only strengthening

the mental health nurses' capabilities within their current organisational positions, rather than moving the mental health nurse toward promotion, progression, or greater influence. Equally so, managerial participants constructed the widest interpretations of mental health nurses' identities, being more focused of developing service user-centred capabilities within their staff than allocating identity labels to their staff.

Within the findings it was apparent that education was a mechanism to escape mental health nursing. This finding mirrors that of Crawford et al. (2008), who found that community mental health nurses used professional development as an exit strategy from the profession. As MHNs receive higher level academic training that allowed them to specialize in therapeutic roles there is a heightened risk that they will leave the profession, despite precisely fitting the profile of the mental health nurse that the profession arguably needs most. Examining the interview data in greater depth offered some possible insights into why this may occur. As stated earlier, identity is a mediated process, in relation to other mental health nurses, managers, and policy (Altheide, 2000), and MHNs who undertook formal training often received no additional expressed organisational worth or advancement. Consequently they seek intrinsic and extrinsic satisfaction for their educational efforts and enhanced therapeutic skills through finding new positions that reward their expanded capabilities. This is highly context bound, however, as in Australia credentialing as a mental health nurse, at present, offers opportunities to deploy such therapeutic capabilities that would not otherwise be available.

For the participants who had undertaken education or training in talk-based therapies there was a sense that they had outgrown their roles, or that they were not accepted by other MHNs as belonging to the profession any longer. The former point highlights the sense of journey, in terms of identity, for these participants, and for the mental health nursing profession generally. This is a journey of escape from a career that is perceived as attracting comparatively low regard and progression opportunities toward an identity of greater influence. This latter point again draws in the service user as a pivotal partner in identity formation. This category of participants experienced greater capability to offer meaningful interventions to service users and consequently generated a greater sense of professional worth from these therapeutic encounters.

Limitations

Wider extrapolations of the findings are constricted through the small sample and qualitative methodology nature of the study. As has been noted, the local context will have a bearing on identity processes.

CONCLUSION

Identity studies and discussions on mental health nursing are absolutely critical. Identity formation is clearly a dynamic process and the extent to which one may identify with a profes-

sion or work role is likely to vary over time. However, without knowing who we are and what we are qualified in, and therefore qualified to do, we risk having our educational and clinical futures being decided by those external to the profession. This paper suggests that mental health nurses need an inclusive view of who they are, as well as having an expansive future eye toward what key roles they can have in delivering talk-based therapies. The apparent fragility of mental health nursing identity found both in this study and the explored literature including America, Europe, and Britain suggest that mental health nursing needs not only direct entry under graduate training, but also specialised postgraduate training and education for roles such as talk-based interventions. Perhaps the most noteworthy finding in this study was the central role service user-centred education and training played in constructing mental health nurses' identities or influencing them to exit the profession. While work-based identity journeys appeared significant, formal education was potentially more transformational for the participants, and culminated in a perceived increased capacity to intervene effectively. This suggests not only that we need more specialised training programmes, but also that the nature and delivery of such programmes could be structured around the service user.

Identifying mechanisms that strengthen identification with the mental health nursing profession as nurses' educational levels and specialised clinical capability increases should be a priority for future investigations, as should ways of formally recognising the roles service users play in mental health nursing education and training.

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REFERENCES

- Altheide, D. (2000). Identity and the definition of the situation in a mass-mediated context. *Symbolic Interaction*, 23, 1–18.
- Barker, P. (2001). Something old, something new, something borrowed, something blue. *Journal of Psychiatric and Mental Health Nursing*, 8(2), 177–180.
- Chatterton, C. (2004). "Caught in the middle?" Mental nurse training in England 1919–1951. *Journal of Psychiatric and Mental Health Nursing*, 11(1), 30–35.
- Crawford, P., Brown, B., & Majomic, P. (2008). Professional identity in community mental health nursing: A thematic analysis. *International Journal of Nursing Studies*, 45, 1055–1063.
- Cutcliffe, J. R., & Ward, M. F. (Eds.). (2006). *Key debates in psychiatric/mental health nursing*. Philadelphia, PA: Churchill Livingstone Elsevier.
- Denzin, N., & Lincoln, Y. (Eds.). (2005). *The Sage handbook of qualitative research* (3rd ed.). London, UK: Sage.
- Deppoliti, D. (2008). Exploring how new registered nurses construct professional identity in hospital settings. *The Journal of Continuing Education in Nursing*, 39(6), 255–263.
- Dutoit, D. (1995). A sociological analysis of the extent and influence of professional socialisation on the development of a nursing identity among nursing students at two universities in Brisbane, Australia. *Journal of Advanced Nursing*, 21, 164–171.
- Eisenberg, E. (2001). Building a mystery: Toward a new theory of communication and identity. *Journal of Communication*, 51, 534–552.

- Fagerberg, I., & Kihlgren, M. (2001). Experiencing a nurse identity: The meaning of identity to Swedish registered nurses two years after graduation. *Journal of Advanced Nursing*, 34(1), 137–145.
- Foucault, M. (1988). The ethic of care for the self as a practice of freedom. In J. Bernauer & D. Rasmussen (Eds.), *The final Foucault* (pp. 1–20). Boston, MA: MIT Press.
- Giddens, A. (1984). *The constitution of society*. Cambridge, UK: Polity.
- Giddens, A. (1997). *Sociology*. Cambridge, UK: Polity.
- Giorgi, A. (Ed.). (1985). *Phenomenology and psychological research*. Pittsburgh, PA: Duquesne University Press.
- Gregg, M., & Magilvy, J. (2001). Professional identity of Japanese nurses: Bonding into nursing. *Nursing and Health Sciences*, 3, 47–55.
- Happell, B. (2006). Would the real mental health nurse please stand up? The relationship between identification and professional identity. *International Journal of Mental Health Nursing*, 15, 155–156.
- Happell, B., & Palmer, C. (2010). The mental health nurse incentive program: The benefits from a client perspective. *Issues in Mental Health Nursing*, 31(10), 646–653.
- Happell, B., Palmer, C., & Tennent, R. (2010). Mental Health Nurse Incentive Program: Contributing to positive client outcomes. *International Journal of Mental Health Nursing*, 19(5), 331–339.
- Harrevel, R. E. (2002). *Brokering changes: A study of power and identity through discourses*. Unpublished Doctor of Philosophy thesis, Faculty of Education and Creative Arts, Central Queensland University, Rockhampton, Qld.
- Holmes, C. (2006). The slow death of psychiatric nursing: What next? *Journal of Psychiatric and Mental Health Nursing*, 13(4), 401–415.
- Hurley, J., & Ramsay, M. (2008). Mental health nursing: Sleepwalking toward a chasm of non-existence? *Mental Health Practice*, 11(10), 14–17.
- King, R., Yellowlees, P., Nurcombe, B., Spooner, D., Sturk, H., Spence, S., et al. (2002). Psychologists as mental health case managers. *Australian Psychologist*, 37(2), 118–122.
- Lynch, L., & Happell, B. (2008). Implementing clinical supervision: Part 1: Laying the ground work. *International Journal of Mental Health Nursing*, 17, 57–64.
- MacIntosh, J. (2003). Reworking professional nurse identity. *Western Journal of Nursing Research*, 25(6), 725–741.
- MacNeela, P., Morris, R., Scott, A., Treacy, M. P., & Hyde, A. (2010). Seen as Core: A Delphi consensus study of essential elements of mental health nursing care in Ireland. *Archives of Psychiatric Nursing*, 24(5), 339–348.
- McLeod, J. (2001). *Qualitative research in counselling and psychotherapy*. London, UK: Sage.
- Mullarkey, K., & Playle, J. (2001). Multi professional clinical supervision: Challenges for mental health nurses. *Journal of Psychiatric and Mental Health Nursing*, 8, 205–211.
- Nursing Midwifery Council. (2009). Confirmed principles to support a new framework for pre-registration nursing education. Retrieved from <http://www.nmc-uk.org/Get-involved/Consultations/Past-consultations/By-year/Pre-registration-nursing-education-Phase-1-/Confirmed-principles-to-support-a-new-framework-for-pre-registration-nursing-education/>
- O'Donoghue, T., & Punch, K. (Eds.). (2003). *Qualitative educational research in action: Doing and reflecting*. New York, NY: Routledge.
- Palmer, S., Harner, A., Callister, L., Johnsen, V., & Matsumura, G. (2005). Nursing education and service collaboration: Making a difference in the clinical learning environment. *Journal of Continuing Education in Nursing*, 36(6), 271–276.
- Peplau, H. E. (1952). *Interpersonal relations in nursing*. New York, NY: Putnam.
- Riessman, F. (1965). The “helper” therapy principle. *Social Work*, 10, 27–32.
- Robinson, S., & Griffiths, P. (2007). *Approaches to specialist training at pre-registration level: An international comparison*. National Nursing Research Unit. King's College, London.
- Titchen, A., & Hobson, D. (2005). Phenomenology. In B. Somekh & C. Lewin (Eds.), *Research methods in the social sciences* (pp. 121–130). London, UK: Sage.
- US Department of Health and Human Services. Health Resources and Services Administration. (2010, September). The registered nurse population. Retrieved from <http://bhpr.hrsa.gov/healthworkforce/rnsurvey/2008/nssrn2008.pdf>
- Wynaden, D. (2010). There is no health without mental health: Are we educating Australian nurses to care for the health consumer of the 21st century? *International Journal of Mental Health Nursing*, 19(3), 203–209.
- Wynaden, D. (2011). Education issues: Always on the agenda for the profession of mental health nursing. *International Journal of Mental Health Nursing*, 20, 153–155.

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