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DIALOGUE CONTRIBUTION

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Towards a new (or rearticulated) philosophy of mental health nursing: A dialogue-on-dialogue

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Abstract

The following dialogue takes up recent calls within nursing scholarship to critically imagine alternative nursing futures through the relational process of call and response. Towards this end, the dialogue builds on letters which we, the authors, exchanged as part of the 25th International Nursing Philosophy Conference in 2022. In these letters, we asked of ourselves and each other: *If we were to think about a new philosophy of mental health nursing, what are some of the critical questions that we would need to ask? What warrants exploration?* In thinking through these questions, our letters facilitated a collaborative enquiry in which philosophy and theory were generative tools for thinking beyond *what is* and towards *what is yet to come*. In this paper, we expand the dialogue within these letters—in a 'dialogue-on-dialogue'—and take up one thread of our discussion to argue that a new philosophy of mental health nursing must rethink the relationships between 'practitioner'/'self' and 'self'/'other' if it is to create a radically different future. Further, we posit solidarity and public love as possible alternatives to foregrounding the 'work' of mental health nursing. The possibilities we present here should be received as partial, contingent and unfinished. Indeed, our purpose in this paper is to provoke discussion and, in so doing, to model what we believe is a necessary shift towards criticality in our communities of nursing scholarship.

KEYWORDS

imagination, mental health nursing, nursing future, nursing philosophy, psychiatric nursing, solidarity

1 | INTRODUCTION

In their 2022 article, Hopkins-Walsh et al. invite us to engage relationally in imagining nursing futures, connecting our ideas together in a call and response pattern. Taking up this call to action, we—two doctoral students—seek here to engage in a generative dialogue that looks towards a new (or rearticulated) philosophy of mental health nursing. In doing so, we reference and expand upon a project of exploratory letter-writing that we exchanged as part of our contribution to the summer 2022 25th International Nursing Philosophy Conference. In this project, we asked of ourselves and each other: *If we were to think about a new philosophy of mental health*

nursing, what are some of the critical questions that we would need to ask? What warrants exploration?

Our collaborative enquiry takes place in the context of recent calls to attend to the identity of the mental health nurse (see, e.g., Connell et al, 2022; Hurley & Lakeman, 2021; McKenna Lawson, 2022) and the foundational role that philosophy could or should play in foregrounding this identity. In the spirit of continuing to build 'rhizomatic', 'tentacular' dialogue within the nursing community, our aim is to invite discussion—to raise up the issue—rather than provide straightforward answers (Haraway, 2016; Hopkins-Walsh et al., 2022). Here, we hope to model dialogue and the messy 'thinking through' of ideas rather than a linear jump to 'solutions' or 'right answers' traditionally associated with positivistic health sciences (Fornssler et al., 2014). As Žižek reminds us: 'The task of philosophy is not to solve problems but to redefine them: not to answer questions, but to raise the proper question' (Žižek, 2006, as cited in Zalloua, 2020; p. 9).

2 | WHAT BROUGHT US TO LETTER-WRITING?

By way of introduction, we are two doctoral nursing students: one based in and between England/Scotland; and one based in and between Canada/US. Our research coalesces around discussions of antiracism and health equity in mental health care and mental health nurse education. We both have experience of psychiatric mental health nursing practice and, in addition, we both have personal experience of living through and recovering from mental health 'disorders' or 'challenges' (the language here is contentious, slippery, unsatisfactory, something Freya has written about previously (Sewell, 2018). Furthermore, normative language appears to vary considerably 'across the pond'). From a chance encounter, our intellectual and personal friendship has grown, in part through the exchange of letters.

3 | IMPETUS AND OBSTACLE: UNEASE, DISSATISFACTION AND MENTAL HEALTH NURSING THEORY

We each came to the original letter-writing dialogue with a level of unease and dissatisfaction about the current state of mental health nursing. Privately, we had been searching for ways to think through a 'yet-to-come'; an alternative vision of practice that was not a (passive) continuation of the present moment, but a (constructive) redirection to inform the future (Táíwò, 2022). We share a sense that this unease and dissatisfaction stems from the intersection of our experiences of practice and our histories of 'lived' mental health experience—two aspects inextricably intertwined in our position, and to which we will return shortly.

Additionally, our position can be understood as a response to the state of the world as we find it in the various nurse-citizen-student spaces we inhabit. The historic harms of mental health nursing practice are severe, multiple and ongoing (Blofeld, 2003; Department of Health and Social Security, 1969; Spandler, 2022; Strang, 2020). Recognizing our part in this legacy is difficult but necessary. As McKeown (2016a, 2016b; McKeown & White, 2015) insists, mental health nursing faces a crisis of legitimacy as harms to patients, and indeed all who have a stake in mental health systems including workers and loved ones, continue unchecked. As we write, undercover reporting by BBC's Panorama television series has exposed all too commonplace abuse in mental health settings (Slade, 2022). In addition to overt abuse, our mental health systems are plagued by the consequences of neglect. Stateside, the fragmentation and underfunding of mental health services has resulted in poor access to care across the country, and even poorer access for those who are already marginalized (Reinert et al., 2021). In responding to this, we contend that the current state of practice is untenable—has been untenable for some time.

As we began to explore the tensions and questions that emerged in our letter-writing, we moved from an original impetus rooted in the self/experience to a search for theory and philosophy that could help us to make sense of our position. Returning first to canonical mental health and mental health nursing theory (e.g., Barker, 2001; Orlando, 1961; Peplau, 1952; Rogers, 1951) also returned us, unsurprisingly, to well-trodden ground where the same roadblocks, inadequacies, and 'yes, but, and…' frustrations occurred. Despite having a clear legacy, mental health nursing remains slippery and hard to define. As Hopton (1997, p. 496) points out, mental health nursing has a long history of borrowing from other disciplines and uncritically adopting their standpoints as its own in a 'mix and match' fashion. It also has a role in policing the status quo of the health care system and societal attitudes towards those who 'use' or are 'subject to' that system (Hopton, 1997). And when considering definitions of mental health nursing, perhaps it is this issue of position in relation to the system that is most influential. Location in the system—as nurse, patient, loved one—bears upon the perspective of what mental health nursing is, does and looks like.

But alas, how easy it is to get bogged down with *what is*. In responding to this *Nursing Philosophy* issue's challenge, 'what has philosophy ever done for nursing anyway?', we remind ourselves that philosophy opens a door to step outside the mechanical 'doing' of mental health nursing—the *what* and *how*—to ask ourselves, but *why are we doing it? In service of whom and/or what?* In this sense, the inadequacy of mental health nursing theory serves, positively, as an obstacle. After all, obstacles are not necessarily terminal. Approached as something to think through, they can provide us with impetus to keep going, and a nudge to utilize different approaches, skills and knowledges. As Dillard-Wright et al. (2020, p. 133) suggest, 'contemporary challenges require us to look outside our current skill set to find new ways of conceptualizing our possibilities'. Beyond the obstacle, we hope for a different mental health nursing future.

4 | DIALOGUE-ON-DIALOGUE

Returning to our introductory questions: *If we were to think about a new philosophy of mental health nursing, what are some of the critical questions that we would need to ask? What are some of the threads/*

roots that warrant exploration?, we begin our enquiry by exploring the tensions and reconciliation between 'self' and 'practitioner'. This was the original concern we took up in our first letter exchange. This was a choice neither fully conscious nor clearly accidental, but rather one that reflects a conviction that we quickly came to realize we both share.

We believe that there is a need to recognize the symbiosis of the personal and professional in 'work' related to mental health. Further, we find that this issue is not accurately captured or adequately resolved by notions of 'therapeutic use of self' (see e.g., Peplau, 1991) or 'self-disclosure' (Warrander, 2020) which assume certain types of professional distance (Harris, 2014) and boundary-making, couched in Eurocentric positivist terms. Unlike other fields of nursing, our work tools consist not of blood pressure cuffs, IVs or other objects that mediate the interaction between nurse and patient (McKenna Lawson, 2022). As mental health nurses, the primary instrument of intervention is our *selves*. Classical mental health nursing theory suggests that in each phase of the developing nurse–patient relationship, the nurse may assume different roles limited only by the client's needs and the nurse's imagination (Forchuk, 1991). These include teacher, counsellor and 'surrogate for mother, sibling or cultural figure' (Forchuk, 1991, p. 39). Absent here is guidance on how to bring *who we already are* to these professionalized versions of 'self'. Compartmentalizing important pieces of our selfhood whilst using 'self' as an instrument feels somehow disingenuous, especially when we compartmentalize aspects of our selfhood that are integral to why we engage in this work at all.

> It's a huge ethical tension to practice as a nurse, upholding a system of care in which you yourself may not like to be treated. Nursing has a lot to reflect on and answer for in how we consciously or unconsciously perpetuate and reinforce oppressive and non-therapeutic systems in all areas, and particularly in mental health because it remains stigmatized … I can certainly recall times during my own addiction that I was treated poorly and told I was taking up a bed in the ER for someone who 'had real problems'. This has been a motivation for me to do things differently – but as you mentioned, as a part of this system, I feel I am still complicit. (KM)

As we move through this exploration, we recognize the need to closely examine the unspoken foundations of the concept of 'self' that proliferate in mental health nursing philosophy. In this context, 'self' often rests on positioning the patient as 'other'. At this stage of the Anthropocene, amid pandemics and climate change, we question whether we can afford to see ourselves as 'other' from anything—least of all our fellow humans. Indeed, we must wonder what is lost when we are not able to be ourselves as mental health nurses, and what power dynamics we create when we construct the self in opposition to the other. Is it time to reconsider the concept of 'self' to open up new possibilities for how we can care, whom we care for and with, and how our care might make a different kind of difference?

Reflecting on moments from our own lives, the most powerful 'interventions' occurred where the professional mask dropped and, even momentarily, there was authentic human-to-human connection. We recognize the risks taken by practitioners in these moments as they subverted the socialized 'distance' expected of 'professional' nurses.

> I've often heard in practice, 'treat them [the patient] as you'd want your relative to be treated', but I found this hollow - does the system want me to treat people in the way that I would want to treat them? I never got that impression, nor did I feel like the system afforded me that degree of agency. It's part of the reason why I didn't go into working with eating disorders, despite - or perhaps because of - my experience of living with and recovering from anorexia … I remember clearly when the practitioner, out of the blue, said to me, 'I don't know what the solution is either'. In that moment where no solutions were being offered, I finally felt heard and supported. It also felt to me as if she somehow diverged from the 'script'. (FCS)

Our contention is that we bring our histories and our whole selves to this work, whether we choose to acknowledge it or not. We are interested in moving towards a philosophy of mental health nursing that is not afraid to grapple with the personal and the professional differently. (How) can we interrupt and transform notions of professionalism? What are the possibilities for transmutation of the personal into the professional?

> I think there's great potential for mental health to be recognised as a space in which we can find solidarity with one another - I recognise the (potential) suffering in you and it speaks to, and of, the (potential) suffering in me. (FCS)

Our conversation leads us to another tentacle (Haraway, 2016): considering the possibilities of using solidarity as a grounding point for our work. This is not necessarily in opposition to classical mental health nursing theory, but a permutation and update, one that recognizes our shared humanity and struggle. Chan (2021, p. 52) states that solidarity connotes a mutual interdependence between individuals and societies that recognizes our 'mutual vulnerabilities'. Counter to contemporary narratives of the undeserving versus the deserving (Katz, 1989; Littler, 2017; Sandel, 2020), dependence is not something that you *are* and I *am not*, but a continuum on which we all exist. As nurse-citizen-students, we have both found ourselves here; we are acutely aware of our human vulnerability.

Embracing our vulnerabilities then—not hiding, disguising or denying them—may be the very thing that authentically connects us with our clients. In *The Care Manifesto*, Chatzidakis et al. (2020, p. 30) make a powerful case for rethinking 'care' as an organizing principle of human life and society: 'Recognizing our needs both to give and

receive care not only provides us with a sense of our common humanity, but enables us to confront our shared fears of human frailty, rather than project them onto those we label as 'dependent''. In this conception of 'care', we are all subject to interdependence in which the boundaries of 'self'/'practitioner', 'patient'/'other' are perhaps not only blurred, but counterproductive. 'Solidarity' too, conceptually and in practice, could imply this kind of interdependence and togetherness, organized around our shared humanity (Gaffney, 2017, p. 3).

> I am reminded of Cornel West's statement that 'justice is what love looks like in public, just as tenderness is what love feels like in private'. In the context of this statement, I think solidarity could also be considered a type of public love. (KM)

Perhaps the word 'love' appears jarring here—what is love doing in a scholarly discussion of mental health nursing? But we leave it here to ask ourselves: (why) should it be absent? Our sense is not to dismiss love out of hand, but to critically enquire into what love might offer us, that our current conceptualizations of mental health nursing professionalism and practice does not as part of imagining alternative modes of connection.

5 | CONCLUSION

Having shared some of our dialogue, thinking, and 'spiralling-towards', we pause our dialogue-on-dialogue here. Our exploration of the tensions between self and practitioner—we believe, inadequately addressed by current philosophies of mental health nursing—leads us to pose more questions than answers. As we respond to the question, 'what has philosophy ever done for nursing anyway?', we are reminded of Zalloua's (2020) assertion that 'today's predominant form of ideological 'closure' takes the precise form of a mental block which prevents us from imagining a fundamental social change, in the interests of a 'realistic' and 'mature' attitude' (p10). The call to 'radical imagining' entails a willingness to unshackle ourselves from the constraints of what mental health nursing currently is, to explore the possibilities of what it might become (Dillard-Wright & Shields-Hass, 2021, p. 205).

Carving out a space to think in visionary terms is critical if we want to push back on the status quo and move beyond reformist projects (Harvey, 1990). Rather than seek to generate a mental health nursing philosophy compatible with the current parcelling out resources and conceptualization of 'care' in our mental health care systems, we are called to imagine a mental health nursing beyond the confines of the system as we find it. We recognize that this must involve a plurality of perspectives. Indeed, envisioning a mental health nursing grounded in solidarity and mutual recognition of self—a joining together—is a process we have attempted to parallel, however limitedly, in the sharing and intertwining of our ideas and those of other scholars; growing broad and entangled roots across continents.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

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