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ORIGINAL ARTICLE

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From self-reflection to shared recognition: Reconceptualising mental health nursing as an intersubjective phenomenon

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Abstract

Existing challenges to the legitimacy of mental health nursing in the United Kingdom and beyond have stimulated a critical self-reflection and discourse around the mental health nursing role, forcing the profession to question its identity and critically re-evaluate its position within the wider healthcare arena. In this discussion paper, I suggest that the current difficulties in conceptualising mental health nurse identity arise from our role being inherently interwoven with distinctive challenges and unique needs of our service users. Emerging from this idea is that the 'being' (and the 'doing') of mental health nursing is firmly situated within the sphere of intersubjective relations. Drawing upon Hegel's ideas of reciprocal recognitive relations, to support the notion that our profession's role and purpose are better understood when defined in relation to the work that we do with our service users, I argue that it is in the understanding (and even *embracing*) of intersubjectivity as a core principle of mental health nursing, where we might not just better understand ourselves but also know how to shift asymmetric relations with our service users towards those which are more commensurate and mutually beneficial.

KEYWORDS
Hegel, identity, intersubjective relations, intersubjectivity, mental health nursing, recognition

1 | INTRODUCTION

Along with many of my academic mental health nursing colleagues, I have already expressed my growing dissatisfaction with the current state of mental health nurse education in the United Kingdom (Connell et al., 2022; Haslam, 2023), precipitated by changes to the Nursing and Midwifery Council educational standards (Nursing & Midwifery Council, 2018), and as highlighted through the ongoing critical discourse both nationally (Bifarin et al., 2024; Collier-Sewell & Monteux, 2024; McKenna Lawson, 2022; McKeown, 2023; Warrender, 2022; Warrender et al., 2024a) and internationally (Foster & Hurley, 2024; Happell, 2014; Hurley & Lakeman, 2021; Hurley, 2009; Lakeman & Molloy, 2018; Lakeman et al., 2024). While acknowledging that global approaches to mental health nursing are very different, the move towards generic nursing educational standards in the United Kingdom is clearly a contentious one, felt to be disregarding the needs of those nursing specialities outside of adult nursing (Bifarin et al., 2024). And in making such changes, the NMC are thought to be replacing irreducible human connection, crucial to mental health nursing, with quantifiable procedures (Connell et al., 2022)

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and standardised, outcomes-focused treatments (Collier-Sewell & Monteux, 2024), thus aligning our profession closer with biomedical models of care and damaging neoliberal ideology (Haslam, 2023). In doing so, however, this move is thought to be undervaluing not just our own skill sets but also the distinctive needs of our mental health service users.

Perhaps, however, such a move is driven by our collective failure as a profession at a global level to clearly conceptualise the role of a mental health nurse, an ambiguous construct not helped by its differing across cultures and clinical contexts (Hurley et al., 2022; McCrae et al., 2014). Further, the navigation of tensions between the delivery of psychotherapeutic care and the inauguration of restrictive practices used to contain risk (Felton et al., 2018; Hurley et al., 2022) add an additional layer of complexity, highlighting our role as one borne of conflict and moulded by inherent contradiction (Haslam & Harding, 2024). Despite ongoing discourse, therefore, it is no wonder that we are still no nearer as a profession to nailing down a clearly articulated identity upon which we can collectively hang our lanyards.

Meanwhile, the legitimacy of the profession has fallen under further scrutiny, following the airing of the BBC undercover programme 'Panorama' (Panorama, 2022; Shanley, 2024) which exposed cultures of restrictive practice and abuse in mental health inpatient settings. In doing so, the programme has figuratively pricked our collective professional conscience, contesting our current acceptance of the status quo, all while further posing an existential challenge to our very 'being' as mental health clinicians (Haslam & Harding, 2024). Admittedly, such a position is not new, given our profession's long-standing involvement globally in those iatrogenic harms resulting from coercive mental health treatments and services (McKeown & White, 2015). This position is further exacerbated by the at-times alienating nature of our work (see McKeown, 2024; McKeown et al., 2017), the divergence between ideal and actual constructs of role ultimately undermining the sense of self and contribution. With the current state of practice being branded as 'untenable', however, we are urged as never before to look inward and to critically re-evaluate our position as a part of the wider mental healthcare arena (Collier-Sewell & Melino, 2023).

As uncomfortable as this imposed self-reflection may be for mental health nursing, I suggest that perhaps what we are collectively experiencing here is a wider transformative phase in our profession's history, as we are forced for the first time to truly understand who we are and to experience ourselves through the eyes of others, most notably through those for whom we provide treatment. Here, I am reminded of Hegelian concepts relating to intersubjective recognition, how one's purpose and understanding of self are defined in relation to the other. Indeed, drawing on Hegel's analogy of the Master and Slave (Hegel, 1807/1977) supports our understanding of how our professional identities as mental health nurses are embedded both within existing relations with our service users and in the nuanced and intersubjective nature of our work.

In this paper, I propose that many of the challenges we have faced in conceptualising mental health nurse role and identity arise first from the notion that much of the 'doing' of mental health nursing is situated within the sphere of intersubjectivity. That is, regardless of clinical context, culture and the socio-political landscape, our 'relationship' work, though universal, allows us through a continued process of interaction with our service users to provide care that is both personal and contextually relevant to the individual before us. Related to this, our 'being' as mental health nurses, as in our sense of purpose and feelings of competence, contributing to our sense of professional self, are intersubjectively attained, emerging through the meeting of the complex needs of those requiring our care *whenever* and *wherever* they might be. And it is in the understanding of how intersubjectivity is core to our 'being' as mental health nurses (the primary focus of this paper) where I suggest that we might both (1) understand how mental health nursing fundamentally differs from other specialities of nursing that are closer aligned with the ontic sciences and (2) comprehend how we can move towards nurse–user relations that are more reciprocal and commensurate.

2 | EXISTING CHALLENGES IN DEFINING MENTAL HEALTH NURSE IDENTITY

I begin this paper by offering a brief overview of the issues in respect of defining mental health nurse identity. Despite its unique history and it being the largest profession within mental health care, mental health nursing has failed to move towards a clear professional identity (Hurley & Lakeman, 2021), struggling to clearly define its function and to articulate its value in respect of the wider healthcare arena (Connell et al., 2022; Hurley et al., 2022). However, by not doing so, the profession has placed itself at a disadvantage, its legitimacy and unique contributions clearly not recognised by those outside of it (Haslam, 2023; Hurley et al., 2022). The consequences of such are demonstrated in the devaluation of crucial mental health nursing skills in recent changes to the United Kingdom's preregistration nursing programmes (Nursing & Midwifery Council, 2018) leading to fears in the United Kingdom that nurse education is moving towards a generic nursing model. This shift is felt likely to result in lower levels of knowledge and confidence and a poorer integration of theory and practice (Warrender, 2022) to the detriment of those cared for. Such concerns in the United Kingdom have precipitated the development of the grassroots movement 'Mental Health Deserves Better' (Warrender et al., 2024a) with the aims of uniting mental health nurses in resisting the loss of specialist nurse education and to look towards the future of the profession (Warrender et al., 2024b).

Challenges in defining mental health nursing identity are further exacerbated by the profession lacking a theoretical position or a model that delineates it from others and that underpins its practice. Still synonymous with the 'psychiatric nurse' title (Wand, 2024) and often defined in respect of other professions such as psychiatry, adult nursing and, more recently, psychology, mental health nursing is often acknowledged as a subgroup of, or even subservient to, other paradigms of care (Connell et al., 2022; Santangelo et al., 2018). In part, a lack of a clear identity may be attributable to mental health nursing curating and adopting skills from other disciplines as its own

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(Collier-Sewell & Melino, 2023), and in the United Kingdom especially, it is further perpetuated through a recent extension in roles that include psychological therapies and nurse prescribing, all of which have led to further diversification and a blurring of boundaries between professions.

In considering, therefore, what makes mental health nursing distinct, it has so far proven difficult to pinpoint those distinguishable features that are solely unique to our own profession. Yet without a formed sense of identity, it is difficult to recognise where we fall short as a profession in terms of what (and *whom*) we represent (McKenna Lawson, 2022). McCrae et al. (2014) point out that it is not enough to simply suggest that compassion, empathy and the therapeutic relationship alone are adequate, despite these being sustained over extended periods of time and across various clinical settings (Cleary, 2004; Stewart et al., 2024). It is also likely that other professions and indeed other specialities of nursing claim these principles, so they do not alone effectively convey our professional identity. Similarly, claims that we are specialists in the therapeutic use of self (Connell et al., 2022; Foster & Hurley, 2024; Freshwater, 2002), while perhaps truer of mental health nursing than of other nursing specialities, are too simplistic, given the inherent power imbalances (Felton et al., 2018) and the potential for intra- and interpersonal dynamics that contribute to the nuanced nature of our work (Peplau, 1988). Such a view also fails to adequately capture the intersubjective nature of mental health nursing that I argue in the next section is core both to the work we do with our service users and perhaps, more crucially, to whom we are as a profession.

3 | INTERSUBJECTIVITY AS A CORE PRINCIPLE OF MENTAL HEALTH NURSING

When considering how intersubjectivity is core to mental health nursing, I begin by drawing attention to the nuanced and often intangible nature of the work that we do. While our work is tacitly known to those who undertake it (Hurley & Lakeman, 2021), outcomes and those actions taken to achieve them are often unique to the individual before us and so are not always as clearly observed by those outside the sphere of mental health nursing (Hurley et al., 2022; NHS England, 2022) or as well-articulated by those already *in the know*. Furthermore, unlike other specialities of nursing, where physical health conditions are managed through task-focused interventions and are mediated by physical tools and equipment (McKenna Lawson, 2022), mental health nursing holds a degree of uncertainty (Franks, 2004; Pomare et al., 2018; Wolfensberger et al., 2019). Such is a constant process of trial and error, requiring us to continually adapt and further refine our approaches, making our work difficult to 'manualise' (Collier-Sewell & Monteux, 2024). We must therefore be comfortable in those spaces where recovery is often incomplete and where we need to hold uncertainty, especially in the face of distress (McKeown et al., 2017).

It is these considerations that allow me to make the claim that much of the 'doing' of mental health nursing is already situated firmly within the sphere of intersubjective relations, facilitated via a continued process of interaction (Peplau, 1988), through which we develop a mutual understanding of our service users' personal need and goals across the multiple relational spaces which we inhabit (Wright, 2010). Further, mental health nursing is at its most efficacious, where we fully participate in active, connected, relationships with those for whom we care (Jones et al., 2024; Pierson, 1999). Such relationships support a co-construction of shared meaning behind distress, risk behaviours and the illness experience (Hartley et al., 2020; Pierson, 1999; Santangelo et al., 2018) allowing us to become the facilitators of change and recovery (Wright, 2021). Intersubjectivity, therefore, as arising from those reciprocal connections we form through 'relationship', is not just woven already into the very fabric of mental health nursing but further has the potential to become the foundation of 'successful' mental health nursing practice if recognised as a core principle of what we do. Certainly, this would facilitate a navigation of the complexities of mental health care in a way that is more responsive, empathic and tailored to each individual's unique experiences; that is, should both we and the systems we work within permit this.

Extending beyond the mere 'doing' of mental health nursing, however, I further assert that we are intersubjectively bound through our relations with our service users and that it is in the recognition of this where we might better comprehend our collective 'being' as mental health nurses, thus linking to broader discussions around mental health nurse identity. Developing this point further, while a lack of consensus among commentators in the earlier sections of this paper has already highlighted the limitations of defining mental health nurse identity through a shared set of core attributes, amidst this cacophony, McCrae et al.'s (2014) assertion that a strength of mental health nursing lies in its pragmatism is possibly the most relevant to discussions here. From our assigned position as the 'worker bees' of the mental health system (Warrender, 2022, p. 171), our role has evolved beyond the execution of psychiatry's 'dirty work' (Gadsby & McKeown, 2021; McKeown, 2024), bridging those gaps that exist in mental health service provision (Connell et al., 2022), hence accounting for its variation being dependent upon the service within which mental health nurses are embedded (Hurley & Lakeman, 2021). While such a position means that our professional identity is better understood as more a 'cluster of capabilities' rather than a singular point of difference (Hurley, 2009, p. 383), what is significant here is how mental health nursing has continued to adapt and evolve in response to the individual and complex needs of our service users across the whole continuum of care.

Such a position also allows me to extend further upon a key point made in a previous paper (Haslam, 2023) regarding the necessary interdependence that exists within the mental health nurse–user relationship, a point which, given my claim here that mental health nursing is grounded in intersubjectivity, also warrants further consideration. I argue that the mental health nurse and service user roles are not exclusive of each other, existing in tandem and as a symbiotic relationship. It is, after all, the service users' unique needs that demand both the understanding and skill set of the mental health nurse, just as it is in

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successfully understanding and meeting the complex needs and individual goals of service users, where the mental health nurse will find a validation of purpose and professional self (Pierson, 1999; Santangelo et al., 2018; Wand, 2024). Truly understanding who we are as mental health nurses, our very 'being', is therefore contingent upon us recognising not just the intersubjective nature of these relationships but also our interdependence with service users given that our competence, sense of self-esteem and professional pride (only experienced relative to the other, see Crossley, 1996) are feelings that are attained through, and are therefore intricately bound to, the work we do with our service users. I further unpack these ideas below, drawing specifically upon Hegelian concepts in respect of self-consciousness and recognitive relations.

4 | CONSCIOUSNESS AND IRONY OF POWER: HEGEL'S MASTER AND SLAVE DIALECTIC EXPLAINED

In 1807, Georg Wilhelm Friedrich Hegel, a German philosopher, published his seminal work 'The Phenomenology of Spirit' (Hegel, 1807/1977), examining the nature of self-consciousness. It is Hegel's central idea that consciousness of the self is inextricably interwoven with the consciousness of another that is of interest to our discussion of mental health nurse identity, self-consciousness arising from the desire humans have to be acknowledged and recognised by the other. Fundamentally, according to Hegel, the identities of individuals do not solely exist within the self but are defined in respect of their relationship (or more specifically, *by their difference*, see McGowan, 2019) to others. Self-consciousness and identity are therefore intersubjective phenomena bound to our interactions with others (Crossley, 1996).

Hegel suggested that this recognition is not something that is automatically conferred but is one that emerges when two independent consciousnesses meet and engage in a mutual struggle for acknowledgement with the other. He used a narrative analogy of the master and slave to explain this struggle, a complex but influential concept within philosophy that explores the dynamic of power, self-consciousness and recognition. Hegel's master represents a figure of authority who pursues a recognition of his own importance and superiority through the subservience of others. Meanwhile, the slave in his more subservient role also desires recognition, seeking legitimacy and a sense of agency and dignity.

What follows the initial encounter is a complex interplay of power and self-awareness whereby the two individuals manipulate the other for their own ends. Hegel uses the metaphor of a life-and-death struggle to emphasise the intensity and existential significance of this pursuit of recognition, and it is through this struggle that Hegel suggests the consciousness of both parties is transformed. Through his initial defeat, the slave comes to realise his own limitations, although over time from his subjugated position, undergoes the realisation that his worth is not necessarily contingent on external validation needed from the master, and instead recognises a sense of agency and validation through his own contributions. Paradoxically, where the master initially views himself as independent of the slave, the master has yet to realise his own limits and his own dependence upon the slave for the acknowledgement of his own importance.

Despite Hegel's analogy having been interpreted in numerous ways over the years, ranging from outright fable to historical commentary (see McGowan, 2019), its discussion of asymmetric recognitive relations has some resonance with, and so permits a critical examination of, existing dynamics within mental health nursing. Likewise, through Hegel's analogy, we might also understand better how our very 'being' as mental health nurses is defined in respect of our service users. The mental health nurse in this instance assumes a role akin to that of Hegel's 'master', already possessing an authority and a degree of power in the relationship, although still requiring recognition and validation in respect of their competence as a practitioner and of their professional expertise, essential for their sense of job satisfaction and purpose. Conversely, the mental health service user, in a vulnerable and feasibly more dependent role and so perhaps lacking authority and personal agency, especially in those initial stages, mirrors that of the 'slave'. They too, however, seek their own recognition in the form of understanding and a validation of their unique and subjective experiences, vital for their own sense of self-worth and dignity.

Upon initially meeting the service user, the mental health nurse shapes the initial course of the therapeutic relationship, setting the stage for a mutual struggle and dynamic interplay of power from which self-consciousness also emerges. Of course, within the context of the mental health nurse–user relationship, the life-and-death struggle is only metaphorically applied, symbolising instead an existential struggle which is both emotionally and psychologically intense. It is the service user's ongoing expression of needs that drives this dynamic, making this a reciprocal process that contributes to the transformation of both parties in terms of awareness and understanding of self and other. Meanwhile, as the 'slave', the service user, despite initially entering the relationship from a subjugated position, thus already acutely aware of their own limitations, may in time gain (or regain) their sense of self-worth and independence. The transformative aspect is not a one-time event, however. This is a continuous and dynamic process, embedded in the dialectical relationship where the self must risk being formed and reformed (Cummings, 2018). It is also a process which allows the mental health nurse, initially from their position of independence and dominance to come to realise their own dependence upon the service user; their sense of self-worth, professional identity and purpose contingent upon the validation received through successfully understanding and addressing the distinctive needs of those under their care.

5 | THESIS, MEET ANTITHESIS: APPLICATION TO THE WIDER MENTAL HEALTH NURSING PROFESSION

I further argue here that Hegel's ideas around recognitive relations can go beyond individual dialectics discussed in the previous section to also facilitate a recognition of broader sociopolitical structures. In doing so,

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they support understanding of our profession's collective position as one of emerging discomfort, given our role in complicitly maintaining existing power relations. Shifts in thought and in 'being', according to Hegel, occur where an existing *thesis* (or the status quo) is undermined by contradiction or the *antithesis*. This contradiction, according to Hegel, is one that arises from the status quo itself, exposing its internal shortcomings and becoming the driving force of change (McGowan, 2019).

Within a practice context, having recognised their established position as one of subjugation, service users have already (and with absolute justification) organised themselves to highlight the shortcomings of current mental health care. A growing demand for emancipation has arisen from a need to challenge existing power structures within psychiatric and mental health care through the drawing of attention to the harmful and traumatic impact of mental health treatments and systems (Adame et al., 2017; Wand, 2024). The survivor movement's challenge can therefore be seen as akin to that of the 'slave' recognising a sense of agency and finding their voice, though in doing so, have prompted a critical self-reflection from those who are recognising that their practices might have inadvertently contributed to such experiences. Both the survivor movement and the perception that in the United Kingdom we are moving towards a generic model of nursing have triggered existential doubt; our current crisis of professional identity mirrors that of the master's struggle in Hegel's analogy. As the antithesis to our existing thesis, we are therefore forced as a profession to re-enter the cycle of consciousness, our collective desire to attain true selfhood and self-recognition manifesting itself through our current self-questioning and in the (so-far futile) attempts to conceptualise our role.

Perhaps, however, these challenges to the status quo are necessary for us to move beyond those more conventional and archaic approaches to treatment (Wand et al., 2021) that still tether us to psychiatry like a redundant umbilical cord. It is through intersubjectivity and recognitive relations that a third position, the *synthesis*, presents itself here as a point of resolution, going some way to reconciling the contradiction that can no longer be sustained between the thesis and antithesis. Rather than attempting to define mental health nursing-*ness* in relation to that of its members' shared skills and attributes (McCrae et al., 2014), we are provided instead with an opportunity to reflect more broadly upon how our professional identity, our very being and purpose is defined in respect of, and so is inherently interwoven with, the very individuals we care for. Not only does this understanding help us to clearly demarcate our profession from other specialities of nursing, but it also permits us to begin to consider how future mental health nurse–user relations might evolve beyond their existing asymmetrical statuses, to realising those which are more commensurate and mutually beneficial.

6 | RESOLUTION AND SYNTHESIS: FORGING A SHARED PATH

By writing this paper, I am, of course, taking liberties with Hegelian concepts that have already been interpreted by many scholars in numerous ways (McGowan, 2019) and which might be critiqued for taking binary and reductionist views to both power relationships and self-consciousness. In reality, I also acknowledge that my application of the master and slave analogy in this paper grossly over-simplifies the complexity and multifaceted nature of mental health nurse–user relations, all while simultaneously ignoring the influence of Individual, cultural and the broader systemic factors that impact. Such a view, I recognise, fails to adequately address the role of individual agency, the messiness of lived experience and the influence of other recognitive relationships (e.g., one might also point to our current position as 'slave' to the NMC's 'master'). Similarly, acknowledging that there are different approaches globally to mental health and psychiatric nursing, the universality of these concepts may resonate differently.

That said, as unrealistic as it might be for Hegelian concepts to capture every aspect of mental health nurse–user relations, these philosophical ideas at least provide a unique lens through which we might view their intersubjective and interdependent nature. Furthermore, as we are forced to critically view our profession through the eyes of others, Hegel's recognitive relations help us to understand how precariously close we are now standing to the precipice of change. While the current state of practice might indeed be untenable (Collier-Sewell & Melino, 2023), my earlier suggestion that a strength of mental health nursing lies in its adaptability (Hurley & Lakeman, 2021; McCrae et al., 2014) fortunately also grants me the freedom to challenge existing dialectics both as ultimate and as an inevitability.

Long-term, we might imagine that both a resolution and synthesis in existing tensions are entirely conceivable: a future unification of 'master and slave' dialectics being possible if both authority and responsibility are commensurate and reciprocal (Kojève, 1969). McKeown (2024, 2023) and McKeown et al. (2017) propose a future, for instance, whereby we forge cross-sectional links with those who use services to democratise mental health care and to launch a unified challenge upon structural causes of social inequality. Similarly, Collier-Sewell and Melino's (2023) evocative invitation to reimagine a future beyond the confines of current systems envisages future mental health nursing as grounded in both a mutual recognition of self and in practising in a spirit of solidarity with our service users. Such a discursive shift would certainly reduce levels of workforce alienation while going some way to remedying the crisis of legitimacy currently facing mental health nursing (McKeown et al., 2017).

While acknowledging, however, that the recognition of service users' personal experience should be at the heart of any political call for improvement to mental health care (Cummings, 2018), reimagining a radically different future for mental health nurse–user relations; one where neither party holds absolute power may still seem idealistic and the road to this, arduous (Haslam & Harding, 2024). Way beyond the reformation of existing patterns of status and the renegotiation of identities, a radical shift is also needed in those existing socio-political structures and social control mechanisms that preserve the complex power dynamics deeply embedded in mental health nurse–user relations to begin with. Emancipatory approaches also require as much the commitment and motivation of

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those who hold the power, as they do dialogue and cautious negotiation (Einboden et al., 2024). Nevertheless, despite true democratic mental health care perhaps being a distant ideal, I suggest that it is in conceiving of ourselves as intersubjectively constituted through our relations with service users is where we might finally understand our professional selves and purpose (Hodge, 2005) and recognise the need to contest existing asymmetric power relations, thus going some way to restoring ourselves from the current experiences of alienation relating to the work we do (McKeown, 2024; McKeown et al., 2017). Ultimately, it is in acknowledging and embracing intersubjectivity as a core principle of mental health nursing which may very well represent the next step in our evolution as a profession.

7 | 'BEING' VERSUS 'BECOMING': CONCLUDING THOUGHTS

Hegelian concepts concerning recognitive relations have provided a unique lens through which we might view how our professional selves are shaped through our interactions with others, and so, I argue, warrant acknowledgement here in the ongoing discourse around mental health nurse identity. While accepting that Hegel did not explicitly discuss his concepts in respect of mental health care, I posit, nevertheless, that his ideas have provided a useful philosophical framework against which we might begin to understand the interdependent and intersubjective nature of mental health nurse–user relations. My intention here was not to provide answers or to claim to have resolved the complex issue of mental health nurse identity but to merely provoke a critical discourse around the intersubjective nature of our profession and how this marks a distinct departure from the more clinical and task-orientated nature of our adult nursing counterpart. More crucially, however, it is in both the understanding and embracing of intersubjectivity as a core feature of mental health nursing where we are finally presented with the opportunity to cast off our 'psychiatric nurse' persona and realise relationships that are more commensurate and mutually beneficial.

I conclude with a reflection upon the notion of our 'being' as mental health nurses, discussed in earlier sections of this paper, and consider how this description is in fact insufficient, given that 'being' perhaps implies a more monolithic or fixed state, at odds with the fluid and ever-changing nature of our profession. Reframing our state of 'being' instead as a state of 'becoming' might more accurately represent the extant 'incompleteness' in our professional identity (see Crossley, 1996). After all, a state of 'becoming' acknowledges that our professional identity is not, and has never been, static, evolving in response to changes in the socio-political landscape and to the increasing complexity of our service users. Furthermore, our 'becoming' as mental health nurses also implies that a potential shift beyond the conventional nurse–user dynamic, and towards future relations that are more reciprocal, is indeed still a possibility.

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The author declares no conflict of interest.

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