



FEATURE ARTICLE

Oxymoronic or synergistic: Deconstructing the psychiatric and/or mental health nurse

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ABSTRACT: Examination of the names used to signify a nurse who specializes in working with people with mental health problems indicates the absence of a shared nomenclature and the frequent conflation of the terms 'psychiatric' and 'mental health'. Informed by the work of Derrida (1978) and Saussure (1916–1983), the authors encourage the deconstruction of and problematization of these terms, and this shows that what nurses who work with people with so-called mental illness are called has depended on where they have worked, the vagaries of passing fashion, and public policy. Further, there are irreconcilable philosophical, theoretical, and clinical positions that prevent nurses from practicing simultaneously as 'psychiatric' and 'mental health' nurses. Related service user literature indicates that it is disingenuous to camouflage 'psychiatric' services as 'mental health' services, and as signifiers, signified, and signs, psychiatric and mental health nursing are sustained by political agendas, which do not necessarily prioritize the needs of the person with the illness. Clearly demarcated and less disingenuous signs for both mental health and psychiatric care would not only be a more honest approach, but would also be in keeping with the service user literature that highlights the expectation that there are two signs (and thus two services): psychiatric and mental health services.

KEY WORDS: deconstruction, etymologist, mental health nursing, psychiatric nursing.

INTRODUCTION

With apologies to William Shakespeare and his classic work, *Romeo and Juliet*, in answer to his comment, 'What's in a name? That which we call a rose by any other name would smell as sweet', we would respectfully disagree with the bard, and suggest: a great deal. At the most fundamental (literal) level, names are simply a collection of letters and/or symbols that identify a person or entity. However, the value and power of names has long been

recognized and expressed throughout human history. Etymologists point out how people's names were far from mere cosmetic or audible aesthetics; they symbolized and communicated specific meanings and messages. Similarly, philosophers engage in (for some, semantic; for others, substantive) discussions about names, characterizing them as, among others, descriptors and linguistic mechanisms for reference. As a result, whether for referential, descriptive purposes or symbolic, communication purposes, names, it seems, matter.

Accordingly, the authors of this paper seek to radicalize a debate that has taken place intermittently concerning the name, existence, nature, function, and place of so-called psychiatric/mental health nursing. We do so because even a cursory examination of the names and terms used internationally to signify a nurse who specializes in working with people with mental health problems

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will illustrate the absence of a shared nomenclature. Nurses who claim to engage in the same form and type of nursing care do not share the same title (signifier). Second, we do so because such transposition of names can be regarded as an 'epistemological sleight of hand', whereby some allege an isomorphic relationship between 'psychiatric' and 'mental health', without ever having substantiated these phenomena as immediately transposable/transplantable. Third, there is a body of evidence (both discursive, and to a lesser extent, empirical) that lends support to the view that there might very well be two distinct phenomena – psychiatric nurses and mental health nurses – that are not necessarily interchangeable.

Accordingly, this paper will respectively: (i) apply an historical analysis identifying and problematizing how psychiatric and mental health nursing have metamorphosed according to service geography, and deconstruct the very terms themselves; (ii) be informed by the work of Saussure (1916/1983) and Derrida (1978) in an attempt to expose/explore multiple meanings, inconsistencies, contradictions, hidden agendas, and multiple meanings in the texts 'psychiatric', 'mental health', and 'psychiatric/mental health' nursing; (iii) highlight the possible existence of psychiatric and mental health nurses as separate but complimentary nurses; and (iv) promote a much-needed, expanded debate about these terms, and the implications arising out of their use/acceptance.

HAS PSYCHIATRIC/MENTAL HEALTH NURSING EVER REALLY EXISTED?

Geography as destiny

Historically, what nurses who worked with people who present with mental health problems were called (i.e. what 'signifiers' such nurses had) has, to a large extent, depended on where they have worked (Rogers & Pilgrim 2001), the various public and/or mental health policy positions (Ramshorn & Pearlmutter 1982), and the vagaries of passing fashion (Nolan 1993). In the USA, for example, Ramshorn and Pearlmutter (1982) point out that psychiatric nursing as a clinical speciality arose during this (medical-therapeutic model 1945–1960) period, whereas the so-called 'community mental health movement' in the USA, with an alleged emphasis on shifting from a psychiatry/medical model to a community-located, mental health model did not occur until after 1960. However, these authors continue to illustrate that while the policy espoused a 'mental health' focus and a corresponding shift in practice, in reality, no such fundamental changes in practice could be demonstrated; these practices were still drawing on a traditional

medical model. On a related note, Hedlund and Jeffrey (1993) assert that the term 'psychiatric nursing' arose in the USA because these nurses wished to distinguish and/or differentiate themselves from their general hospital counterparts: 'the addition of mental health to psychiatric nursing . . . dates back to the early 1990s. . . . This (community mental health) movement led nurse educators to believe that psychiatric nurses had an important community health role to play'.

Interestingly, while the signifier of mental health nursing was added to reflect the change in the geographical location where the care occurred, and to reflect the shift in mental health policy, the evidence indicates that little significantly altered in terms of practice delivery. In this sense, the psychiatric or mental health nurse has been a signifier of where one works in much the same way that domiciliary, community, or public health nurses qualified their titles. Indeed, Peplau (1989) suggested that it might be useful to think of nurses who practice in psychiatric settings as psychiatric nurses.

Similar shifts in the signifier can be located in UK historical and policy literature. Nolan (1993), for example, points out that the attendants of the asylum became 'mental nurses' in the mental hospitals of the UK. The titling (signifier) changed as 'mental hospitals' were rebranded 'psychiatric hospitals', and services expanded to become 'mental health' services. Various reports, for example, the 1968 UK Government report, 'Psychiatric Nursing Today and Tomorrow', clearly use the term 'psychiatric nursing', as did the Salmon Report (Nolan 1993). Indeed, while there is some small degree of variance in the terms used pre-1982 in the UK, the common signifier is 'psychiatric nurse/nursing'. Two key phenomena appear to be closely linked to the shift from psychiatric to mental health signifiers during the 1980s: a policy shift towards community care and the so-called 1982 syllabus. As with the USA, community (mental) health care was supposed to promote a person-centred approach and an emphasis on (mental) health promotion (Nolan 1993); according to Rogers and Pilgrim (2001), it held out the promise of a humanitarian alternative to long-term institutionalized care. It also contributed to a shift in signifier for those nurses who worked in the community alongside people with mental health problems; they became known as 'community mental health' nurses. Evidence of this can be found in the UK Department of Health's Mental Health Nursing Review, commissioned in 1992, and resulting in the document 'Working in Partnership' (Department of Health 1994). Clarke (1999, p. 9) makes this point most clearly: 'One recommendation of the Mental Health Nursing Review Team (1994) was that all psychiatric

nurses – whether in the community or located in the hospital – be awarded the title “mental health nurse”.

Similarly, the 1982 syllabus was written specifically to emphasize interpersonal skills and interpersonal ways of working, to distance such nurses from the ‘asylum or institution’ (both in terms of where the education/preparation occurred, and in terms of the imagery/associations and views of such institutions that were pervasive in the general population). Just as the name (signifier) of ‘asylum attendants’ had shifted to ‘nurses’ during the 1920s (Nolan 1993), the issue of names (signifiers) was once more of central importance to this population of nurses during the 1980s, which saw an increase in the use of the terms ‘therapist’ and ‘mental health’. Again, while the use of these terms was not consistent, and often the terms ‘psychiatric’ and ‘mental health’ were used interchangeably, even a cursory review of the extant literature will show a dramatic increase in the use of the term ‘mental health’ nurse during and subsequent to this period.

This analysis is clearly not the full story, as, at least for nurses themselves, the title is imbued with symbolism, and in the case of mental health nursing, it might at least signify aspirations for a particular kind of praxis (Chambers 2006). In the text entitled *The Mental Health Nurse* (Tilley 1997), various nursing leaders of the time, in their chapters, used the terms, ‘mental health’ or ‘psychiatric nurse’, interchangeably. This professional ambivalence about the title seems to be resolving, if the titles of contemporary nursing text books are any indicator. While occasionally nursing texts prior to 1990 included the term ‘mental health’ in the title (e.g. Morgan & Moreno 1973), more often the term ‘psychiatric nursing’ was used (e.g. Stuart & Sundeen 1987). This gave way to various combinations: psychiatric–mental health nursing (e.g. Glod 1998), psychiatric mental health nursing (e.g. Fortinash & Holoday-Worret 1996), or psychiatric and mental health nursing (e.g. Barker 2003). While this change has been by no means a linear process, in certain parts of the world (e.g. the UK, Australia), one is far more likely today to have the ‘psychiatric’ omitted altogether (e.g. Fontaine 2009; Norman & Ryrie 2004). Consider, for example, the very title of this journal, or that the Royal College of Nursing (2011) stated, at their most recent congress, that ‘Community mental health nurses (CMHNs), formerly community psychiatric nurses, have been instrumental in the transition of mental health services from an institutional setting to a community setting’.

However, in other parts of the world (e.g. Canada, the USA), the term ‘mental health’ nurse is rarely used. Indeed, Nolan and Hopper (2000), in referring to nursing in the 1960s, use the term ‘mental health’ nursing, which

would have been unthinkable in that era. Norman and Howell (2000, p. 560) consign ‘psychiatric’ nursing to the past when they use the phrase ‘psychiatric nursing (now mental health nursing)’. Notwithstanding that these texts reflect different styles, somewhat different emphases, and particular geographical outlooks, a ‘shelf browser’ would be hard pressed to discern any substantive differences that might somehow signify a different philosophy or practice associated with mental health nursing, psychiatric nursing, or any combination thereof. We extend this position in the following section.

Deconstructing psychiatric and/or mental health nursing

In our deconstructive approach to the psychiatric and/or mental health nurse, we are informed by the work of Saussure (1916/1983), who was interested in semiotics, the science of signs, and the problem of how they are representative of the world. We were also influenced by, and drew upon, aspects of the work of Derrida (1978), who used the term ‘deconstruction’ in a specific way as the work of exposing multiple meanings, inconsistencies, contradictions, and hidden agendas in texts. ‘Text’ in this context is not just written words’, but includes conversation, art, non-verbal communication, and practices; essentially, anything that can be ‘read’ for meaning. Saussure divided a sign into a signifier (the written or spoken word) and the signified (the concept or meaning of the word). Taken together, they refer to something in the world. Saussure pointed out that there is no necessary relationship between the signifier and the signified; for example, between the word ‘schizophrenic’ and the concept of so-called psychotic illness (or, as we shall argue later, between the words ‘psychiatric nurse’, ‘mental health nurse’, or ‘psychiatric/mental health nurse’, and the concepts of psychiatric/mental health nursing), as one could just as easily conjoin the concept of psychotic illness with the word ‘fantasia’. In addition, there is no necessary relationship between the sign (the signifier + signified) and its referent in the world. For example, the sign (as word and concept) could be replaced with other words and concepts. Accordingly, using the labels ‘psychiatric nursing’, ‘mental health nursing’ or ‘psychiatric/mental health nursing’ is a way to distinguish people in practice, and implies a set of skills that can then be presumed in each person so labelled, although we confront that assumption later in the paper.

PSYCHIATRIC NURSE

Psychiatry is allied to the biomedical model, and its quest is therefore, at least in part, for the ‘magic bullet’ to cure

so-called mental illness. However, despite many promises, medication to treat the underlying bio-dysfunction of so-called mental illness has had, at best, equivocal results (Antonuccio *et al.* 2002; Breggin 1994; 2000; Cutcliffe & Lakeman 2010; Kirsch *et al.* 2002; 2008; Lehman 2004; Moncrieff *et al.* 1998; Storosum *et al.* 2001). Despite the questionable track record of psychiatry, psychiatric nurses have attached themselves to the biomedical version of distress, and this might represent, at least in part, a political agenda in relation to supporting the case for arguing that nursing is a profession. For example, the relatively recent emergence of psychiatric nurse prescribers has shifted nurses' practice closer to the traditional role of psychiatrists (Bailey 1996), and moreover, describe this practice shift as 'advanced psychiatric nursing'. This alliance offers a 'geographical location', that is, the dysfunctional brain, that defines practices in the same way that nurses previously have been described and directed by their physical location, as argued earlier. Indeed, in this instance, the signifier 'psychiatric nurse' does have a relationship with its signified; the concept of the 'psychiatric nurse' who is assisting in the execution of a biopsychiatric approach. Together (as a sign) they point to specific practices; for example, monitoring symptoms, ensuring medication compliance, tracking response to medication, observing to prevent risk to self and others, and engaging in control and restraint; each of which are practices that are easily detected. However, in a paper reviewing what psychiatric nurses do on a day-to-day basis, Cowman *et al.* (2001) found that there was more scope to the role than suggested by the sign. Notwithstanding the possible lack of conceptual clarity in some of the described activities in Cowman *et al.* (2001), these authors found that psychiatric nurses typically assessed patient needs and planned care, were engaged in caring interactions and pharmaceutical interventions, were involved in education (teaching and learning), documented information, and coordinated services of nurses and other professionals. Furthermore, they communicated with other professionals and other grades of staff, and managed the administration/organization of the clinical area. Cowman *et al.* (2001) looked at psychiatric nursing across a range of clinical environments, and so might have inadvertently described the activity of psychiatric and mental health nurses, leaving the signifier, signified, and sign 'psychiatric nursing' intact.

MENTAL HEALTH NURSE

If the text 'psychiatric nurse' deconstructs itself, is the text 'mental health nurse' any better placed? One issue immediately arises in relation to the multiple meanings of the

word 'mental', ranging from 'cerebral, mind, psychological, rational, and intellectual' to 'mad', although the range is rarely acknowledged. Such multiple meanings are problematic in relation to the articulation between 'mental', 'health', and 'nursing'. Accordingly, one should ask: what is mental health? Is it 'psychological health' or 'mad health'? Many global health organizations have consistently defined mental health as more than the absence of illness (e.g. World Federation for Mental Health 2004), and for some, it is now *de rigueur* to speak of holistic health promotion (i.e. no health without mental health). Mental health nurses sometimes deal with these matters by claiming a holistic approach and an emphasis on mental health promotion (Jane-Llopis *et al.* 2005; Parham 2008; Wand 2011), but problems arise: (i) if the scientific and mental health-care community is unable to advance a definitive view of mental health *per se*, does this not undermine any attempts to promote mental health (Cutcliffe & McKenna 2011)? This issue is further bedevilled by the multiple, and not necessarily convergent, definitions of 'mental health'. If mental health nurses are not conceptually clear on what exactly it is that they are supposed to be promoting, how can they then be sure that they are promoting it?; (ii) holism is expansive, and so requires a position of knowing all (Clarke 2006; Forster & Stevenson 1996; Russell 1946). In effect, valuing breadth, while trying to define the specialty of mental health nursing, means that deconstruction happens; and (iii) traces of the 'psychiatric' linger in mental health nursing practice, despite claims to being more holistic. For example, some nurses, now described as mental health nurses, are adept at reinventing the 'psychiatric' in their new arenas of practice. Holmes (2006) makes a similar point when he refers to the UK's Chief Nursing Officer's (2005) call for mental health nurses to prioritize moving clients towards more healthy lifestyles when the predominant discourse in education and service ideologies is biomedical. This awkward conflation of mental health nursing with psychiatric nursing is also evident in the Scottish (Scottish Executive 2006) and English (Department of Health 2006) reviews of mental health nursing, which both emphasize the importance of recovery and the value of nurses acquiring prescribing privileges.

The political agenda concerning the development of mental health nurses has been touched upon in relation to the move from the asylums to more community-based care, and with it the idea that a more proactive mental health promotion approach was possible. Here was a discipline in need of redefinition, and the conjoining of 'mental', 'health', and 'nursing' was an attempted solution. Three studies serve to demonstrate the arbitrariness of

the signifier/signified mental health nurse, as multiple meanings of it are generated. Porter (1993) has argued that post-institutional mental health nursing is splitting into different specialties. Kudless and White (2007) point out the community mental health nurses function in a range of behavioural health-care settings, and those different roles require different skills and competencies. Norman and Howell (2000, p. 560) noted that different camps have polarized the debate about the nature of mental health nursing, with one camp promoting the uniqueness of mental health nursing, and the other seeing it as a function that is shaped by a multidisciplinary mental health service that can be fulfilled by anyone. In summary, a deconstruction of mental health nursing reveals how tenuous the relationship between the term and the actual practice is. The everyday activity of many mental health nurses typically has little to do with mental health, and the term 'mental health' remains undefined, ambiguous, and amorphous; perhaps a misnomer, but maybe it serves as an aspiration.

REINVENTING THE ALREADY-PUNCTURED WHEEL: THE PSYCHIATRIC/MENTAL HEALTH NURSE

Psychiatric and mental health nursing is an inherently conflicted combination. Barker (2008, Foreword) states that the 'concept of psychiatric/mental health nursing is quite a mouthful, and one that is not easily digested', and we would argue, indigestible. We disagree with the largely unexamined prescription for practice, namely the conflation of 'psychiatric' with 'mental health' nurse. How can a psychiatric/mental health nurse practice when the philosophy of one part (biopsychiatry) is in conflict with another (holistic, person-centred care)? There are many examples of how this philosophical conflict might impact on practice: the person who refuses or insists on taking psychotropic medication, the person who insists that they don't have psychosis, and the person who situates her/his problems in family dynamics. Cutcliffe (2008) has advanced a similar argument. In response to the rhetorical questions – What is psychiatric and/or mental health nursing? and What do nurses do in enacting psychiatric/mental health nursing?, Cutcliffe (2008) alluded to fundamental differences between two broad groups of psychiatric/mental health nurses, and these groups can be categorized as those describing themselves as psychiatric nurses, and others as mental health nurses. For Cutcliffe (2008), psychiatric nurses can be described as a largely subservient discipline, and an extension of psychiatry's social control mechanism(s), for the policing, contain-

ment, and correction of already marginalized people. Psychiatric nurses carry out a number of defensive, custodial, uncritical, and often iatrogenic practices and treatments, which are based on a false epistemology and misrepresentation of what are, by and large, 'human problems of being', and represent these as so-called 'mental illnesses' (Cutcliffe 2008). Whereas those describing themselves as mental health nurses can be described as a specialty branch of the discipline of nursing; a specialty craft, if you will, that operates primarily by working alongside people with mental health problems, helps such individuals and their families find ways of coping with the 'here and now' (and past), assists in discovering and ascribing individual meaning to the person's experiences, and explores opportunities for recovery, reclamation, and personal growth, all through the medium of the therapeutic relationship (Cutcliffe 2008).

Given the contentious nature (for some) of these positions, it behooves the authors to offer explanation and substantiation. As alluded to earlier, the extant literature is unequivocal in identifying that psychiatric nurses, by and large, locate the causation and aetiology of mental health problems as having biological origins; these views are in turn based on biomedical, Cartesian principles of mind-body dualism and reductionism (Beresford 2010; Descartes *et al.* 1988). Similarly, this particular aetiological construct then leads logically to 'standard' or common medical model interventions, not least pharmacological responses, and thus, their embracing of nurse prescribing (e.g. Bailey 1996; Gournay 2000a,b; Jones & Gray 2008a,b). They utilize the term 'mental illness', and refer to this as an illness like any other. For psychiatric nurses, mental illness is seen to reside in the individual, thus the frequency of terms/expressions, such as people 'having a mental illness' and 'people with schizophrenia' (see Hannigan & Cutcliffe 2002). The literature shows that this group of nurses adopt (and/or are comfortable with) a range of care practices that are in keeping with these views. Pharmacological interventions are seen as de rigueur, and indeed, the mainstay of psychiatric nursing practice; Jones and Gray (2008b) for example, refer to antipsychotic drugs as the cornerstone of treatment for people with schizophrenia. This group of nurses regard mental illnesses as 'disorders' that need fixing, and that sometimes the person with the 'disorder' might not know what is in his/her own best interests. For this group of nurses, this not only necessitates, but morally sanctions, the use of a range of containment and/or control practices (e.g. Vuckovich & Artinian's (2005)). Whether this is the forced administration of medication, the use of physical restraint, seclusion rooms, forcibly 'assisting' the person

to undertake electroconvulsive therapy, locking doors, restricting the person's freedom of movement, removing personal items, or placing the person 'under' close observations, all such activities are allegedly undertaken 'for the patient's own good – or/and for the safety of others' (Cutcliffe 2008).

In comparison, mental health nurses, by and large, acknowledge the current uncertainty and ambiguity concerning the aetiology of mental health problems, and leave room for the view that these are human problems or living, being or existence; an unavoidable (and maybe necessary) part of the human experience or condition. They emphasize and hold sacrosanct the interpersonal nature of mental health nursing, believing that they themselves are the most useful therapeutic 'tool' at their disposal (Barker 1999; Peplau 1952). Although mental health nurses can be seen to embrace a range of theoretical approaches to interpersonal work (and/or therapy), there is consensus on the view that such talking therapies exist, at least to some extent, to help the person experiencing mental health problems cope with (and find meaning in) their experiences, and not necessarily cure or fix them (see Wilhelminia 2011). The pioneering and seminal contributor to the recovery movement in the USA, Dr Pat Deegan (2011), makes this point most clearly when she states:

Recovery does not refer to an end product or result. It does not mean that one is 'cured' nor does not mean that one is simply stabilized or maintained in the community. Recovery often involves a transformation of the self wherein one both accepts ones limitation and discovers a new world of possibility. This is the paradox of recovery i.e., that in accepting what we cannot do or be, we begin to discover who we can be and what we can do.

For Cutcliffe (2008), mental health nurses are uncomfortable with adopting psychotropic pharmacological interventions as the mainstay (or cornerstone) of mental health care, especially in the light of the documented, questionable efficacy of, and well-documented iatrogenic harm caused by, many of these agents (Cutcliffe & Lakeman 2010; Healy 2003; 2005; Lakeman & Cutcliffe 2009; Moncrieff & Kirsch 2006; Moncrieff *et al.* 1998; 2005).

In summary, as identified earlier, a deconstructionist view might conclude that there is an unspoken agenda embedded in the confluence of the signifiers 'psychiatric nursing' and 'mental health nursing'. With the well-documented shifts in policy from institutionalized care, including the closure of large psychiatric institutions, to community-based care, with the increased recognition of

consumer-led and/or consumer-informed care, and more recently, a shift in mental health policy that embraces a 'recovery-focused' approach, psychiatric nurses had to reinvent/re-align themselves to be congruent with these shifts in policy. In this context, the conjoining of psychiatric nursing and mental health nursing might be seen as a rhetorical device aimed at convincing the external world of the discipline's development. When examined, however, the device is exposed as unsustainable because of the problematic connection and the conflict between a psychiatric model, which implies control and coercion (Barker & Stevenson 2000), and one that is allegedly oriented more to the whole person in context.

'JANUS'-LIKE OR IRRECONCILABLE: OUR ONGOING ATTEMPTS TO SQUARE THE CIRCLE

Having engaged in the deconstruction of psychiatric and/or mental health nursing, the authors of this paper liken the awkward and ill-thought-out attempt to conflate psychiatric and mental health nursing under the same homogenous title as akin to attempts to square the proverbial circle, which was, despite a considerable intellectual effort by geometers, found to be impossible. Even a cursory examination of the relevant theoretical, discursive, and empirical literature will show that many authors/scholars continue to use these signs interchangeably. Others might wish to advance the position that psychiatric and mental health nurses are metaphorically two different sides of the same coin or the faces of the two-faced Roman god, Janus. In such a case, the authors cannot ignore the symbolism here, whereby one of Janus' faces is looking into the past, and the other facing into the future. However, our deconstruction illustrates that there are currently too many irreconcilable philosophical views, theoretical positions/underpinnings, and practice examples which illustrate that such a conflation does not reflect the realities of clinical practice. Moreover, rather than being esoteric musings, it is worth examining how this unfitting conflation impacts on mental health care. In order to do so, we return to the issue of signs/signifier.

Consider the expectations that signs have of/for mental health service users. The client who uses or wishes to use mental health services has certain (implicit and/or explicit) expectations, which are, at least in part, based on the signifier, just as clients who use other health-care services do. For instance, when one chooses to visit the 'dentist' (sign), one has certain expectations that the dentist will examine and/or treat one's teeth (and gums, to a lesser extent, although a periodontist might disagree).

One would be shocked and disappointed if the dentist ignored one's teeth and focused on one's fingernails, neurological status, or the alignment of your spine. Similarly, when a woman visits the obstetrics–gynaecology clinic, she has a clear expectation of where the clinical practice/examination will focus. If the physician focuses only on hair loss or checks her long-distance vision, one would expect that the woman would be reluctant to use that obstetrician/gynaecologist again.

Accordingly, it is worth examining the literature to see if there is any record/evidence of what mental health services users expect to receive when the signifier is mental health services. The first key finding is that while services use the signifier 'mental health', what service users actually mostly encounter is a service dominated by the medical model; they actually encounter psychiatric care (with its focus on diagnosis, symptomatology, and associated pharmacological response), and this is a repeated bone of contention for service users (e.g. Beech & Norman 1995; Boardman 2005; Coffey *et al.* 2004; Cutcliffe *et al.* 1997; Elbeck & Fecteau 1990; Forrest *et al.* 2000; Gordon *et al.* 1979; Mental Health Foundation 2000; Murray 1997; Rose 2002; Shephard *et al.* 1995; Walcraft 2003). The second key finding reported in this literature is the overzealous reliance on medication, the desire for talking therapies in place of (or in addition to) medication and the (extensive) level of dissatisfaction with this overuse of medication (and its associated iatrogenic effects.) The third key finding is the value that service users place on interpersonal relationships with their mental health clinicians, particularly if such relationships are natural, warm, and human, rather than distant, cold, and professional, and if they are founded on respecting the person's dignity, treating him/her with due respect, and providing emotional support (Cutcliffe 2008).

Not only do these findings clearly resonate with early policy positions emanating from the mental health service user recovery movement (Deegan 2011), but very similar findings continue to appear in more recent service user service evaluations and surveys. Findings reported in the Mental Health Foundation's (2000, Rose 2002) report indicates an overwhelmingly predominant theme running through service users' most helpful supports: the role and value of relationships with other people, in all their different forms, and in many cases, the specific relationships with mental health professionals. Similarly, Bowcroft (2011), reporting on the first official survey of UK National Health Service Mental Health inpatients, revealed high levels of dissatisfaction with services. According to Bowcroft (2011), two particular areas of

concern were highlighted (again): the failure to focus on patients' needs, and the dangers posed to vulnerable individuals by potentially-violent fellow patients. Bowcroft (2011) reports that almost half (48%) said the potential side-effects of prescribed medicines were not explained to their satisfaction, and only 41% said they were given enough time to discuss their condition with nurses. Disturbingly, similar findings have been repeatedly reported and highlighted by MIND (MIND 2011). MIND surveys and reports indicate that: (i) 98% of respondents visiting their general practitioner for mental health problems were prescribed medication, despite the fact that less than one in five had specifically asked for them; (ii) over half (54%) of respondents felt they had not been given enough choice; and (iii) of those who had tried alternative treatments, over one in three had to take the initiative and ask for them, and often pay for them, themselves.

This body of literature illustrates that while there is some sense of satisfaction with some aspects of the psychiatric services, there is more corresponding discontent and dissatisfaction with the lack of mental health-focused services. This is despite the extant policy literature being replete with rhetorical hyperbole regarding recovery (e.g. the US's President's New Freedom Commission on Mental Health 2003). Furthermore, there is also some evidence to suggest that psychiatric services are often a wolf in sheep's clothing; that is to say, service users are sold a bill of goods that they should expect to receive mental health care and then what they actually receive is psychiatric care. One final inference that can be drawn from the key findings in this body of work is that the current documented and widespread dissatisfaction of many service users with mental health services is, at least in part, attributable to expectations based on the signs, which ultimately bear little or no resemblance to the signifier. One wonders if there is a sense of service users feeling duped, that there was an element of dishonesty, or more accurately, disingenuousness in the portrayal of so-called mental health services.

CONCLUSIONS

Our deconstruction of the limited literature indicates that what nurses who work with people with mental health issues are called has, to large extent, depended on where they have worked (Rogers & Pilgrim 2001), various public and/or mental health policy positions (Ramshorn & Pearlmutter 1982), and the vagaries of passing fashion (Nolan 1993). Accordingly, while it might presently be in vogue to refer to the conflated term 'psychiatric/mental

health nursing', our deconstructionist view is that there is, at least in part, an unspoken agenda embedded in the confluence of the signifiers 'psychiatric nursing' and 'mental health nursing'. There are currently too many irreconcilable philosophical views, theoretical positions/underpinnings, and clinical practices to enable nurses to practice simultaneously as both a psychiatric and mental health nurse. In this context, the conjoining of psychiatric nursing and mental health nursing might be seen as a rhetorical device aimed at convincing the external world of the discipline's development, and communicating to service users the type of care they can expect to receive. Unfortunately, compelling evidence within the service user evaluation literature indicates that it is disingenuous to camouflage psychiatric services as mental health services, and as signifiers, signified, and signs, psychiatric and/or mental health nursing are/is sustained by political agendas that do not necessarily prioritize the needs of the person in distress or dovetail with the contemporary mental health policy literature.

There are real implications for practice designated as psychiatric and/or mental health nursing. Being less restricted in the flow of practice, by abandoning the existing grammar (Wittgenstein 1953) of psychiatric and/or mental health nursing, and in place, having separate but parallel psychiatric and mental health services (and nurses) would offer opportunities for a different, more individualized recovery-oriented approach to those in emotional trouble. However, this is difficult to envisage in the established knowledge/power nexus of psychiatric/mental health services with vested professional interests. Furthermore, clearly demarked and honest signs for both mental health care and psychiatric care would not only be a more honest approach, it would also be in keeping with the service user literature that highlights the expectation that there are two signs (and thus two services): psychiatric and mental health services.

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