THE NATURE OF NURSING

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Nurses: Still invisible after all these years

When people have a 'mental breakdown', the Hollywood film drops them into the arms of a brilliant, humane and invariably caring psychiatrist[1]. Nurses, by contrast are invisible or, as de Carlo noted, they occupy an "aberrant, secret, and dangerous world" where their role is mainly that of 'custodial companionship'[2]. If Nightingale was the icon for physical care nursing then, Nurse Ratched, from 'One flew over the cuckoo's nest', has become the mental health nursing icon[3].

Real life tells a different story. In hospital or community care, psychiatrists are few in number, and only fleetingly present at the care face[†]. In the 'real world' nurses are the only caring constant[4]. Despite the media hype, when people talk about their 'recovery' from mental illness, they rarely name doctors, psychotherapy or even drugs. Instead, they talk about support, comfort, presence and other "human" stuff, [5] which they believe sustained them on their recovery journey. They thank people who offered extraordinary human support, who nourished their souls. Apart from friends, families and other 'patients', invariably they thank *nurses*. This should not surprise us since 'psychotherapy' originally meant the 'healing of the soul (or spirit)', and nursing, originally meant 'to nourish'.

Some years ago, I had the privilege of spending time with Pat Deegan[6], the famous American psychologist, survivor and key proponent of 'recovery' in mental health[7]. We discussed her original 'breakdown', when she was diagnosed as a "chronic schizophrenic" at 20 years of age and told "not to hope for much". Her recovery really began when she was discharged from hospital to a boarding house, where she roomed with "a bunch of hippies". This "assortment of oddballs" supported her as she wrestled with her demons. "They treated me like a person, not a patient," Pat recalled. Their caring acceptance appeared to kick start a process in which Pat began to care for, and also accept herself, for who she was. Although she went on to become a psychologist, rather than a nurse, her work emphasises the social construct of nursing[8]: how to *support people* in facing life's challenges; how to help them *grow* and *develop as people*.

For Pat Deegan, what "made a difference" was being accepted as "just another human being", albeit with some problems in living. Those around her 'nursed' her in the most traditional manner, helping her to live and grow, from day to day. Ironically, this caring attitude was miles away from the kind of 'care' she had known as a hospital 'patient'. There are however, many encouraging signs, that nurses are beginning to reclaim 'genuine nursing' with all its human and social values.

[†] Nurses often talk about the 'realities' of their everyday work as the 'coal face', implying that this is hard and dirty work. However, nurses have to 'get close' to the people in their care, becoming a recognisable face that the person comes to trust. In that sense, it might be more realistic to talk about the 'front line' of nursing as the *care face.*

What is Psychiatric and Mental Health Nursing?

In 2007, my colleague Poppy Buchanan-Barker and I tried to clarify the concept of PMHN and what it involved in practice. We asked nurses from different countries to tell us: '*what is psychiatric and mental health nursing*?' and '*how do PMH nurses do nursing?*' To help them provide a brief answer we supplied examples of two line definitions of medicine, psychology and social work, drawn from the internet, and asked a range of practitioners, leaders, researchers and professors - to *define* and *describe* their discipline in simple language. Most replied saying that they needed "time to think about this". Some needed weeks, others needed months, to come up with an answer. A few said such a definition *couldn't* be done, or for various philosophical reasons, *shouldn't* be done. Almost all admitted that these were difficult questions[9].

However, lay people were more forthcoming:

- Nurses *help* people;
- Nurses *relieve* a person's distress;
- Nurses help people *get through the day*, and *through the night*.
- Nurses help people *'deal with stuff…all sorts of stuff'*[10]

However, behind these obvious, if not common-sense descriptions, lies a wealth of hotly-disputed debate, concerning: what *is* (or is not) nursing; the *proper focus* of nursing[11]; and the often subtle difference between *care* and *treatment.* Maybe the nurses we involved in our study were trying to define PMHN as a *professional* idea, whereas the lay people described this as a human or social *service*.

Few of the nurses in our study referred to *caring* or *care,* except in very general terms – such as '*nurses give nursing care'*, which is rather like saying 'doctors practise medicine'. However, one professor of nursing from the USA said that the field was divided into two 'camps'.

i. " *a subservient discipline and an extension of psychiatry's social control mechanism(s), for the policing, containment and correction of already marginalised people", which carried "out a number of defensive, custodial, uncritical and often iatrogenic practices and treatments, based on a false epistemology and misrepresentation of what are, by and large, 'human problems of being' ,rather than so-called 'mental illnesses'." (and)*

ii. *"a specialty craft that operates primarily by working alongside people with mental health problems; helping individuals and their families find ways of coping with the here and now (and past); helping people discover and ascribe individual meaning to their experiences; and exploring opportunities for recovery, reclamation and personal growth - all through the medium of the therapeutic relationship"*

PMHN – A DEFINITION

Of course, nursing was adequately defined over fifty years ago.

> Nursing is a significant, therapeutic, interpersonal process. It functions co-operatively with other human processes that make health possible for individuals in communities…Nursing is an educative instrument, a maturing force, that aims to promote forward movement of personality in the direction of creative, constructive, productive, personal and community living[12].

Peplau was defining what nurses focus on *doing*, and further developed this definition to represent nursing *unique* focus:

> Nursing can take as its unique focus the reactions of the patient or client to the circumstances of his illness or health problem.[13]

Peplau was highly influential in the development of the *American Nurses Association's* definition of nursing:

> Nursing is the diagnosis and treatment of *human responses* to actual or potential health problems[14].

The distinction between psychiatric *nursing* and psychiatric *medicine* was clear cut for Peplau. The nurse's *primary* responsibility was to *nurture* and *aid* patients in their personal development through nursing services; helping "*guide patients in the direction of understanding and resolving their human dilemmas*[15]". The nurse's *secondary* responsibilities include co-operating with physicians who prescribe psychiatric treatments for patients"[16]. Regrettably, in recent years, many PMH nurses have focused their attention on these *secondary* responsibilities. Some even assume that by emulating the work of their medical colleagues – e.g. by increasing their involvement in psychiatric diagnosis or prescribing of medication – they are 'advancing' the practice of nursing.

What is the purpose of nursing?

I have, for many years endorsed both the ANA definition of nursing and Peplau's description of the 'proper focus' of psychiatric nursing. However, although the focus of nursing is clear, its *purpose* – what it was for – appeared less clear. Almost 20 years ago I tried to extend Peplau's original definition, by defining the purpose of nursing as *trephotaxis* – from the Greek, meaning '*the provision of the necessary conditions for the promotion of growth and development*'.

- When nurses help people *explore* their distress, in an attempt to discover ways of *remedying or ameliorating it,* they are practicing *psychiatric* nursing.
- When nurses help the same people *explore* ways of *growing and developing*, as persons, exploring how they presently *live with* and might *move beyond*, their problems of living, they are practicing *mental health nursing.*

These two forms of caring practice are closely related, with a highly fluid border separating them. The former might be seen as *problem-focused* or situation-specific,

whereas the latter is more *holistic:* concerned with the person's life - how it is lived, along with its many inherent meanings.

By emphasising the *purpose* of nursing, rather than its many different *processes*, more emphasis is given to the *developmental* and *educative* aspects of nursing, first described by Peplau. However, nurses do *not* 'make' people develop, far less 'change' them; *neither* do they 'teach' them anything directly. Instead, they provide the conditions necessary for the person to *experience* growth, development and change, and to learn something of significance from their own experience[17].

Emotional Rescue and psychiatric nursing: When people are acutely distressed, under threat – whether physical, psychological or spiritual - or presenting a risk to themselves or others, the high drama of the situation requires an equally dramatic nursing response. Here, the nurse might need to make the person and the environment as *physically safe* and *emotionally secure* as possible. This requires great skill and composure on the nurse's part. Such dramatic help is akin to the work of the lifesaver rescuing someone from drowning, or the fire-fighter delivering a person from a burning building. When people are suicidal or tormented by 'voices' they require just this kind of 'emotional rescue'. In such a situation:

- The nurse provides the kind of *supportive conditions* that will reduce the experience of distress and prepare the way for a more detailed examination of what needs to be done *next.*

When nurses respond to people's distress by helping to contain it, delimit it, or otherwise *fix* it, they are practising *psychiatric* nursing. Both the nurse and the person are locked in the present. The emphasis is on stemming the flow of distress, or keeping a watchful eye out for any signs of exacerbation of the original problem of living.

Growth and mental health nursing: As soon as the 'crisis' has passed, and the person – or their circumstances – appears to have calmed down, the focus turns to something more constructive and *developmental.* Once the 'drowning' person has been dragged ashore and is judged to be 'safe' the emphasis switches to 'rehabilitation': what needs to happen *now* to help the person return to normal living. If the person appears to have played a part in their own crisis – whether by accidentally falling or intentionally jumping into the river – the focus turns to an examination of the person's motives, or understanding of the risks involved. Of necessity, this will involve a more detailed, longer-term inquiry, which aims to ensure the person's safety and well-being *in the future.* In such a situation:

- The nurse tries to foster active *collaboration* – 'caring with' the person[18], developing an active alliance, so that *together* they might develop an *understanding* of the problem, its personal meanings and relationship to the overall *life* of the person.

Such a careful, paced, developmental approach to clarifying the person's understanding of the *function* and *meaning* of her or his problems of living, and their possible solutions, is the substance of *mental health* nursing.[7]

Nursing as a social activity: However, even if 'professional nursing' did not exist, people would still find 'ordinary nursing' in different areas of everyday life. People have been 'nursing' one another long before the birth of nursing, as a professional discipline. The most enduring example is the supportive care offered by parents to their children, which spans nations and cultures and is largely indistinguishable from the parenting found in the animal kingdom.

Being responsible for their offspring, parents shape the immediate physical environment of their young, ensuring that the 'space' is safe *and* will provide adequate room for growth. In the early stages of development, parental support is intimate and often very directive. As the child grows, the parents step back, allowing the child more opportunity to make decisions, *and mistakes*; helping the child towards autonomy and personal determination. If parents do not foster autonomy, they risk 'smothering' the child, suffocating its natural development. The ultimate aim of parenthood is *redundancy*: parents want their children to be able to survive without them. Nursing should embrace a similar ambition for redundancy.

Similar forms of 'ordinary nursing' are to be found in a variety of formal and loose-knit social groups, where members engage in mutual support, in an effort to develop resilience and encourage growth. The 'buddy system', made famous by *Alcoholics Anonymous*, over 70 years ago, [19] inspired a range of other mutual-support and 'self-help' groups. These do not try to control people, but to provide the kind of social support that might help members 'grow and develop', through and beyond their immediate problems. In many cases, the aim is to 'learn to live with' some problem; demonstrating that a full life is possible, even despite the presence of a disability.

BACK TO BASICS: THE NATURE OF NURSING

The 'postmodern' problem

PMH nurses have struggled to *define* themselves and their work[20]. Some argue that the question of what nursing *is* "*has been 'done to death' over the years, and we are no closer to a definition than we were fifty years ago*"[21].Other, experienced and senior figures even question whether their discipline "*should be called 'nursing' at all*"[22]. Such comments are typical of the tortured self-examination found in the PMH nursing literature. Indeed, some contemporary authorities would argue that it is *impossible* to define PMH nursing as it involves a "*spectrum of roles, responsibilities and practices, defined by the economics, instititutions and policies of the day[23]".* However, if nursing is simply to be whatever the 'economic, institutional and political' influences of the day demand, how do we avoid a repeat of the kind of 'nursing' that developed during the Third Reich [24].

In these 'post-modern' times it has become unfashionable to attempt to 'define' things explicitly[25]. Some nursing academics argue that "*postmodernism considers reality to be subjective, not fixed or true and immutable* [26]" and that 'postmodernism' defies absolute definition because the words we use to describe it (or anything else) cannot be separated from the context in which those words are used.[27]" If we offer a definitive answer to a question, such as 'what is nursing?' we risk presenting our

view as "*something special…another authorised version (grand narrative) of the nature of knowledge, from the academy*.[28]" The problem with such post-modern debates, as Burnard argued, is that:

> "*while they undermine any strong position, they also leave the commentator (or reader) unable to take any strong position for him or herself. Or, rather oddly, the reader can take* **any** *view. The writer's* **own** *view can, of course, always be undermined by another reading of that view. And so it all goes on, in a never-ending spiral that ultimately takes us nowhere particularly useful*[29]."

Burnard seemed to be frustrated by *relativism*, which has been around for at least 2,500 years[30]. However, when people say that their beliefs are 'true', do they mean "just for me"? The philosopher, AC Grayling, does not think so, and offers a graphic example:

> "(Relativism may apply) *in cases of taste or preference, and sometimes when there is known to be no way to settle a choice of view. But if I say that camels have humps, I do not mean to imply that it is simultaneously the case that camels have no humps just because someone else believes as much*[31]"

This is the problem with so much 'philosophising' in PMH nursing: it addresses 'things' in the abstract, but pays no attention to 'real things'.

I am uncomfortable with 'sitting on the fence' positions. I like to take a 'strong position' on issues, which I consider to be important. In taking such a strong position, I have often found myself in conflict with received opinion, with traditional values and practices, and also with colleagues. So be it. If we believe that something needs changing, then discomfort may need to be part of the process of change.

Over a decade ago I wrote:

> "*we need to forget how once we valued: competitiveness, domination, exploitation, fragmentation, blind reason and detached objectivity. (However) In these postmodern times, I remain comfortable declaring myself a humanist*[32]."

It may be interesting, amusing and sometimes enlightening to see how people disagree about the nature of reality. However, if I was asked: "Could I take a relativist view of nursing and say that *everyone's view* was *true*?" my answer would be 'No'.

- The people who sit in corridors, observing distressed people in their bedrooms, from a distance, may be called 'nurses' but *are not practising nursing*.
- The people who tell anguished people what is 'wrong with them' and then lecture them, however kindly, about the nature of their 'symptoms' may be called 'nurses', but *are not practising nursing*.
- The people who helped frail and disabled people to the gas chambers at Auschwitz, may have been called 'nurses' but were *not practising nursing*.

One of my mentors[‡] once said that "*a nurse is a person registered with the appropriate nursing council – there is no other definition*". This was, and still is

[‡] Annie T Altschul

accurate, but not particularly helpful. I want a definition of nursing that 'works'; that is more than just a label. Does it *do* what it says on the tin? If nurses *do not* 'provide the conditions necessary for growth and development', they may be doing something that is valued or approved by some professional body, but they are *not practising nursing* – as I understand it.

The nurses at Auschwitz were 'nurses'. We might excuse their actions on the grounds of 'just following orders', but could you describe their actions as 'nursing'? [§]

Common denominators

To gain any 'real' sense of 'nursing we need to deal with more basic issues. We need to grasp some fundamentals. Of course, 'nursing' will be different, in different situations, for different people, under different circumstances, at different times. However, we need to put these 'differences' to one side and ask – what do these 'different' contexts have in common?

Despite the many different ways that nursing might be defined, there are some 'common denominators', which the philosopher might say represents some 'universal truths'.

- People look after themselves, their family members and friends, animals, the environment, their prized possessions and a range of other 'things', in a way that might be called 'nursing'. They provide the conditions, under which the kinship, friendship, welfare or value of the person or thing will grow, develop or prosper.

- The athlete who sustains damage to a tendon or ligament is often said to be 'nursing an injury' – acting in such a way as to prevent the injury getting worse trying to promote healing.

- The seasoned drinker is often described as 'nursing a pint' – taking time over the consumption of a beer, savouring each mouthful, in a vain effort to prolong this enjoyable experience.

- The nurseryman, responsible for planting and overseeing a new forest, 'nurses' his new shoots. The fragile new growth is sheltered from strong winds, and adequate drainage, irrigation and – most of all – *space* is made available, all of which are necessary if growth and development are to take place[33].

In English, the words *nurse* and *nursing* have been used to represent fostering, tending or cherishing 'things' at least since the Middle Ages. PMH nursing stands in the shadow of those of those dictionary definitions, owing its very existence to ancient notions of the human value of tending, and cherishing things, as part of our hopes to foster their growth and development.

THE CRAFT OF CARING

Blending art and science

[§] I chose this example for my mentor, Annie Altschul, *was* Jewish *and* a refugee from Nazi Germany.

Nurses have also debated whether nursing is an art *or* a science[34]. I believe that the practice of nursing requires both knowledge (science) and aesthetics (art), however these are blended to form a *craft*. Craft workers use their skills and knowledge to satisfy the demands or expectations of patrons or customers, while satisfying their own aesthetic and technical ambitions.

Craftwork blends aesthetics and technique with the expectations of the patron. The craftsperson needs to know how to weave, dye or cut cloth; how much pressure silver will take without breaking; how high a temperature is needed to fire a piece of clay. This craft-*science* is augmented by some aesthetic - marrying shape, form and colour to suggest an unspoken, often culturally embedded message. The meaning and value attached to a wedding dress, a talismanic piece of jewellery or a pot, however, comes from the owner *not* the maker. Such value-making is invisible but transformative. Through such attribution, the crafted object becomes unique, if not magical; like no other, despite possible surface similarities.

The proper focus of nursing is the *craft of caring*. The value of care is defined by those who receive it[35]. How could it be otherwise? Yet, the nurse also brings value, expressed through carefulness and expertise. Knowing when to talk, what to say and when to remain silent while nursing a depressed, distressed or dying person takes great skill. This is not something that can be learned on a course, far less from books. It requires a lifelong apprenticeship, where the human tools of the trade are sharpened with every encounter.

The traditional image shows the craftsperson hunched quietly over the work, carefully, attentively and sensitively transforming the base material into something worthy of value. Genuine caring needs the same intimacy, quiet, care, attention and sensitivity to create the conditions under which the patient might begin to experience healing and recovery. In the clamour of the ward or clinic, nurses make a space - however metaphorical - for this to happen by being creative and resourceful, not by following protocols or national guidelines.

However, as health and social care has become increasingly organized, and subject to the influences of economics and the political philosophy of the day, this fundamental appreciation of nursing can become lost in a morass of policies, protocols and legislation.

However, although the term ‘care’ may have lost some of its original currency in nursing, ‘caring’ remains the universal, common denominator of PMH nursing. In the late 20th Century, many nurses grew dissatisfied with *caring,* exploring instead the idea of nursing as a *therapeutic* activity – in particular a behaviour-change or psychotherapeutic activity. Of course, when nurses *care* effectively, what they do will be therapeutic – it will begin to provide the conditions under which the person can begin to be healed. As Nightingale observed: *“It is often thought that medicine is the curative process. It is no such thing; ... nature alone cures. ... And what [true] nursing has to do ... is to put the patient in the best condition for nature to act upon him."*[36].

Psychotherapy originally meant the ‘healing of the soul (or spirit)’. When nurses organize the kind of conditions that help alleviate distress and begin the longer term process of recuperation, resolution and recovery, those activities become

therapeutic, engendering the potential for healing.

Caring, sensitivity, attention to detail and respect

We should also value *caring* because it emphasises the caution, attention to detail and sensitivity necessary when handling something precious. The archaeologist who seeks some long lost treasure, may begin his work with strenuous and dramatic digging – excavating the site until there are signs that something of value might lie somewhere just below the surface. Then the powerful tools of excavation are exchanged for smaller tools, which can be used more sensitively. Finally, when a 'find' begins to emerge, these small tools are exchanged for brushes, used even more *carefully* to remove the earth and dust that hides the treasure.

The archaeologist's *care*-ful approach to unearthing and finally revealing a possible find suggests a *concern* and *respect* for the treasure. The team may have unearthed a relic from a bygone age, or they may simply have uncovered another stone. Either way, their work is characterized by *care*, *sensitivity* and *attention to detail.* These 'finds' are priceless – whatever their market value.

If a piece of pottery, buried in the earth a thousand years ago, is considered 'priceless', a person who is by definition unique, should also be viewed as *priceless*. Respect for the person – irrespective of age, class, nationality, creed or colour, or the presumed nature or origins of their problems – lies at the heart of all the contributions in this book. If this is not a universal, defining characteristic of nursing, it should be[37].

THE PURPOSE OF NURSING

This book considers the highly-contested notion of 'mental health, which lacks any single, official definition[38]. However, this book is about *nursing* not about 'mental health'. In this sense, I hope that readers will discover in this book many examples of how, by *caring for people* diagnosed with one 'mental disorder' or another, they help those people to reclaim or attain the mercurial state known as 'mental health'. I hope that they will also discover how nurses might become social agents, in a much broader sense, helping families, communities and society at large, to grow and develop, so that they might become healthy, meaningful and productive. Most of all, I hope that you will understand better what it is that nurses *do* in the name of nursing care, and why they do this rather than anything else[39].

The Progress of Psychiatric and Mental Health Nursing

In 2006 'reviews' of mental health nursing were published in England and Scotland[40] [41]. One might have expected these reviews to talk, enthusiastically, about 'care' and 'caring'. Instead, the focus was on 'interventions', 'evidence' and 'technology'. Perhaps caring is no longer considered sexy, but science and technology is exciting! If the *craft of caring* is to make a difference in the world of mental health then nurses will need to embrace, carefully, both science and art, blending these together, to form a meaningful, practical reality – the *craft of caring*.

However, if a mental health 'revolution' is needed today, we need to ask to what extent *science* – in any form – will help make a significant contribution. History

suggests that, however useful science in its various forms might be, it is not a necessary part of the 'mental health revolution'.

- Two hundred years ago, when the abolition of slavery began, this movement was not based on science or 'evidence' regarding the 'rights' or 'wrongs' of slavery, but on a *particular set of human values*.
- One hundred years ago, when the emancipation of women began, this movement was not based on science or 'evidence' regarding the 'rights' or 'wrongs' of votes for women, but on a *particular set of human values*.
- Fifty years ago, when the civil rights movement began in the USA, this was not based on science or 'evidence' regarding the 'rights' or 'wrongs' of racial equality, but on a *particular set of human values*.
- Thirty years ago, when the gay rights movement began to be taken seriously, this movement was not based on science or 'evidence' regarding the 'rights' or 'wrongs' of freedom of sexual expression, but on a *particular set of human values*[42].

As Burnard eloquently said, *caring* "can give unselfish and even 'unrewarded' pleasure[43]. Perhaps, the countless numbers of people who participated in the four 'revolutions' noted above, *cared* sufficiently to commit themselves - many at the expense of their health if not their lives - to make a change in their social world. It is difficult to imagine how those revolutions could have come about in the absence of caring.

Despite the absence of any solid 'scientific evidence', the significance of caring is obvious.

> However it is viewed, it would seem that caring is an almost universal phenomenon and one linked to the very process of becoming and being a person …caring remains at the centre of the process of nursing, for whatever it is *not,* nursing is ultimately bound up with all aspects of the person[44].

Nursing the world

In 2007, the WHO and the International Council of Nurses published *Atlas: Nurses in Mental Health*[45]. This reported that the number of skilled nurses was far too small to meet mental health service needs worldwide, and that basic and specialist training in mental health nursing was often absent or seriously deficient, even in more developed regions such as the European Union. In all continents, except Europe, there are *fewer than three nurses in MH settings per 100,000 people*.

Reporting these sobering statistics, Salvage cited international mental health nursing expert, Ian Norman, as saying: "*the evidence base for MH nursing interventions is at its strongest for decades. Yet it is alarming that these interventions are not being delivered to patients in many parts of the globe because of inadequate training*[46]". Professor Norman listed: *prescription and collaborative medication management;*

education and training of service-users to manage their illness; family psychosocial education; assertive community treatment; supported employment; and integrated treatment for people with mental illness and co-occurring substance use disorders, as examples of the kind of 'evidence-based interventions' to which he was referring[47].

All these interventions are covered in later chapters, and may be good examples of mental *illness* services. However, if people in the more troubled and disadvantaged parts of the world are to realise their *'mental health'* then something more radical will be necessary. They will need something more like the social actions that brought an end to slavery, opened the door to the emancipation of women, and guaranteed rights for 'people of colour' and gay and lesbian people.

If we are to 'make a difference' for people across the world, first of all, we need to care deeply about them and their plight. This intangible human value will fuel our advocacy, will sustain our interest in them and their problems of human living, and will foster the development of the range of innovative projects needed to address the wide range of uniquely different social contexts

If you are to make a real difference for the people in your village, city or community, you will need to *care about them*, as persons, so that you can begin to develop forms of collaborative support that will begin to address their unique problems of human living.

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[3] See http://en.wikipedia.org/wiki/Nurse_Ratched

[4] The British psychiatrist, Albert Kushlick, once described everyone *except* nurses, as "DC10s – offering direct care (DC) for only 10 minutes, before 'flying off' somewhere else. See P Barker *The Philosophy of Psychiatric Nursing* , Edinburgh, Churchill Livingstone, 1999, p.82

[5] Barker P, Jackson S and Stevenson C (1999) The need for psychiatric nursing: Towards a multidimensional theory of caring. *Nursing Inquiry* 6, 103-111

[6] All the quotes here are taken from an interview with Pat Deegan, recorded in England in 1997.

[7] www.patdeegan.com

[8] Barker P Reflections on the philosophy of caring in mental health. *International Journal of Nursing Studies* 1989, 26(2) 131-41

[9] Further details of this study are available from the author at:phil.j.barker@btinternet.com

[10] These are some of the replies we received when we asked a group of lay people *"what do nurses do?*

[11] Barker P and Reynolds B. Rediscovering the proper focus of nursing: a critique of Gournay's position on nursing theory and models. *Journal of Psychiatric and Mental Health Nursing* 3 1996 1: 75-80

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[20] See J Cutcliffe and M Ward, Editorial in *Key Debates in Psychiatric and Mental Health Nursing* , Edinburgh; Churchill Livingstone, Elsevier, 2006, p. 22

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[22] Collins J "Commentary ",p.46 in Cutcliffe and Ward *op cit.*

[23] Barker p and Buchanan-Barker P *ibid*

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