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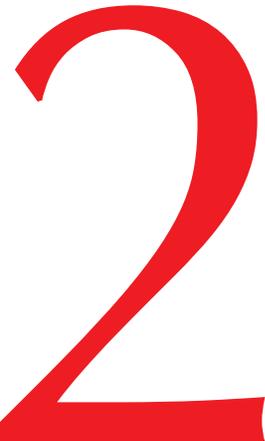
Abstract

This paper explores cultural identity within General (Adult) and Psychiatric (Mental Health) nursing as reflected in healthcare literature; illustrating how significant cultural differences associated with the history of the disciplines, representation of their fields of practice, professional knowledge, power, status, gender and employment rights affect interdisciplinary communication and working relationships. Applying Social Identity Theory (SIT), it argues that psychiatric nursing is a low status group compared to general nursing and highlights actions, congruent with SIT, which can be regarded as attempts to enhance the status of this discipline; so far with very limited success.

Keywords culture, identity, nursing, social, theory

Cultural differences in General and Psychiatric Nurses: A critical analysis using Social Identity Theory

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Introduction

A quarter of the United Kingdom (UK) population now experience a mental health problem during their life.[1] Some mental health problems have specific biological causes or physical symptoms and every physical health problem has a psychological dimension. Moreover, many individuals experience physical disturbances for which no identifiable biological cause can be found.[2] In the UK, nursing care for adults with physical and mental health problems is provided by two practitioner groups who hold distinct qualifications located on separate parts of the Nursing and Midwifery Council (NMC) register. General (or Adult) nurses primarily offer physical healthcare, whilst Psychiatric (or Mental Health) nurses largely address an individual's psychological health problems.[3]

Although both disciplines have a history of formal training from the late nineteenth century, their origins are very different. The establishment of modern general nursing is commonly attributed to mid/late nineteenth century pioneers such as Florence Nightingale and Ethel Bedford-Fenwick introducing improved standards of hygiene, discipline and hospital organisation.[4,5] In contrast, psychiatric nursing developed from the late eighteenth/early nineteenth century 'moral treatment' movement within the asylums, led by reformers such as Phillippe Pinel and William Tuke.[6,7] Indeed, general and psychiatric nurse training was entirely separate until the early 1980s[8] and although UK nurse education is now based on generic and specialism-specific competences[9] 'often those who focus on physical health have little professional exposure to people with mental ill-health and vice versa'.[10, p20]

Arguably, the cultural identity of nursing is evident in its 'values, visions, norms, nomenclature, systems, symbols, beliefs, and habits'[11, p242] and this identity affects the way nurses interact with one another, different professional groups, those receiving care and other stakeholders. Although not without its critics, Social Identity Theory (SIT), developed by Tajfel and Turner four decades ago, has been described as 'one of social psychology's pre-eminent theoretical perspectives'.[12, p745] This theory suggests social identity emerges from 'people's identification with the groups and social categories to which they belong'.[13, p282] Each social category into which an individual either falls or feels an association provides a definition of who this individual is in terms of the defining characteristics of this category.[14]

SIT suggests social identification initially involves forming 'a reflexive knowledge of group membership' and then developing 'an emotional attachment or specific disposition to this belonging' [15,p.25]. Categorization and a drive for self-enhancement affect an individual's beliefs about relations between their own 'ingroup' and identified 'outgroups'; accentuating the perceived similarities between the individual and other ingroup members and their differences to outgroup members [16]. Although such beliefs may not reflect reality, they still affect 'the specific behaviours that group members adopt in the pursuit of self-enhancement'.[14, p260]

Whilst 'little research has been conducted into the development of the professional identity of nurses',[17, p165] written records provide one method by which to understand a professional culture.[18] Applying SIT principles and as an attempt to stimulate further discussion/debate on the topic, this paper explores cultural identity within general and psychiatric nursing as reflected in healthcare literature, illustrating how differences associated with the history of the disciplines, representation of their fields of practice, professional knowledge, status, gender and employment rights currently affect practitioner interaction and working relationships in the UK. Academic Search Complete, BioMed Central, CINAHL with Full Text, the Directory of Open Access Journals, Emerald Premier, Internurse, OvidSP Journals, Pub-Med, Sage Journals Online, Taylor & Francis Journals Online, several online UK 'broad-sheet' newspapers and healthcare websites were employed within the literature search. Key search terms and interdisciplinary differences were derived from professional discussions with academic colleagues involved in the delivery of general and psychiatric pre-registration nursing programmes and assertions within the paper driven by the extent of literature discovered to support them.

Origins of the disciplines

SIT proposes that individuals seek to acquire and maintain a positive, secure social identity[19] and enhance their self-esteem by making favourable comparisons between the social group to which they belong and other different relevant outgroups[12]; a process known as 'social comparison'.[20] Such comparison often lead outgroups to be reductively characterised by members of the ingroup, leading to stereotyping and prejudice.[15]

The positivist biomedical model of illness, which is based on the principles of biological abnormality, diagnosis, treatment and cure has dominated healthcare for over a century[21,22] and much general nursing practice is still based on this model. [23,24] Sellman[5, p130] argues that Florence Nightingale's approach to nursing was founded on the nineteenth century social more that individuals should display 'conformity with the orders of those with purported greater knowledge'. Physicians are deemed the experts in a biomedical approach to healthcare and so within this model the nurse's role is to accurately carry out medical directives, most of which focus on the physical needs of the patient.[25,26] In physical healthcare medicine therefore dominates nursing;[27,28] an assertion supported by the results of several research studies. Casanova et al.[29] suggested physicians often regard nurses as an extension of their role, whilst Manias and Street[30, p445] found general nurses reported 'a sense of marginalization during their encounters with doctors'. General nurses interviewed by Tang et al.[31] displayed poor professional identities; regarding themselves as subordinates to physicians in ward rounds. It is argued that technical advances, in which 'the nurses' act of care may be reduced to the pressing of buttons and the monitoring of digital symbols' [32,p.253], have led blurred the distinction between medical and general nursing activities. 'Nurses are increasingly taking on doctors' roles' and undertaking clinical tasks such as 'endoscopy, minor surgery, and anaesthesia'[33, p337] and specialist nurse practitioner roles involve prescribing medication, examining patients, diagnosing illnesses, and providing treatment in much the same way as physicians.[34]

Despite the influence of biological psychiatry and psychopharmacology, psychiatric nursing is described as 'less well rooted in the biomedical tradition than general nursing',[35, p129] and considered to have 'distinct attributes, which are at odds with a positivist and reductionist paradigm'; an approach which may dismiss individual needs in favour of categorising and medicalising patient experience.[36, p371] In contrast to general nursing, psychiatric nursing is founded more on a bio-psycho-

social model of intervention;[37,38] perhaps because the biomedical model has failed to provide a physical cause, or consistently effective medical treatments, for many mental health problems.[39,40] Medicine is therefore less dominant in mental health and provision based on a more collaborative model of multidisciplinary team (MDT) working,[41,42] involving clinical psychologists, occupational therapists, social workers, art therapists, psychiatric nurses as well as psychiatrists.[43] Research suggests that all these disciplines make a significant contribution to the MDT,[44] that their combined expertise delivers a more holistic and comprehensive mental health service[41] and that working relationships between psychiatrists and psychiatric nurses are stronger and more positive than those between physicians and general nurses.[45]

Stereotyping, status, and stigma

The impact of differing theoretical foundations underpinning the practice of nurses within both disciplines may account for various reported phenomena that reinforce outgroup stereotypes. General nurses are commonly portrayed as the doctor's helper[46] or handmaiden,[26,28] displaying 'an obsession with physical care' and perceiving the care recipient as a diagnosis rather than a human being.[25, p46] Sercu et al.[47, p311] explored the reasons Belgian psychiatric nurses gave for entering the discipline and their responses reflected some of these general nursing stereotypes:

> 'In general hospitals it's the doctor who decides and you will carry it out in practice'.

> 'General nursing is very technical. The contact with the people [service users] is medicalized, and because of the efficiency policy you have a lot of short, often too short, hospitalizations, which means that people are approached in a less human way [than in mental health nursing]. It makes it impossible to encounter the person as a human being'.

> 'I worked for three years in a general hospital and I wasn't happy. The contact with service users was different, everything had to go fast and the people were numbers. Individuals became their disorder, they didn't know service users' names.'.

Nurses working outside general nursing are often described in equally critical terms; being regarded as not 'real'[48,49] or 'proper'[50] nurses and inferior to colleagues in general nursing.[51] Specifically, psychiatric nurses have been portrayed as having a primarily custodial job[52] founded on little more than common sense[53] and regarded as lazy; avoiding hard work and instead chatting to patients.[54] Furthermore, Sabella and Fay-Hiller[51, p3] report overhearing general nurses 'telling other non-mental

health nurses that mental health nurses are crazy'. Clearly, such negative stereotypes may adversely affect the nature of interactions between members of both disciplines.

The tensions between general and psychiatric nurses which originate from different theoretical perspectives underpinning their practice are perhaps greatest where their roles intersect; most notably when individuals require specialist physical and mental healthcare, since it may be these occasions when nurses display greatest variation in their values, perceptions and subsequent practice. For example, research suggests people failing to ensure appropriate nutritional intake or comply with dietary advice are perceived by general nurses as refusing to control their eating disorder, despite being able to do so [55], and are therefore considered difficult patients for whom it is not satisfying to care.[56]

Similarly, studies indicate those receiving treatment following deliberate self-harm are often perceived negatively by general nurses;[57] being regarded as manipulative,[58] attention-seeking and wasting staff time.[59] Research also suggests individuals with health problems arising from substance misuse are considered by general nurses to be responsible for their own ill-health, lacking self-control[60,61] and being 'an annoyance within general health care provision'.[62, p39] Perhaps the tendency for psychiatric nurses to consider the potential psycho-social origins of these problems explains why discussion with general nursing colleagues on appropriate care planning may be difficult.

General nursing has a higher status than psychiatric nursing within healthcare. Consistently underfunded,[63] mental health has long been described as a 'Cinderella service' and the 'poor relation' to physical healthcare;[64,65] whilst mental illness continues to be stigmatised.[38,47] Indeed, research exploring how general nurses in Brazil perceived having psychiatric care beds in a general hospital clearly illustrates such stigmatisation.[66, p4-5] Comments regarding individuals admitted for mental healthcare within the hospital included the following:

> 'I am afraid of them'

> 'I really can't feel empathy with them'

> 'They scare me, especially when everyone is asleep. I am afraid of physical assault'

> 'I feel uncomfortable with their presence here, particularly because it is very close to the maternity'

Similarly, second year general nursing students in Finland had 'prejudices and negative attitudes towards mental illnesses and psychiatric settings'.[67, p622] Via 'courtesy stigma', or stigma by association, mental health practitioners

may also be negatively perceived within and beyond the health services.[68,69] In Canada, the public were found to regard psychiatric nurses as evil and corrupt;[70] whilst research regarding the way psychiatric nurses were portrayed in international films between 1942 and 2005 identified ten archetypes, almost all negative; namely 'mother, sex kitten, mean spinster, hardened working-class man, bull dyke, Nazi custodian, kindly companion, mincing queen, brutal rapist and unquestioning obedient servant'.[71, p341] It seems improbable that such negative representations do not adversely affect the perception of psychiatric nursing held by both general and psychiatric nurses and interaction between such practitioners.

According to SIT a low status group member can reacquire positive social identity, an action called 'social change',[20] by various means. One technique is to make more flattering comparisons to the subordinate group.[19] Although literature apparently designed to deliberately demean general nursing and thereby heighten the standing of psychiatric nursing is reassuringly rare, one example appears to be a paper by an academic and psychiatric nurse regarding pre-registration nursing programmes. Clarke[72, p39] argued that although psychiatric nursing students are 'susceptible to the types and levels of debate that are appropriate to a university' and the breadth and depth of their programmes necessitates university-based study, many students on general nursing programmes 'crave more input on anatomy and physiology', fail to appreciate the importance of psychosocial studies and have 'anxieties about entering the workplace with limited knowledge about the medical tasks that await them'. Moreover, the academic claimed that general nursing students 'seek descriptive curricula, watered down versions of medicine, and they generally resent being denied this' [p.40], their programmes should last only two years and that their professional training be 'completely separate from mental health and other branches of nursing'.[p41]

Unsurprisingly, this paper triggered a heated debate in the nursing press, but no retraction or apology from the author. Indeed, his argument was developed in a subsequent book[73] where he describes the 'phenomenon of adult students coming to me tears streaming down their cheeks, clutching failed assignments titled: 'Critically assess the therapeutic properties of transactional analysis' and exclaiming 'But I came here to be a nurse!'[p176] and asserted that general nursing students should have a curriculum 'fitted around a two year – non-university – programme which gives them the professional equipment to work competently in medical settings'.[p180] Although these publications only capture the

views of one psychiatric nurse it seems reasonable to assume that general nurses aware of them may believe they reflect a wider body of opinion within psychiatric nursing and thereby influence impression formation and subsequent interactions with members of this discipline.

Moral and ethical reasoning

In the UK, psychiatric nurses have legal powers which, under clearly defined circumstances, permit them to deprive an individual of their liberty and those receiving mental healthcare may be subject to detention and treatment against their will. The psychiatric nurse's 'moral duty to ensure safety'[74, p848] whilst optimising individual freedom[75] has therefore been emphasised. Indeed, it is suggested psychiatric nurses require a detailed appreciation of wider legal issues associated with providing treatment and care as well as a multidimensional understanding of moral and ethical reasoning to achieve this goal.[36,76]

Such reasoning is perhaps most evident in psychiatric nurse perceptions of lifestyle behaviours. For example, although smoking has been described as a habit which nurses should actively discourage,[77] research suggests that psychiatric nurses have more liberal attitudes to smoking than other healthcare practitioners,[78] believe it is an individual's right to smoke, are cautious about imposing their own values on smokers, 'mindful of the power imbalance in their relationship with patients' and base decisions about smoking on the ethical principles of autonomy, beneficence and non-maleficence.[79, p113] Inevitably, different views held by general and psychiatric nurses on emotive topics such as lifestyle behaviours that may have adverse physical consequences may reinforce inter-disciplinary negative stereotypes and impair discussions regarding care provision involving nurses from both groups.

Language and role redefinition

SIT suggests members of an inferior group may enhance their social identity by highlighting new, distinctive or positive dimensions about the group.[20] Arguably, by developing a distinctive set of concepts and vocabulary to describe their work, psychiatric nurses are adopting this strategy to raise their status. The term 'patient' is traditionally used to describe the person whom a physician treats[80] and implies a subservient and passive role for the individual,[81,82] which is considered incompatible with contemporary psychiatric nursing. Although still commonly used within the wider health services, this word is now employed less frequently in psychiatric nursing literature, where the individual is more

often referred to as a 'service user'.[37,47,83,84]

Nursing is a predominantly female occupation [4,85], but psychiatric nursing has always had a more balanced gender composition.[86] Recent data suggests that whilst only 10% of general nurses are male,[87] this figure rises to more than 38% in psychiatric nursing.[88] In response to the feminised nature of nurse training [89] and female-oriented descriptions of nursing care [90] there appears to be growing use of more gender-neutral psychiatric nursing terminology, with phrases such as 'nurturing', 'compassion' and 'sympathy'[5,86,87,91] being replaced by 'empowerment', 'facilitation' and 'empathy'.[36,84,92]

Furthermore, psychiatric nurses now emphasise distinctive features determining their practice, including holism, the therapeutic relationship, person-centred approach and therapeutic use of self[38,93,94] and sometimes even occupy roles from which the term 'nurse' itself is absent.[37] Whilst employing different language to describe psychiatric nursing interventions may increase the discipline's distinctiveness and possibly even help raise its status, it may also be divisive; increasing interactional misunderstandings between general and psychiatric nurses and raising suspicions about professional motives and conflicting values.

Members of a subordinate ingroup may seek to downplay less desirable aspects associated with their group[19] or reinterpret them in positive ways.[20] Arguably there is evidence of both activities within psychiatric nursing literature. The discipline's history includes many disturbing, unpleasant or uncomfortable features and there remains an ongoing tension between the psychiatric nurse's duties in respect of care and control.[95] In recent decades, however, some psychiatric nursing academics have sought to re-evaluate the discipline's history. For example, O'Brien[6] argues that, albeit in a rudimentary form, the importance of a therapeutic relationship was recognised in some asylums, poor asylum care was commonly the result of institutional overcrowding and even in the early part of the nineteenth century more enlightened asylum workers believed restraint was more likely to cause mental disturbance than prevent it.

Nurse retention and turnover

SIT proposes that members of an inferior group may enhance their self-esteem by leaving this group.[19] The NMC[96] reports that 27% more nurses are now leaving the professional register in the UK than joining it, but staff shortages in psychiatric are almost 42% higher than for general nursing.[1] Between 2014 and 2017 there was a 6.2% reduction in the total number of psychiatric nurses practising in England;[97] a situation partly attributed to these staff feeling overworked, undervalued and poorly paid.[98,99] Moreover, high staff turnover affects nursing morale and productivity; creating a less desirable working environment for those remaining[100] and thereby encouraging more staff to leave. Clearly, high psychiatric nursing workforce turnover may suggest, congruent with SIT, that some psychiatric nurses are indeed leaving this discipline because of its inferior status. Such action, however, may worsen the discipline's low status and lead general nurses to be less inclined to perceive colleagues in psychiatric roles as their peers; thereby reinforcing power inequities between both groups.

Ironically, one initiative implemented to promote recruitment and retention of mental health staff in the UK National Health Service (NHS) may have increased the number of psychiatric nurses leaving practice. 'Mental Health Officer status', which mirrored existing schemes in some mental hospitals before the formation of the NHS in 1948, was designed to compensate professionals practising in the less attractive field of mental health and allows staff to retire with an occupational pension from 55 years. Although this status was closed to new NHS pension scheme entrants in 1995,[101] it continues to affect early retirement levels in psychiatric nursing and perceived discrimination in the employment rights of experienced general and psychiatric nurses may have further damaged the working relationship between members of both disciplines.

Challenging the status quo

According to SIT, members of a subordinate group may engage in activities which seek to overturn the existing hierarchy.[19] Arguably, the UK government's recent decision to address the historic funding imbalance between physical and mental healthcare by 2021, recruit 2,000 new psychiatric nurses, consultants and therapists whilst attempting to encourage some of the 30,000 psychiatric nurses no longer practising to return to the NHS [102] might suggest that campaigning by nurses and other mental health practitioners has contributed to this policy change and is therefore an example of such group behaviour. This initiative, however, could harm professional relationships between general and psychiatric nurses if members of the former group fear it will be achieved by Central Government reallocating already limited resources in physical healthcare to fund these improvements.

Inter-disciplinary & inter-professional education

SIT proposes one final strategy which members of an inferior group may employ to improve their position; namely to

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'adopt those positive characteristics attributed to the high-status group, so increasing the likelihood of a merger with that group'.[20, p44] Indeed, this approach may be the most promising way to redefine group identity and reduce inter-group conflict.[12] The current pre-registration nurse education programmes for different nursing disciplines in the UK have been described as 'training nurses in silos'[10, p21] and inter-disciplinary and inter-professional education are therefore advocated as means to promote more integrated healthcare provision and strengthen working relationships between different practitioner groups.[2,41,107]

As a result, there have been calls for UK pre-registration nursing programmes to be fully integrated.[2,98] Recent NMC[106] draft proposals regarding the future of nurse education, however, have ignored such calls; instead retaining specific nursing branches and professional qualifications. This conservative response to serious recruitment and retention issues may have been influenced by awareness that fully integrated pre-registration nursing curricula introduced in Australasia and North America, in which psychiatric nursing became a post-graduate specialism, appears to have increased recruitment problems to the discipline on both continents.[37,75] Nyatanga[107, p175] claims that 'professional ethnocentrism derived from professional identity and socialisation' acts as a key barrier to inter-disciplinary learning and it appears there is indeed evidence to support this assertion. An important shortcoming of any integrated pre-registration educational structure for psychiatric nursing, however, may simply be that young people, not yet directly exposed to nursing culture but with a specific desire to become psychiatric nurses, are unwilling to complete three years of undergraduate study on a generic nursing course before being able to focus on their specific field of interest.[53]

Perhaps of equal if not greater concern is the suggestion that, in those nations where fully integrated pre-registration nursing programmes have been launched, psychiatric nursing has experienced 'a growing uncertainty about itself as a profession'.[108, p550] It seems most unlikely, at least for the foreseeable future, that the implementation of this approach to address the status inequity between general and psychiatric nursing in the UK and thereby strengthen working relationships between members of the disciplines will occur. If a more equitable status between general and psychiatric nursing is to be achieved, then this may instead require psychiatric nurses to take further action reflecting the principles of SIT. Such efforts might need to include more aggressive lobbying to acquire a stronger voice within

healthcare leadership,[109] continuing to challenge the stigma of mental ill-health,[9,47] or even undertaking 'a complete rebranding of mental health nursing'.[69, p17]

Limitations

Despite the value of SIT as a conceptual framework to examine general and psychiatric nursing, several limitations of this theory have been highlighted. Whilst SIT has been frequently used to retrospectively explain intergroup activity it has been much less effective in predicting such behaviour [103] and research has not so far provided evidence of a strong correlation between individual self-esteem and the perceived status of their ingroup.[12] Moreover, SIT has been criticised for failing to clearly articulate the specific psychological and social factors involved in group processes.[14] Given the expectation that, to be deemed a robust and credible explanation, any scientific theory must be falsifiable, the ability of SIT to account for an extremely wide range of observed phenomena means that it fails to comply with this requirement.[104] It is even questionable whether individual beliefs, values and modes of communication can ever be solely attributed to individual identification with a social group.

Inevitably, this paper cannot capture all differences associated with the cultural identity of general and psychiatric nursing and is shaped by the perceptions of those involved in its development. Moreover, word limitations mean it has intentionally focused on areas of difference rather than aspects of similarity as an attempt to stimulate further discussion/debate on a topic which has received comparatively little attention to date.

Conclusion

In conclusion, healthcare literature suggests differences in cultural identity related to the origins of general and psychiatric nursing, representation of these fields of practice, professional knowledge, power, status, gender and employment rights may significantly affect interactions between members of the two disciplines; manifested in the contrasting approaches to the care which they deem appropriate for individuals, the emphasis given to different forms of care, arguments surrounding the most suitable professional training for practitioners, conflicting views on lifestyle behaviours and the use of different language to describe nursing interventions.

Indeed, it appears that, as members of a low status group, psychiatric nurses are managing this status inequity by

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employing many, if not all, of the strategies identified within SIT. More than a century after both disciplines introduced formal training, however, it is questionable whether any of these actions have yet measurably enhanced the status of psychiatric nurses; except perhaps for those choosing to leave this discipline. Since healthcare funding is finite and NHS budgets in the UK often described as over-stretched, however, inter-disciplinary tension between general and psychiatric nursing is arguably both a predictable and an unavoidable consequence of the way UK healthcare is provided.

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