The Cloaked Self. Professional de-cloaking and its implications for human engagement in nursing.

Fintan Sheerin PhD RNID

Lecturer in Intellectual Disability Nursing,
School of Nursing and Midwifery,
The University of Dublin, Trinity College Dublin.

Address for correspondence:

Dr. Fintan Sheerin
School of Nursing and Midwifery,
University of Dublin, Trinity College Dublin,
Dublin 2.
Ireland.
Tel: +35318964072

Email: sheerinf@tcd.ie

***The Cloaked Self.* Professional de-cloaking and its implications for human engagement in nursing.**

Introduction

Identity is a complex concept and one that has been variously defined in terms of innate (genetic) and extraneous (personal upbringing and experience) aspects. Amongst these extraneous aspects are formative processes such as those experienced during professional preparation. It has been suggested that 'identity reflects not only the professional, educational, and pedagogical aspects of being a...[professional]...but – more importantly – the imprints of the complex interconnectedness of one's cumulative life experiences as a human being' (Bukor 2015, p. 323).

Awareness of the role of identity is crucial when one attempts to understand how individuals interact within the nurse-patient relationship. Newman et al. (2008: E17) propose that this relationship is central to the provision of appropriate and quality nursing care and is, in fact, 'the central focus of the discipline'. They note the mutuality of that relationship and its potential to 'tap into what is meaningful for the patient...[opening]...the way for relevant action' (Newman et al. 2008: E16). This, however, does not make explicit the greater potentiality of such a relationship, as the nurse-patient relationship is, in fact, grounded in human engagement, a dialogic concept which has implications, not only for the successful outcome of care, but also for achieving far-reaching outcomes in respect of the social realities that underpin health and wellness (Willis et al. 2008). Too often though, nurses find themselves providing service in contexts where that engagement is framed by the roles they play, with power

and passivity balanced in favour of the professional. This can severely limit the possibility of successful dialogue being achieved.

Problem Identification

In this paper, I will reflect on this, drawing upon engagements with people who experience intellectual disability in Ireland, people in poverty in rural Malawi, and those whom I met in a refugee camp in northern France. Furthermore, I will reflect on the *internal voice*, which drives professionals to respond within predetermined perspectives, such that both groups' positions are often reaffirmed and an unspoken *status quo* maintained. I will similarly consider the *external voice*, which drives disempowered people to do likewise. In doing so, I hope to ponder on the need to create spaces where 'de-cloaking' can take place, where professionals can attempt to divest themselves of the role, privilege and vestments of their given positions in order to enter into situations of real dialogue; of true human engagement.

Reflecting on Professional Development and Identity

Lived experience is highly formative. When I left secondary school at 18 years of age, I entered Roman Catholic religious life, with the intention of becoming a missionary priest. The dearth of young women in the seminary quickly led me to understand that this was not to be my path in life. However, over the year and a half that I spent in the seminary, I became aware of forces that were attempting to mould me into a religious student and, through that, into a priest. In religion, this process is called *formation*. The aim of formation is to instill in the person a subjective identity of self as priest (Congregation for the Clergy 2016). The forces behind it are subtle and entail controlled environments, creation of uniformity in appearance and action as well as the imposition

of rules and mores. After I left, I saw these changes develop in the young men who joined with me; they learned how to walk and talk like a priest.

As chance would have it, though, I was drawn to a career in nursing and was accepted by a school where, ironically, I underwent ‘formation’ as a nurse. Freidson (1986) has written extensively on the development of professions and their maintenance of their power. The traditional regimentation which is often seen in the formation of professionals such as nurses, primary teachers and clerics is particularly effective (Beauchamp & Thomas, 2009; Apesoa-Varano 2007). It is based on the inculcation of a very particular body of knowledge, carefully bounded, which affirms the role, position and activities of the professional. It focuses on the specific set of values and beliefs which underpin such activities and which inform attitudes towards others who are outside the privileged group (Illich 2010). This might be termed the *subjectivised formation* of the professional because it instils in the professional while configuring her/him in the social setting – *the internal voice* (figure 1). Ten Hoeve et al. (2013: 303) refer to this as the ‘self-concept’ of the nurse, an idea closely aligned to professional identity. The expression of this self-identity/self-concept, and the use of associated symbols and uniforms, provides ‘others’ with expectations and beliefs about the professional which, in turn, reinforce her/his view of self. (*the external voice*)

This also results in the *objectivised formation* of the professional. These forces are maintained by the ever-present disabling illusions of the modern world (ten Hoeve et al. 2013). Drawing on the work of Illich (2010), these illusions include that: people are born to be consumers; technological progress is a kind of engineering product licensing more professional domination; effective tools for lay-use must first be certified by professional tests; experts are the informants for limits to growth (what you do not need); and experts are the informants for what you need now. Thus, the needs of society

and the solutions to these needs are determined by others. Using the medical profession as an exemplar, Illich (1985:1) contends that this effectively allowed for the creation of need and the location of its answers in the authoritative hands of professionals: ‘...medicine has gone on to define what constitutes disease and its treatment’. By stripping people of their hitherto societal and caring roles, this has effectively disabled society.

Figure 1: Instillation of professional values in the individual

These formative processes serve to contextualise the instance of interaction (the interface) between the professional and those in receipt of her/his expertise. Thus, the encounter is one that is pre-contextualised as are both parties.

Whilst the discussion, heretofore, has focused on the object of the formative process, it is also important to consider those who engage in professional formation: educators, preceptors and mentors. It is likely that these individuals were subjected to similar forces during their development and that their conformity was reinforced by their

preparation for formation roles. This control is evident in the fact that many professions employ educators who are trained to teach the relevant professional cohort, for example, registered nurse tutors who have a qualification in teaching *nurses*. My own teaching qualification is a post-graduate diploma in education *for nurses*. Such educators also find themselves working in contexts where pressures for professional socialisation compliance exist and teaching from highly prescriptive, professionally validated syllabi. And so, the *status quo* is likely to persist. Compliance, as a form of obedience, marks the removal of the critical, *human* voice and the instillation of the professional (Freire 1993). Denial of the *human* voice results in a situation whereby true and dialogic engagement is no longer possible. This is a challenge for nursing which has been portrayed as an oppressed profession; one which professionalised only in the wake of male-dominated medical profession (Sheerin 2012). Thus, it may reflect the duality of which Freire (1993) wrote: its voice is professionally suppressed, yet it unwittingly perpetuates the suppression of others' voices.

Looking back on my career, I can see now that both the recipients of my service and I, came to the instance of interaction (care) with immense baggage. Whereas my endowment was largely positive and empowering (experiences, resources, education, competence) my clients were negatively endowed (material poverty, poverty of experience, social discontinuities, lack of education, lack of competence). To compound this, I also brought the aforementioned professional clothing.

As a registered intellectual disability nurse, most of my clientele have been people who experience intellectual disability. Any attempt to recount the history of such people will probably identify that a number of forces (eugenics, religion, fear, perceived deviancy) have impacted on how they have been viewed and understood (Sheerin 2008; 2013). Furthermore, the valuing of cognition that inherently underpinned the post-industrial

and post-scientific revolution societies, led to a situation whereby these people could never *really* be included in our societies and so, custodial service models developed, funded by charitable contributions (Trent, 2016). What we have, therefore, is an acutely inequitable situation whereby people with intellectual disabilities are routinely denied real inclusion and are regularly offered something that *looks like* real inclusion: work-like activity; inclusive education; limited choice *etcetera* (Sheerin et al. 2015). This is similar to the realities that have been described by many critical theorists in relation to colonialism, oppression, feminism, racism etc. When considered together, they appear to be oppressive in nature.

In the face of such a situation, and with self-identities grounded in, and maintained by, strong professional and social forces, one might ask if real dialogue and human engagement can ever be achieved.

Broadening Perspectives

This question of dialogue and human engagement prompted me to reconsider my identity as a professional nurse and my role in the lives of other people. I had a glimpse of a possibly different reality to that which was inculcated in me during my professional formation. I saw myself potentially being Friere's (1993) unsuspecting oppressor; one of Young's (1990) well-intentioned people going about the normal processes of everyday life; Memmi's (1990) colonialist, born into privilege and living based on the de-privileging of others. This moment of self-revelation, or *professional de-cloaking*, was terribly painful and caused me to be stripped of that which had defined me for so long. It was a moment of conversion due to an honest encounter with another's reality (Ellacuría, 2013).

I found myself in a situation whereby I had to change and this was to manifest itself in a greater focus on engagement and on learning from the voice of others. It was also to coincide with a very fortunate meeting — a chance encounter with two people who brought me into contact with the project *Transformative Praxis: Malawi* (TPM). This project is grounded in the belief that real change can only come about when people are empowered to be agents in their own lives. It seeks to build agency through social engagement and knowledge-transfer activities, bringing academics, professionals, students and local Malawians together through dialogue and participatory action. The work is grounded in Freire's (1993) ideas but seeks to achieve transformation of dichotomous positions, which have so strongly formed various constructs: colonialist/colonized (Memmi 1990); Global North/Global South (Mignolo 2011); professional/non-professional (Illich 2010); rich/poor (Sobrinho 2008); student/teacher (Freire 1993); Black/White (Fanon 2008). During the first of my now-annual five-week visits to Malawi, I began to notice the same types of positionality that I had previously encountered in my nursing career. In attempted dialogue with people in Malawi, I again became aware of the baggage that is brought to such encounters – baggage that has a determining role in how one sees oneself and how one sees others.

People looked to me to provide them with answers, rather than proffering such themselves for to do so could leave one vulnerable. Interactions appeared to be attempting to maintain a situation, whereby powerlessness and passivity were maintained on the part of the Malawians, thus reaffirming the position that I was perceived to have. Indeed, I also noted a tendency amongst colleagues to not hold any Malawian person accountable for his/her action or inaction. Reminiscent of the historic infantilisation of people with intellectual disabilities (Wilkinson et al. 2015), it was as

if there was no expectation that Malawian adults were, in fact, adults. Of course, if one treats another person as a child, it is unlikely that s/he will act as an adult.

Irrespective of the marginalised, oppressed group under consideration, it appears that the underlying responses remain the same: deviancy-making; marginalisation; congregation; control; violence; isolation; and enforcement of obedience or passivity (figure 2) (Wolfensberger 1972; Young 1990; Memmi 1990). This leads to the *objectivised* and *subjectivised* formation of people who experience inequality and when allied to the outcomes of previously-mentioned formative processes among professionals, the potential for real dialogue and human engagement is markedly reduced.

Figure 2. The process of dehumanization (Wolfensberger 1972; Young 1990; Memmi 1990).

Learning to change

The publication, in September 2015, of a picture of a three-year old Syrian boy, washed up on a beach in Turkey, brought home a reality which had hitherto been distant and disconnected. As such, it led to the possibility for engagement to be initiated as it connected with the emotional sensitivities of many people. Across the world, groups mobilized and sought a meaningful way to respond to what they were becoming aware of. One such response was the organization of an Irish convoy to *Le Jungle*, in Calais. In early October 2015, I travelled to northern France, along with fifty-two others, leading the health team in their efforts to address some of the medical needs of the camp's 4000 residents. Over a five-day period, we treated more than 1200 people for a variety of medical complaints: some population health issues; some injuries caused by prolonged walking or by falls from trucks; physical and emotional scars of torture; and

other injuries inflicted by police. I travelled to Lesbos the following month and returned to Calais almost monthly throughout 2016.

Shortly before visiting Calais for the first time, I had a bizarre experience which brought me face-to-face with the challenges to engagement. It happened during an encounter with an Irish pharmacist who configured the refugee/migrant crisis within stereotypic conceptualizations of Islamophobia, terrorist threats, and economic migrancy. Once she found out that I was travelling to Calais, the pharmacist proceeded to ask my opinions on the refugee/migrant crisis, stating she had heard on the radio that they were infiltrating terrorists, and that they wanted to come to Ireland to *kill us all*. Such perspectives feed into the processes of disengagement and encourage the avoidance of any understanding or acknowledgement of the realities of others. On the other hand, engagement can facilitate humanization and it is within this that knowing of the other's reality can take place. Indeed, this is an important role in nursing: '...nursing facilitates humanization by engaging experiential human beings...' (Willis et al 2008: E34).

As a university lecturer and having engaged actively as an intellectual disability nurse in social education and skills-training with people who experience disability, I have come to understand that *human engagement* is vital if dialogue and change are to take place. I am often drawn to the work of the El Salvadoran theologian, Jon Sobrino, who contends that engagement is central to interpersonal interactions and is found in the dialogic nature of such interactions. Furthermore, he argues that it is in such engagement that knowledge of reality is ascertained (Sobrino, 1988). Sobrino, suggests that liberation from situations of oppression (and power imbalances) involves three main achievements.

The first is that we must be honest about reality and should recognise things *as they actually are*. Such an idea harmonizes closely with Freire's (1993) thoughts on dialogic

engagement for he proposes that true solidarity can only take place when people move away from abstract perspectives and enter into the honest recognition of the other's reality. Thus, when we congregate people under terms such as *intellectually disabled*, *migrants*, *patients* and *nursing professionals* we risk losing sight of the individual human beings. Furthermore, we may ascribe the stereotypic characteristics that are popularly associated with such groupings; the baggage that is often used to pre-conceptualise them in the eyes of others. Removed from such baggage, the knowledge which derives from such an engagement can lead to an uncovering also of the historicity of a person's reality and of one's role in its genesis or maintenance. It also leads to an awareness of the innate humanity of the other person, of what is shared and of the goodness that is in them, irrespective of pre-conceptualisations (Grandin and Barron 2016).

The second achievement is that, once we have come to terms with the reality of another person's situation, we must be faithful to this reality, committing to staying the course with the person, despite the pain that this may bring to us. Achieving a level of honesty about reality is often a painful process, as it calls all partners to a situation of vulnerability and nakedness, which exposes partners' actions and inactions, activity and passivity in bringing about or maintaining that reality. Roles must be recognized; partners must be identified for the persons they are, and not as members of some abstract category; injustice, deprivation of voice, exploitation and lies must be acknowledged; and pious, sentimental and individualistic gestures must be discontinued (Freire 1993). The call for justice arises from this and further demands action *in solidarity* and *in participation* with the other (Sheerin 2011). It is clear, though, that those who stand with oppressed people often find themselves entering into their reality and experiencing the pain and abuses that they have been subject to (Front

Line Defenders 2013). During my travels to Calais and Lesbos, I was privileged to be allowed to engage in relationships with people who have experienced trauma, personal/material loss, dehumanization and who sought the opportunity to reclaim their humanity in Europe. Through such engagements, I became sensitised to the pain of these individuals to the extent that it was impossible not to continue alongside them in their plight. I felt the need to remain faithful to the reality that I had been privy to. To disengage would be, I thought, hypocritical and unfaithful.

The third of Sobrino's achievements, demands that we must be open to being 'swept along' by the possibilities that faithfulness to reality brings. An inherent consequence of being faithful to the reality is that one will be open to the possibility of extending one's actions of justice to others. It is also in keeping with a growing personal conviction, that a world of social justice and humanization is achievable but only if people who share in a vision of this alternate reality, work together to make it happen (Ellacuria 2013; Freire 1993). This is the possibility that can be strived for.

Implications for Professional Nursing

As I reflect on the above experiences, it has become clear to me that dialogic engagement with others, whereby knowledge and realities of others are shared, is fundamental if nurses are to meet the needs of their clients and patients, particularly those who experience marginalisation and disempowerment. However, the informality that is implied in such engagement requires that we move away from titles and constructions of power and divest ourselves of positions that create distance between us and our fellow human beings. Rather than confining ourselves to professional roles of service (figure 3), in which we are tasked to enter the margin of inequality, addressing issues using 'special' approaches and then exiting back into the valued world, we are challenged to enter instead into engagement as humans, as citizens of diversity, ready

to work alongside our fellow humans both within and *towards* the dissolution of the margin. We are also challenged to work towards removal of the inequity which exists in the broader society, and upon which exclusion/oppression is predicated (figure 4).

Figure 3: The current professional mode of action (Sheerin 2011a)

Figure 4: An alternative approach to action (Sheerin 2011a)

This requires that we become aware of the gap that has been created and which is maintained in ways that we are often not conscious of. By doing so, we have the chance of throwing off the things that maintain distance and of coming into solidarity with our fellow humans, open to the possibility of reaching a situation of knowing the other (*solidarity*) and of attaining a point where the *praxis* of dialogic human engagement is really possible (figure 5).

This is hard, though, as it is easier for us to maintain the *status quo*: it is easy for me to be the professional and for you to be the client; for me to give and for you to take; for me to be an actor and for you to be an object; for me to be an adult and you to be the child; for me to be powerful and for you to be powerless.

Figure 5: From solidarity (knowing) to action.

As a nurse working with people who experience intellectual disability, this has significant implications. Despite recent advances in service provision, much of their

experience is grounded in the societal valuing of cognition and competence which define the mainstreams of education and work, a situation which, by its very nature, excludes and marginalises. It is also linked to the continuing ‘entrenched stereotypical beliefs and negative attitudes towards’ them (Lunsky et al. 2009: 170). Furthermore, an increased focus on risk has fueled concerns regarding vulnerability (Parliament of the United Kingdom 2006; Government of Ireland 2012), with this pre-configuring many supposedly-naturalistic relationships. Thus, the educational, occupational and social domains of life are fraught for people who experience intellectual disability and the issues are so embedded in mainstream societal structures and mindsets. Human engagement compels me, as a nurse, to work, not only within the confines of service setting, but also to work alongside my clients, as fellow human beings, towards redressing the social inequity upon which their experience of disability is based (Sheerin, 2011).

It may seem to some that there is not much that can be done. Change such as this is utopian in nature and, for many, may seem to be unachievable. If that is the case, then I believe that there can be no hope. I prefer, however, to side on the part of hope and to believe that fundamental change can take place. Indeed, it *must* take place, for we, as health and social care professionals, surely have at our core, a desire to effect positive change in the lives of those to whom we provide service. In the situation of human engagement, that can alter history (Ellacuriá, 1989).

References

- Apesoa-Varano, E.C. (2007) Educated caring: the emergence of professional identity among nurses. *Qualitative Sociology*. 30, 249-274.
- Beauchamp, C. and Thomas, L. (2009) Understanding teacher identity: an overview of issues in the literature and implications for teacher education. *Cambridge Journal of Education*. 39(2), 175-189.
- Bukor, E. (2015) Exploring teacher identity from a holistic perspective: reconstructing and reconnecting personal and professional selves. *Teachers and Teaching: theory and practice*. 21(3), 305-327.
- Congregation for the Clergy (2016) *The Gift of the Priestly Vocation*. Vatican City: L'Osservatore Romano.
- Ellacuriá, I. (1989) Los últimos escritos: El desafío de las mayorías populares. *Estudios Centroamericanos*. 493-494: 1078.
- Ellacuriá, I. (2013) 'Monseñor Romero: One Sent by God to Save His People'. In: M. Lee (Ed.) *Ignacio Ellacuriá: Essays on History, Liberation, and Salvation*. Maryknoll: Orbis Books. 285-292.
- Fanon, F. (2008) *Black Skin White Masks*. London: Pluto Press.
- Friedson, E. (1986) *Professional Powers*. Chicago: The University of Chicago Press.
- Freire, P. (1993) *Pedagogy of the Oppressed*. London: Penguin Books.
- Front Line Defenders. (2013) *Global Trends in 2013 for Human Rights Defenders*. Dublin: Front Line.
- Government of Ireland (2012) *Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012*. Dublin: The Stationery Office.
- Grandin, T. and Barron, S. (2016) *Unwritten Rules of Social Relationships*. Arlington, Texas: Future Horizons Inc.
- Illich, I. (1985) *Tools for Conviviality*. London: Marion Boyars.
- Illich, I. (2010) *Disabling Professions*. London: Marion Boyars Publishers.
- Lunsky, Y., Federoff, P., Klassen, K., Gracey, C., Havercamp, S., Federoff, B. and Lennix, N. (2009) 'Medical rights for people with intellectual disabilities'. In: F. Owen and D. Griffiths. *Challenges to the Human Rights of People with Intellectual Disabilities*. London: Jessica Kingsley Publishers. 155-183.
- Memmi, A. (1990) *The Colonizer and the Colonized*, London: Earthscan Publications.
- Mignolo, W.D. (2011) The Global South and world dis/order. *Journal of Anthropological Research*. 67(2), 165-188.
- Newman, M.A., Smith, M.C., Dexheimer Pharris, M. and Jones, D. (2008) The focus of the discipline revisited. *Advances in Nursing Science*. 31(1), E16-E27.
- Parliament of the United Kingdom (2006) *Safeguarding Vulnerable Groups Act 2006*. London: HMSO.
- Sheerin, F. (2008) Diagnoses and interventions pertinent to intellectual disability nursing. *International Journal of Nursing Terminologies and Classifications*. 19(4), 140-149.
- Sheerin, F. (2011) The nurse's role as specialist practitioner and social activist. *Learning Disability Practice*. 14(10), 31-37.
- Sheerin, F. (2011a) Intellectual disability nursing: responding to health inequity. *British Journal of Intellectual Disabilities*. 40, 266-271.
- Sheerin, F. (2012) *Describing Intellectual Disability Nursing*. Saarbrücken, Germany: LAP Lambert Academic Publishing.

- Sheerin, F. (2013) Jesus and the Portrayal of People with Disabilities in the Scriptures. *Spiritan Horizons*. 8, 63-71.
- Sheerin, F., Griffiths, C., de Vries, J. and Keenan, P. An evaluation of a community living initiative in Ireland. *Journal of Intellectual Disabilities*. 19(3), 266-281.
- Sobrinho, J. (1988) *Spirituality of Liberation*. Maryknoll: Orbis Books, 1988.
- Sobrinho, J. (2008) *The Eye of the Needle: No Salvation Outside the Poor*. London: Darton, Longman and Todd.
- ten Hoeve, Y., Jansen, G. and Roodbol, P. (2013) The nursing profession: public image, self-concept and professional identity. A discussion paper. *Journal of Advanced Nursing*. 70(2), 295-309.
- Trent, J. (2016) *Inventing the Feeble Mind: A History of Intellectual Disability in the United States*. Oxford: Oxford University Press.
- Wilkinson, V.J., Theodore, K. and Raczka, R. (2015) 'As normal as possible': Sexual identity development in people with intellectual disabilities transitioning to adulthood. *Sexuality and Disability*. 33, 95-105.
- Willis, D.G., Grace, P.J. and Roy, C. (2008) A central unifying focus for the discipline: facilitating humanization, meaning, choice, quality of life, and healing in living and dying. *Advances in Nursing Science*. 31(1), E28-E40.
- Wolfensberger, W. (1972) *Normalization: The Principle of Normalization in Human Services*. Toronto: NIMR.
- Young, I. (1990) 'Five Faces of Oppression'. From *Justice and the Politics of Difference*. Princeton: Princeton University Press. 39-65.