

## Community, culture and character: the place of the virtues in psychiatric nursing practice

A. McKIE<sup>1</sup> MA RGN RMN Dip nurs (London) PGCLT & J. SWINTON<sup>2</sup> PhD BD RMN RNMH

<sup>1</sup>Lecturer in Nursing, School of Nursing and Midwifery, Faculty of Health and Social Care, The Robert Gordon University, Hilton Campus, Hilton Place, Aberdeen, AB24 4TP, <sup>2</sup>Lecturer in Practical Theology, Department of Divinity with, Religious Studies, Kings' College, University of Aberdeen, Aberdeen, AB24 3UB, UK

Correspondence:  
Andrew McKie  
School of Nursing  
and Midwifery  
Faculty of Health and  
Social Care  
The Robert Gordon  
University  
Hilton Campus  
Hilton Place  
Aberdeen AB24 4TP  
UK

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### Community, culture and character: the place of the virtues in psychiatric nursing practice

In this paper, the authors address the serious neglect of the 'classical' virtues in ethical reflection upon mental health nursing. The virtues are offered as a possible alternative paradigm for mental health nursing in its search for new models and approaches. Embodied in the notion of a moral community, the virtues have important implications in addressing problems adherent in various 'dualisms' so described. By invoking the concepts of practical wisdom and praxis, the interrelationship between theory and practice, action and reflection and self and community, is shown. The contextual nature of the virtues is shown in a number of examples and their potential for the transformation of practice is shown. The opportunity is now present for mental health nursing to strengthen its basis for practice by distancing itself from scientific models. In so doing, it can embrace an approach which is consensual and contextual and which places ethical reflection at the centre of practice.

*Keywords:* character, community, context, practical wisdom, praxis, virtues

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### Introduction: the significance of the virtues for mental health care

This paper seeks to explore the role of virtue ethics within contemporary psychiatric nursing practice. Recent commentaries on nursing have been strangely silent with regard to the place of the character traits known classically as the virtues (hereafter referred to as 'the virtues'). 'Virtue ethics' is ethical reflection having the virtues central to its work. Whilst the general area of ethics and the importance of ethical reflection remains high on the mental health agenda (Barker & Davidson 1998; Kentsmith *et al.* 1986), the tendency is to remain rooted in the Kantian quest for universal principles that are applicable to all people at all times.

According to such an outlook, ethics are worked out primarily within the context of *dilemmas*. From this perspec-

tive, ethics is something that is done apart from the normal day-to-day practice of caring; a specific reflective skill is brought into play when the mental health nurse is faced with a dilemma about which she has to make a specific decision regarding the appropriate way to proceed within a given situation.

However, whilst Kant's deontological approach and categorical imperative may function very well in principle, in practice the actual care a patient will receive is always limited by the character of the mental health professionals seeking to offer care. Michael Stocker (1976) captures this inadequacy in Kantian theory in the following example:

'now suppose you are in a hospital, recovering from a long illness . . . you are very bored and restless and at loose ends when Smith comes in once again. But . . . the more you two speak, the more it becomes clear

that . . . it is not essentially because of you that he came to see you, not because you are friends, but because he thought it his duty . . . surely there is something lacking here – and lacking in moral merit or value.’ (Stocker 1976, p. 462)

Stocker here correctly identifies a missing element in Kantian moral theory. A Kantian emphasis on impartiality subordinates an ethic of virtue to a deontological maxim of duty. An ethic that focuses primarily on dilemmas, individual autonomy and abstracted principles, to the exclusion of character and the significance of community, will inevitably fall short of truly person centred care. It is not enough for nurses simply to attempt to practice ethically by adhering to a set of principles or obligations which somehow function apart from the character of the nurse or the particular needs of the patient. Rather, general principles need to be supplemented and clarified by an ethic of virtue. Such an ethic takes seriously the moral position of the nurse and the importance of understanding nursing as providing a ‘moral community’ that will nurture and sustain virtues appropriate for effective practice of mental health care.

One recent exception to the general trend has been the work of Cash (1998). In discussing the status of tradition and practice, Cash argues that nursing theory, by looking for ‘other dominant epistemologies’, has been leading nursing in the wrong direction. Cash calls for a debate ‘about the virtues of nursing’. This paper aims to build upon Cash’s proposition about the importance of the virtues for mental health nursing.

## Aristotle on the virtues

Whilst they may not command a great deal of attention within contemporary mental health ethics, within the overall history of ethical development the virtues have held a prominent place. Unlike deontological approaches that seek to show what person should *do*, Hauerwas (1981) observes that in previous times

‘ethics grew from consideration of what individuals should *be*; armed with answers, the ancients then turned to prescriptive modes’. (Hauerwas 1981, p. 111, emphasis added)

This is an important distinction that highlights clearly the unique perspective offered by virtue ethics. In order to draw out the implications of this, it will be helpful briefly to explore the thinking of Aristotle, whose writings on the virtues have been crucial to the debate.

In the *Nichomachean Ethics* (Aristotle 1963), Aristotle described virtue as a state of excellence (*arete*) or disposition whose aim is the highest Good (*eudaimonia*). In essence, for Aristotle, the term ‘virtue’ meant ‘that which

causes a thing to perform its function well’. ‘*Arete*’ was an excellence of any kind that denotes the power of anything to fulfil its function. Thus, the virtue of the eye is seeing, the virtue of the knife is its cutting edge, the virtue of a horse is running, and so forth. As a moral category, the virtues are dispositions that form passions and/or create habits. Human virtue is that which causes us to fulfil our function in a way that is appropriate to our status as human beings. For the mental health nurse, virtue is that which causes her effectively to fulfil her function within that particular role (Brody 1988).

Thus, such virtues as love, wisdom, commitment, justice, compassion, hope and faith may be considered particular virtues that cause a mental health nurse to function well within her role. Such virtues help to develop the type of character that will enable her to make appropriate decisions on a daily basis (Lutzen & Barbosa 1996).

Whilst emphasizing the essential unity of the virtues, Aristotle did distinguish between *moral and intellectual* virtues. The former included qualities of character (courage, temperance, patience, truthfulness and care) and were acquired by exercise of habit. The latter, divided into art or technical skill (*techne*), scientific knowledge (*episteme*), practical wisdom (*phronesis*), intelligence (*nous*) and wisdom (*sophia*), were best acquired by instruction.

The Aristotelian intellectual virtues suggest a model of practice that binds together theory, practice and ethical reflection. Closely connected to *phronesis*, is the concept of *praxis*. Praxis is practical knowledge-in-action. It is the reflective practice of a specific community as it seeks to work out the essence of right living and correct practice. Such *praxis* is both *transformatory* of practice and *revelatory* of hidden meanings that underlie practice. Graham (1996, p.99) observes that human

‘practice is never a set of technical procedures, nor the exercise of instinctive action. . . . Even if one is acting *in isolation*, one’s practice is governed by rules and systems of meaning which have been historically formed.’ (emphasis added)

Aristotle further contrasted the form of knowing underlying *praxis* with another form of knowledge, namely *theoria*. This describes what we commonly understand as theory. Neither opposites, nor derivative of each other, *theoria and praxis* are complementary, but distinct, forms of knowing animated by different interests and contexts and employing different methods. (Fowler 1987) *Praxis* is not a substitute for theoretical knowledge, but is a complementary form of knowledge required for true and faithful living.

*Praxis*, then, is action saturated with meaning/theory. In reflecting upon one’s *praxis*, one gains considerable knowledge about the true nature and intention of that specific

practice. Such a position challenges the domain of rational, 'scientific' knowledge in its elevation of theory to a position above *praxis*.

Similarly, in ethics such a stance challenges the prioritization of external (theoretical) universal codes over responses that may be quite specific to particular situations and contexts. (Glen 1999, Lutzen 1997)

## The concept of community

As a way of ordering human affairs, the idea of community is wide ranging and diffuse. According to Peters & Marshall (1996), community serves, *inter alia*, 'effectively ... as ideology'. Ignatieff (1984) goes further and questions its continuing relevance for current social policy analysis. Clearly, as a concept, 'community' is open to distortion and manipulation. For current purposes, we shall use a simple definition of community as:

'the face-to-face close comfort of regular personal contact with valued others'. (Parker 1999, p. 41)

Such a definition applies to nurse-patient, as well as nurse-nurse, relationships and allows us to begin to grasp the significance and meaning of community for mental health nursing and its caring intentions.

The Aristotelian practice of the virtues, in pursuit of the good, presupposed the existence of some form of community. (Aristotle 1963, p. 64)

It is within the community that we learn the virtues and come to understand the gestures that make for a good life. More than that, it is in the community that we discover who we are as individuals. Contrary to Enlightenment assumptions, a person 'acts' (not merely 'thinks') and, in so doing, acts towards, and is acted upon, by others. Personhood is not constituted individually, as our Cartesian heritage might affirm. Rather, personhood is the product of our relations with one another. (MacMurray 1949) We only become the people we are, in and through, those whom we encounter. The idea of an isolated individual is a fallacy. Human beings are by nature persons-in-relation (MacMurray 1991). In addition, chief characteristics of this relationship are mutual respect and affection.

All of this moves us towards a very important conclusion: *the emphasis upon* community gives ethical reflection its own specific social and moral tradition. The virtues cannot be understood as 'free-floating', universal principles standing above, below or beyond history in the way suggested by Kantian moral law. The virtues, as forms of practice, are products of *particular* moral communities. Context, alongside the virtues themselves, is a crucial consideration.

One of the central features of the virtues is its challenge to rationalistic dichotomies (e.g. theory-practice or action-

reflection) in whatever forms they appear. In the community, there is an intimate connection between theory and practice, action and reflection and the self and the community. The Aristotelian unity of the virtues challenges the enlightenment notion of autonomy in the areas of knowledge, practice and ethics.

## Nursing as a moral community

The virtues are thus seen to be the product of context-specific, historical moral communities. The question is: *in what ways can mental health nursing be seen as a moral community?* What could bind mental health nurses together and enable them to become a therapeutic context for the development of the Virtues?

One approach is through the perspective of *tradition*. By 'tradition' we do not mean 'traditionalism'. By using the term 'tradition' we seek to recognize the disparate influences, past and present, which impinge upon, and help to shape, a particular practice or set of practices within a specific community.

MacIntyre (1984, p.222) defines tradition as a:

'historically extended socially embodied argument, and an argument precisely about the goods that constitute that tradition'.

According to Cash (1998), traditions are practices which are bounded, legitimate and bear important legal implications. Within one practice multiple traditions can exist, and compete, with each other. Traditions thus form powerful epistemological frameworks that profoundly affect the forms of practice that arise within each moral community.

What features of identity and tradition apply to the moral community of psychiatric nursing? The history of psychiatric nursing reveals a series of changing paradigms and shifting traditions. These include the influence of disease models of treatment (Horsfall 1997), psychoanalytic perspectives (Tryer and Steinberg 1998), humanistic psychological theories (Pavis *et al.* 1998) and, particularly recently, an 'economic paradigm' which provides an overall context and primary source of legitimation for many other traditions (Hewitson & Wildman 1996).

In addition, we have already highlighted the dominance of the rational deontological approach to ethics that has had a deep impact on the process of ethical reflection within psychiatric nursing. Whilst providing a rich and potentially valuable moral tradition, it is arguable that such disparate influences have fragmented the nursing community and weakened psychiatric nursing's collective identity (Fulford & Hope 1994, Cash 1998).

## Rediscovering virtue: the praxis of psychiatric nursing

Nevertheless, despite the confusion and diversity, it is possible to identify certain themes that mark out psychiatric nursing as a specific form of community within a particular tradition impinging upon its practice. We will highlight four such themes here and draw out their implications for the practice of virtuous psychiatric nursing. Each of these themes correlates with a particular virtue or virtues that are potentially beneficial for the nursing process: the four themes and corresponding virtues are presented in Fig. 1 below. Each theme will be addressed in turn.

### Care

The concept of ‘care’ is both a theme and a virtue in itself. Heidegger (cited in Patton 1993, p. 17) argues that care is: ‘basic constitutive phenomenon of human existence, and the clue to its interpretation . . . Care is what makes the human being human. If we do not care, we lose our humanity.’

Care is thus seen to be a fundamental human concern and, as such, basic to a psychiatric nursing practice possessing a primary objective in offering effective and authentic mental health care. As such, it is an indispensable theme running through all of the nursing paradigms.

That care needs to be *authentic* (and not merely *effective*) takes us into the realms of the virtues. Care is also a virtue that springs from, and guides, all forms of authentic nursing practice. Tillich (as cited in Patton 1993) describes care not simply as something we *do*, but as ‘an unconscious expression of who we are’. We do not simply care because it is our duty. Authentic care is an expression of one’s character: that is, it reveals the nature of one’s being. According to Blustein (1991), the word care can mean:

- 1 to care *for* (liking);
- 2 to have *care of* (responsibility);
- 3 to care *about* (a person who cares about something is, as it were, invested in it), and
- 4 to care *that*.

The detached, professional model of nursing might find its focus in point 2, with no necessity to consider points 1, 3 or 4. Within such a context, ethics would be worked out according to dislocated principles which may be legally and professionally correct, rather than what might bring about the greatest moral good for the client. In distinction, an ethic of virtue takes full cognisance of the range of meanings incorporated within the concept of care, and seeks to work out both theory and practice accordingly. Importantly, the psychiatric nurse who focuses on an ethic of character will not be afraid of a genuine involvement with patients. Such involvement is central to the idea of authentic care. Mayeroff (1971) puts this point thus:

‘In caring for someone one experiences the person as an extension of oneself, yet still as something separate from oneself that can be respected in its own right. . . . The union with the other differs from that found in a parasitic relationship. Instead of trying to dominate and possess the other, I want it to grow in its own right, or, as we sometimes say, to ‘be itself’, and I feel the others growth as bound up with my own sense of well-being. The worth I experience in the other is something over and above any value it may have for me because of its ability to satisfy my own needs.’

Thus, at the centre of the process of authentic care lies a genuine sense of commitment, connection, personal relationship and community, all of which, it has been argued, are vital for virtuous practice. Care, then, is a virtue and provides a central nursing theme that forms the basis for the development of other important virtues such as faithfulness, patience and kindness. As such, it provides an important context for the practice of the virtues.

Theme drawn from psychiatric nursing tradition	Corresponding virtue
Care	Care
Personal Relationships	Friendship, Trust, Honesty, Faithfulness, Commitment
Alleviating Suffering	Hope, Courage, Patience, Justice
The complexity of the Human	Respect, Insight, Empathy

Figure 1

## An emphasis on the centrality of personal relationships for the process of caring

Psychiatric nursing is a profession that finds its primary purpose in the development, restoration and maintenance of meaningful personal relationships. Whether one adopts a psychoanalytic, humanistic, behaviorist or biological model of nursing, the objective remains the same, either implicitly or explicitly: *to enable individuals to gain and maintain personal relationships*. Whilst the primary model upon which practice is based tends to be the distanced professional relationships, a concentration upon the virtues allows psychiatric nurses to diversify into other important areas of the relationships. A good example of this diversification would be the incorporation of the relationship of *friendship* into standard nursing practice.

### Friendship

For Aristotle, friendship was the fundamental human relationship upon which community was built. (Aristotle 1963) For MacMurray (1949), friendship between two people was the essence of community. Such a relationship is a “unity of persons as persons” (MacMurray 1949) which cannot be reduced to function or purpose. For both Aristotle and MacMurray, equality and freedom were the central and essential features of friendship. As such, this relationship stands in stark distinction from any conception of the mental health professional as necessarily distanced and decontextualized. The virtue of friendship, in its committed and subjective elements, allows the nurse to move into areas of relational development and therapeutic possibility. Such areas are closed in forms of relationship which demand objectivity and professional distance. (Davies 1995)

What features of friendship might apply to the nurse-patient relationship in mental health? At one level, an emphasis on friendship allows for the development of a ‘conversational’ model of care in which overtly therapeutic dimensions are necessary, but not sufficient for, effective holistic care. This allows the nurse to incorporate everyday themes as they freely arise between nurse and patient, thus enabling the primary focus to remain on the patient as a *person*, rather than the patient as a *problem*.

The ‘exclusive’ aspect of friendship can also enhance the person-to-person aspect of the therapeutic relationship. By addressing a client by name we are seeing them primarily as a person and not in terms of a diagnostic label. In this way, nurse and patient are literally ‘called’ into dialogue. (Taylor 1989) The implication for care when the opposite is shown is starkly revealed by Sayers (1990), in the novel

*The Comforts of Madness*, where it was a matter of indifference whether a client’s name was used or remembered. Reflection on the virtue of friendship allows the nurse to recognize that some nursing interactions, such as ‘befriending’, may not be ‘about’ anything in particular, but still be viewed as important and crucial. Such reflection on the alchemy of some nurse-patient relationships also reveals the freedom aspect of friendship. One particular nurse-patient relationship ‘works’ whilst another does not. Such insights show the limitations of any rigid application of primary nursing or ‘key worker’ systems to the delivery of care.

Nevertheless, several aspects of the virtue of friendship require qualification when applied to mental health nursing. What notions of equality and freedom apply, for example, to a person with a severe schizophrenic disturbance? Often there is no direct point of contact between the carer and the cared-for. In a very real sense, nurse and patient inhabit different worlds. Friendships based on likeness and common interest are unlikely to succeed if there are such fundamental communicational and epistemological divides between the two participants. What is needed is a form of friendship that moves beyond likeness and common interest to offer solidarity and comfort in the midst of confusion.

McFague (1988) uses the expression ‘solidarity-friendship’, a form of relating which says ‘we are not our own’, but it also says, ‘we are not on our own’. Many persons within psychiatric hospitals feel that they ‘do not belong to themselves’. This is, in part, the result of certain forms of mental illness. But it can also be a result of an ensuing sense of dispossession, disempowerment and consequent lack of confidence and self esteem. The virtue of friendship, interpreted as ‘solidarity-with-the-sufferer’, transcends the limitations of conceptualizations such as those of Aristotle and MacMurray, that demand commonalities which are often unavailable within the context of psychotic illness. Such friendships take the principle of ‘caring solidarity’ as a fundamental defining criterion for authentic care, and seeks to relate personally and meaningfully even with individuals with whom one might appear to have little in common.

If, as Ritter (1997) suggests, one purpose of psychiatric nursing is the ‘management of ambiguity’ internally (between patient and their condition) and externally (with services and agencies), then friendship opens up the possibility of the nurse embodying a form of healing, and an understanding of mental health, which moves beyond the medical model to a place where hope and meaning are offered in the midst of suffering. By reflecting on the rich tradition and nature of friendship within the context of psychiatric nursing praxis, a new and revitalized concept

of friendship will arise with potential to transform current praxis.

### Trust, honesty, faithfulness and commitment

Intimately connected with the virtue of friendship are the virtues of *trust, honesty faithfulness and commitment*. To trust someone is to live as though one can fully depend on the other irrespective of circumstance, context or any other intervening factor. As Hauerwas (1977, p. 110) puts it:

‘trust, like all aspects of human culture, is a luxurious skin stretched over the taut bones of survival’.

Inextricably connected with the virtue of trust are the virtues of honesty and faithfulness. If we think, for example, of the care of a suicidal patient, the relevance of these virtues for practice will become clear. Lutzen & Barbosa (1996, p. 207) offer the following description of a depressed female patient telephoning from home:

‘She didn’t directly say she wanted to kill herself and didn’t want me to call her doctor, even when I asked her. There was conflict for me. I felt that she trusted me; it had taken a long time to build up a good relationship with her. What should I do? My choice was either to call the doctor anyway – which would probably mean sending out the police – or waiting until the next day. I couldn’t go behind her back, she would never have trusted me again. What I decided to do was *to tell her of my dilemma*, be firm but kind and tell her that I was going to tell the doctor. In the end she agreed to this and eventually was brought in by a relative.’ (emphasis added)

A deontological ethic may have guided the nurse simply to call the doctor in order that she might have been seen effectively to fulfil her duty. However, within this particular scenario the nurse approached the situation virtuously, drawing upon her character as an honest and trustworthy person genuinely seeking to offer authentic care to her patient. By being honest with her client and expressing her desire to care by sharing her proposed actions with the client, the nurse managed to maintain the vital bond of trust. Although the client may not necessarily have agreed with her decision, the possibility of them retaining an open and meaningful relationship was maintained.

In approaching this situation in such a manner, the nurse also actualized the virtue of faithfulness. It is clear that the virtues point *beyond* the fiduciary (public confidence) responsibility of mental health nurses to care for their clients. Hauerwas (1981, p.114) states it this way:

‘we ought to be people who can be trusted because we are faithful. And who would trust persons who think their moral responsibility reaches no further than *fulfilling duties?*’ (emphasis added)

In striving not only to save the woman’s life, but also to maintain the integrity of the relationship, the nurse revealed a level of faithfulness that transcended ‘mere duty’ and, in so doing, helped engender hope and new possibilities for her client.

To demonstrate the virtue of *commitment*, Cash (1998) utilizes care within the context of nursing people suffering from AIDS. Issues of personal risk and commitment given, over extended time periods, are highlighted. In a similar way, mental health nurses care for a group of clients who, because of their condition, are largely marginalized from, and stigmatized by, society at large (Brunton 1997).

This may resurrect the concept of vocation or ‘calling’ as a valid feature of a moral community. Reservations to this concept notwithstanding (Lutzen and Barbosa 1996), a sense of ‘calling’ can illustrate the committed and ‘other-regarding’ nature of much of the care carried out by mental health nurses.

### The desire to alleviate suffering through effective therapeutic intervention

The desire to alleviate suffering is a common theme underlying all nursing practice. Within that context, the virtues of *hope, courage, patience and justice* spring to the fore as important aspects of the caring process. In one sense, all therapeutic interventions, particularly in the face of interminable mental illness, is designed to instil and inspire these important virtues.

### Patience and hope

There is convincing evidence to suggest that hope and courage are instrumental in recovery from, and coping with, long term mental illness such as schizophrenia.

(Kirkpatrick *et al.* 1995) There is also evidence to suggest that the presence of these virtues within these carers inspires, and is inspired by, the hope and courage of those to whom care is offered (Byrne *et al.* 1994). Likewise, the virtues of patience and hope can be demonstrated in the care of a patient with lowered mood state. By practising patience and exercising hope, the nurse can offer to the patient the prospect, although not the certainty, of recovery. By looking beyond the present (and the past), but not denying their pressing and painful claims and conditions, the nurse can obviate criticism and despair in the mind of the patient, as well in themselves. Hope is future orientated (Hauerwas 1977). In this way, the virtues of patience and hope can transform a nurse-patient relationship by providing a sense of shared meaning and renewed purpose.

## Courage

The virtue of courage can be revealed in the care of vulnerable clients. An instance of this is the care of a suicidal person. In responding to the revealed (and hidden) unpredictabilities and ambiguities of a person actively intent on taking their own life, the mental health nurse may, on occasion, have to act in ways that might be termed 'courageous'. This is a complex aspect of the prevention of suicide and runs counter to commonly accepted notions of individual autonomy. (Fairbairn 1995) However, the application of this virtue within the context of the moral community suggests that there are areas for mental health nursing practice where *limitations* to a client's autonomy are, for certain periods, demanded.

## Justice

The virtue of justice can be demonstrated by a community psychiatric nurse's efforts in securing greater community resources for clients. In the area of mental health promotion, recognition of social, economic and political factors is considered fundamental (Pavis *et al.* 1998). The influence of justice can assist in identifying causal factors in mental health. Engagement in common cause with others in promoting issues conducive to mental health can be part of the transformation of clients' lives.

## The understanding of human beings as complex creatures

From Freud and Jung, we have discovered the complexities of the human mind. From Bowlby and his followers, we have discovered something of the complexity of human relationships. Contemporary biological and genetic research into the etiology of mental illness has revealed another level of complexity to the human condition. In the light of this, central nursing concepts such as the virtues of *respect, insight and empathy* are seen to be indispensable aspects of virtuous experience.

## Conclusion

We have argued that virtue ethics is a viable model for psychiatric nursing in its search for new paradigms and frameworks. As psychiatry sheds its institutional skin but not, arguably, its dependence on scientific models of diagnosis and treatment, psychiatric nursing has an opportunity to stake a claim for its own moral legitimacy, knowledge base and practice (Ritter 1997). By loosening its adherence to objectifying models of practice and acknowledging the influence of organizational factors on

practice (Ryan 1997), psychiatric nursing can begin to explore other paths.

The moral community, with its emphasis on the demonstration of the virtues in specific contexts, makes use of ethics which are personal, relational and shared. Such an approach offers potentially transformative results for practitioners and clients alike. Virtue ethics plots a *via media* between, on the one hand, the application of external and universal codes and, on the other, a diffuse approach which makes the *search* for guidelines the prime motive directing understanding in this area. (Barker & Davidson 1998)

An ethic of virtue would suggest that mental health care ethics should not focus purely on the seeking of rules to govern particular actions. Particular actions are so variable that they require a good deal of judgment, or *discernment*, rather than inflexible rules. An ethic of virtue asks what kind of character a mental health nurse should develop in order to become the kind of person who will discern well in these variable situations. Rather than beginning with the question of what the mental health nurse should *do* in particular situations, virtue ethics asks the question 'what type of person must the mental health nurse *be* in order to make correct decisions?'

Importantly, virtues are learnt skills. Aristotle argues that it is possible to teach the virtues through a system of mentorship. In this way, the kind of embodied theory (praxis) which is necessary for this type of ethical approach can be learnt and passed on. This has obvious implications for the ways in which ethics is taught within the mental health professions, and the ways in which we might constructively utilize the vital insights virtue ethics offers to nurse education and practice (Sellman 1997).

There are, of course, difficulties with the virtues. The problem of identifying a tradition within psychiatric nursing as the primary moral context for the virtues has already been discussed. A common tradition needs to be found if the real danger of ethical relativism is to be avoided. Another problem is the absence of behavior grounded in virtue opening up the possibility of abuse and self centred decision making ('I am good . . . therefore . . .'). However, the thematic approach of this paper offers one way of addressing such theoretical and ethical diversity.

The practice of the virtues might also be considered problematic. It is possible, for example, that the development of the relationship of friendship opens up the possibility of over involvement and the danger of losing important aspects of critical distance. These are vital concerns and must be addressed. However, whilst the emphasis of this paper has been redressing the balance away from objective methods of ethical reflection and nursing practice, it is not necessary to take an '*either/or*' approach.

Rather, we should explore the relationship between an ethic of distance and principle and an involved embodied ethic of virtue from the perspective of 'both/and'. A constructive dialogue between deontology and virtue is required in order that effective and authentic forms of ethical practice can emerge from the continuing dialectic between these two important strands of ethical thinking. It is the hope of these authors that this paper will at least open up the debate and enable us to explore what truly holistic and authentic ethical praxis might look like.

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