The 'un-doing' and 're-doing' of nurses' derealisation: Exploring the effects of the heroic keyworker discourses during the COVID-19 pandemic

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Abstract

Using, and extending, Butler's theory of recognition and censorship, this article examines the way in which nurses' subject positions were regulated in the transformative liminality of the COVID-19 pandemic, where normal matrices of power were 'undone' and new ones formed. During the pandemic, societal discourses regarding nurses shifted from treating them as less-

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than-human and their care-work invisible and unrecognised (derealised), to an elevated position where they became appreciated and treated as heroes, then reverting to a derealised state. As part of the building of subjectivities in this liminal period, nurses constructed boundaries against 'unmoral' others, either members of the public, or other nurses. This article highlights how the 'derealisation' by powerful discourses compels nurses into ongoing and ambivalent negotiations with self and others as they struggle to be recognised for the risky edgework they performed with lasting consequences for the nursing profession.

1. Introduction

There is a widespread literature which details the psychological ill-health or wellbeing of nurses in the UK (e.g. Kinman et al., 2020; West et al., 2020). This article conceptualises wellbeing as a state 'in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community' (HEE, 2019: 9). Nurses in the UK have been shown to be at greater risk than the rest of the UK population from work-related stress, burnout and mental health problems such as depression and anxiety (Kinman et al., 2020), a consequence of a cocktail of unmanageable work demands and limited autonomy (Christodoulou-Fella et al., 2017; WHO, 2006; 2021). Nursing work can be conceptualised as edgework, involving 'a clearly observable threat to one's physical or mental well-being or one's sense of an ordered existence' (Lyng, 1990, p. 857). The concept of edgework has been associated with 'extreme work' cultures and patterns (Ward et al., 2020) and as such seems highly applicable in the UK and in an arguably global (nursing work) context.

From the origins of the profession, nursing stereotypes both in public and healthcare organisational discourses, emphasised innate caring alongside a self-sacrificing and altruistic nature assumed to result from the gendered nature of nursing work (Boulton et al., 2021). Care work has been positioned as intrinsic to the nursing profession by many theorists (Boulton et al., 2021; Traynor, 2017) with nurses expected to remain calm and compassionate even in the most difficult of circumstances. The authenticity of the emotions nurses display has been questioned with some, such as Hochschild (2013), theorising that many workers, nurses included, undertake emotion work either by surface or deep acting their care and compassion. However, this conceptualisation has been problematised with others such as Tracy and Trethewey (2005) persuasively arguing against the real-self/fake-self dichotomy. Nursing can generally be argued to have extreme edgework type conditions, including long shifts and a culture of invulnerability, which is characterised by a 'put up and shut up' culture, where raising concerns, whistleblowing, or not being compassionate or resilient enough, are viewed as individual failings (Traynor, 2017; Conolly et al., 2022; Maben et al., 2022).

Prior to COVID-19, nursing work could be considered to be edgework, but with the advent of the COVID-19 pandemic this became irrefutable, with nurses facing unprecedented working conditions. These included the threat of an unknown virus, shortages of personal protective equipment (PPE), reduced numbers of, or no, breaks and redeployment to unknown settings with minimal training opportunities (Maben et al., 2022; Couper et al., 2021; Lapum et al., 2021; Ustun, 2021). Nurses, who frequently work in cultures of edgework, have been in a consistent state of derealisation, that is, they are unrecognisable and de-humanised in terms of dominant discourses within society (Butler, 2009; Varman and Al-Amoudi, 2016). The

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COVID-19 pandemic 'shone a light' on nurses' work and their working conditions (e.g. Daniels et al., 2022). The effect of the pandemic and subsequent labelling of key workers as heroes and angels served to recognise their work, making their working conditions visible and elevating them as above human. However, this elevation and new visibility was temporary and the return to their derealised state during the liminal period (defined below) of the pandemic made nurses question their own, and each others', identities and commitment to the profession.

This phenomenon has been examined previously, but to date no studies have used either longitudinal qualitative data or a Bulterian theoretical perspective. For example, and perhaps most notably, Mohammed et al. (2021) conducted a Foucauldian discourse analysis of Canadian newspaper articles during the early stages of the pandemic. They employed the theoretical ideas of truth, power, knowledge, subjectivity, and normalization, to explore the mass media's constructions of nurse as hero during COVID-19. They argued that the hero discourse was a tool used to achieve multiple aims, such as the normalization of nurses' exposure to risk, the enforcement of model citizenship, and the preservation of existing power relationships that limit the ability of front-line nurses to determine the conditions of their work (Mohammed et al., 2021: 8). Mohammed et al.'s (2021) study did not involve nurses as research participants, but some qualitative interview based studies have found that nurses viewed the hero label negatively and attributed it to curtailing discussions about safety, risk and working conditions (e.g. Stokes-Parish, 2023). Additionally, some studies have examined the hero discourse from the perspective of other healthcare professionals during COVID-19. For example, Rees et al.'s (2023) metasynthesis of qualitative studies identified how paramedics mostly felt ambivalent to hero narratives which were attributed to politicisation and objectification.

This paper offers a unique contribution to the field through the use of Butler's concept of derealisation and our longitudinal qualitative data set. Our use of derealisation enables us to go further than previous work in the area to examine how nurses at times acted to reinforce matrices of control (see below for definition) and at other times resisted them. We begin by examining Foucault's notion of discourse followed by Butler's theory of recognition and censorship, which illuminates how individuals can be 'undone' by organisational matrices of control that instigate boundaries by which 'definitions of valid subjects, and excluded ones, come into being' (Kenny, 2018: 1026). Butler's notion of impossible speech, in which subjecthood is denied or granted based on the kinds of speech acts engaged in by individuals, is then examined. Next the case is made for the suitability of using longitudinal qualitative research to examine these issues and the concept of liminality is assessed. The findings discuss how nurses, who were used to being unrecognised, were recognised during the first wave of the pandemic and were governed by matrices of control, such that a boundary was set up delineating valid subjects. The dynamics of selfhood with the construction of boundaries between nurses who act morally to fulfil the requirements of their roles, and 'others' who do not are then examined. As the hero discourse waned, some nurses resisted the 'redoing' of their derealised position through revealing their vulnerabilities. Implications for nursing research are discussed, along with the limitations of the article. The article concludes by outlining the value of using longitudinal qualitative methods and the relevance of drawing on Butler's insights for studies of nursing and nursing work.

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1.1. Dominant discourses and the derealisation of nurses

In this article the term discourse is used to mean a system of thought, knowledge, communication beliefs, attitudes and behaviours that constructs the objects of which they speak and our experience of the world. In Foucauldian thinking, discourses are relatively rule-bound sets of statements which impose limits on what gives meaning (Philips and Jorgesnsen, 2002). Knowledge and power are often joined together through discourses enabling individuals and institutions in power to use discourses to achieve their aims (Foucault, 1980). Foucault argued that 'true' knowledge can be established through the utilisation of dominant discourses to reinforce certain views and exclude other views or possibilities (or 'false' knowledge) (Foucault, 1980). Butler's conceptualisation of derealisation involving censorship as a form of discursive power, which can illuminate the impacts of prevalent discourses, is now examined.

Butler focuses on the link between recognition and social normativity and, like Hegel, situated recognition as a reciprocal, not unilateral, process produced in the struggle between two structurally similar self-consciousness (Lloyd, 2007). Butler believed individuals are recognised as human through terms that are socially articulated (Butler, 2004). The scene of recognition itself assumes a set of cultural norms that conditions who is a recognisable human (Lloyd, 2007). Therefore, social norms determine not only what people can be but whether they can be recognised as human at all. Butler's conceptualisation of censorship has been used in organisational literature (e.g. Varman and Al-Amoudi, 2016) and refers to the production of particular kind of subjects by positioning a boundary separating legitimate from invalid utterances (Kenny, 2018). Individuals can be viewed as 'derealised' when they are unrecognisable or invisible, in the terms of dominant discourses, they become excluded from discourse with the effect of creating ungrievable lives (a life is only grievable when individuals can identify with suffering and may feel ethically responsible) (Lloyd, 2007; Butler, 2009; Varman and Al-Amoudi, 2016). Consequently, an ungrievable life is one that is disavowed and is incomprehensible (Lloyd, 2007). Derealised groups can be treated badly, even violently, but the treatment is not registered in discourse as such (Lloyd, 2007). By failing to represent this negative treatment in any way, a derealising or normative violence occurs. As Lloyd (2007: 146) argues, such bodies:

> 'Do not figure in the reality constructed by the media, military, state and other organs and institutions. They are erased; they simply cannot be thought within the "contemporary order of being as human"'.

For Butler, violence includes the insidious, and equally harmful, forms of non-physical and symbolic violence that make coercion unaccountable (Butler, 2004, 2009). Normative power, which can be conceptualised as a matrix of control that operates by producing and regulating the intelligibility of certain concepts, including subject positions, creates the conditions for derealisation to occur (Butler, 2004). The matrix of control operates within a local and global culture that expects certain performances. For Butler these performances were first conceived as gendered and therefore required the straightest of straight performances as they were embedded in a hegemonic 'heterosexual matrix' (Renold, 2006). Latterly, Butler conceived these matrices of power as expanding beyond gender as she explored how the limits of cultural intelligibility were set by other factors such as ethnicity. Butler argued that a matrix of control

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can be understood as a 'grid of cultural intelligibility through which bodies, genders, and desires are naturalized' which 'assumes that for bodies to cohere and make sense' all must adhere to a stable identity and this is 'oppositionally and hierarchically defined through the compulsory practice' (Butler, 1990, p. 151). This article highlights the varying matrices of control, power and subjectivity that nurses encountered during the liminal period of the pandemic, a time that can be defined by its ambiguity and uncertainty, in which individual's were betwixt and between (Chreim, 2002). Individuals may be between two identity constructions in a liminal state, as they are neither one thing nor the other (Beech 2011). Some writers in professional identity literature have termed liminality as a transitional period during which participants either lack or gain social status (e.g. Wyatt et al., 2020). These matrices of control discussed by Butler, can be viewed as productive as they were able to yield new subject positions. Norms differentiating legitimate, from impossible, speech were used as a measure of control and a means to exercise power over organizational subjects (Kenny, 2018), in this case, nurses during the COVID-19 pandemic.

The unique contribution of this article lies in our extension of Butler's theory regarding derealisation and our examination of the fluidity of this process during a liminal time, the COVID-19 pandemic. This article presents research from two samples of self-selecting participants which totaled 50 nurses from mental health, community and care home settings and 18 nurses who were redeployed during the first wave of COVID-19 in the UK. Participants were interviewed up to four occasions; the first interview time period was in June 2020, the second was in December 2020, the third was in August 2021 and the fourth was in April 2022. Qualitative longitudinal research is highly pertinent for studying individuals' feelings within liminal periods because it affords the opportunity to study fluctuations and changes in participants accounts. This form of research enables consideration of individuals' ongoing, processual sense-making about their lived experiences, fluid identity constructions and life transitions (Shirani and Henwood, 2011). The aim of this article is to examine the effect of the sudden 'undoing' of nurses' derealisation, which occurred with the advent of the hero discourses during the COVID-19 pandemic. The 'redoing' of the derealisation of nurses, which took place after the first wave of COVID-19 in the UK, is also examined and the effect this had on nurses is explored.

2. Methods

The data examined in this article are from longitudinal qualitative research following nurses in the UK throughout the COVID-19 pandemic. A social constructionist perspective was adopted to emphasise how the meaning of lives in progress is established in daily living (Holstein and Gubrium, 2000), enabling our consideration of participants' understandings of their lives and circumstances and how these may change through time (Elliott et al., 2018). Thus, the constructionist epistemology situated the research participants as meaning-makers (Warren, 2002) and recognised that accounts are co-constructed during the interview encounter. The in-depth, narrative interviews facilitated the authors' ability to 'grasp the internal logic and contextualised meanings of participants' life experiences and social worlds' (Shirani and Henwood, 2011).

2.1. Sampling and data collection

Submitted 09/01/2022 – Accepted 09/11/2023

Fifty nurses, divided into two samples, took part in narrative in-depth interviews with the aim of relating their experiences over the trajectory of the pandemic. Participants in sample one (n=27) took part in four interviews, over 20 months, the first taking place in July 2020. Twenty-five were interviewed in December 2020, 26 in August 2021 and 21 were interviewed for the final time in March 2022. Interviews with Sample two (n=23) began after the second wave of COVID-19 in the UK in August 2021 and 19 of the nurses in this sample were reinterviewed in March 2022. Recruitment of participants occurred through an opt-in method where individuals who had completed national nurse and midwife surveys expressed an interest in being contacted to take part in other research (Couper et al., 2021). Purposive sampling occurred with both samples. The addition of sample two ensured a breadth of participants' experiences as the nurse participants worked in a range of settings and specialities, differing experiences and worked at differing levels of seniority. Nurses were based in varying geographical locations throughout England, Scotland, Wales and Northern Ireland and sampled from varying ethnic groups and age ranges. Out of the 50 participants, two were men. More information about the demographics of the participants is provided in Table 1 below. Ethical approval was received from the (Anonymised University).

A non-directive interview topic guide was used loosely during the interviews with the researchers asking participants to 'tell me what happened' and allowing the story to unfold uninterrupted. It was important to us to follow respondents ordering and phrasing as their narratives were elicited to allow participants to discuss areas they perceived to be relevant (Hollway and Jefferson, 2013; Conolly et al., 2023). Longitudinal qualitative methods, in the form of repeat interviews, were used to identify and characterise personal trajectories as the pandemic progressed. Interview times ranged from 45 to 90 minutes. All transcripts were held securely on password-protected computers after verbatim transcription. To ensure anonymity we removed all identifying information and allocated pseudonyms. After each interview participants were provided with a list of wellbeing resources and the opportunity to speak with a member of the research team. The research team supported each other with the emotional effects of interviewing which was at times demanding and distressing and this is reflected on further in Conolly et al., (2023).

2.2. Data analysis

A narrative analysis was conducted to preserve the form of each participant's narrative and interviews were also inductively analysed for themes using NVivo 12. In accordance with the narrative analysis, pen portraits, or interview summaries, were produced to avoid fragmentation of the data (Hollway and Jefferson 2013; Riessman 1993; 2002). As per Riessman's (1993; 2002) description of narrative analysis, during the analysis segments of text were identified that took the form of narrative, and examined structural and linguistic features to analyse how they support particular interpretations of the lived experience of each research participant (Riessman, 1993; 2002). The production of secondary level themes, which were used along with the pen portraits, aided the longitudinal holistic approach to the analysis of each participant's narratives (Hollway and Jefferson, 2013). Each participant's interviews were compared and then cross-checked with data from other participants at the same time point and then across all time points (Hermanowicz, 2013).

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3. Findings

Collecting data longitudinally enabled us to map the changes and similarities of the interviewees' trajectories over the pandemic. These were mapped using an extended version of Butler's typology of derealisation. In figure 1 Butler's notion of realisation/derealisation is depicted. In figure 2 the broad typology of nurses' trajectories during the COVID-19 pandemic, from derealised to elevated and back to derealised is charted. The typology of nurses as derealised then elevated extends Butler's conceptualisation of derealisation which categorises humans as either realised or derealised.

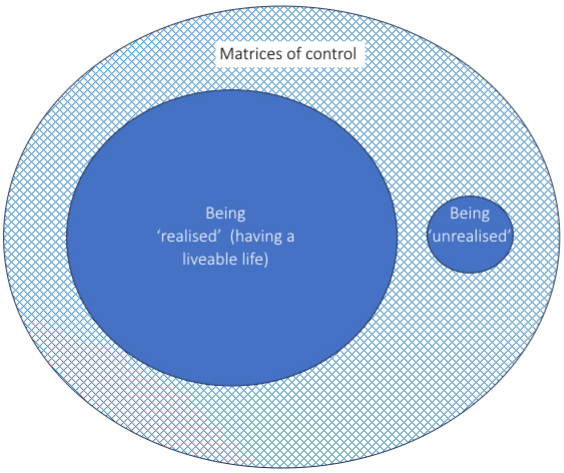

Figure 1: Butler's conceptualisation of derealisation

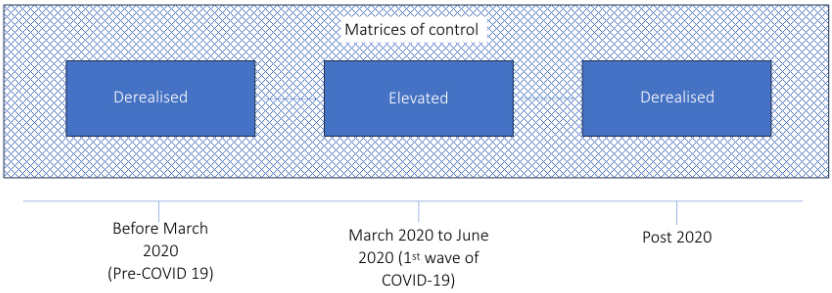

Figure 2: Broad typology of nurses' trajectories through the signifying economy of hero discourses in the COVID-19 pandemic in the UK.

Using Butler's conceptualisation of derealisation and how this changed for nurses over the course of the pandemic has enabled the findings to detail the impact differing signifying economies had on the nurses during their edgework in the COVID-19 pandemic, with four

Submitted 09/01/2022 – Accepted 09/11/2023

key themes, or prevalent narratives, presented that emerged inductively from our analysis. The four themes represent the trajectories experienced by the nurses across the course of pandemic and can be viewed as: Constructions of the hero discourse, Labelling 'bad' nurses, From hero to derealised and Resisting by revealing vulnerability. As can be seen in the table below, Community, hospital and care home settings appeared to have similar rates of the four themes prevalent in their narratives. There also appears to be little variation by grade.

Table 1

Key

1. *Constructions of the hero discourse*
2. *Labelling 'bad' nurses*
3. *From hero to derealised*
4. *Resisting by revealing vulnerability*

X No interview

Participant name	*Ethnicity*	*Age*	*Grade [1] at start of COVID -19*	*Redeployed or student during COVID-19 wave 1*	*Clinical setting*	*Interv. time point 1*	*Interv. time point 2*	*Interv. time point 3*	*Interv. time point 4*
Chloe	White British	51-55	5	.-	Care home	x	x	1,2	3
Amanda	White other	51-55	5	-	Care home	x	x	1, 2	x
Jemima	White British	61-65	2 to 4	-	Care home	x	x	1, 2	3, 4
Raheem	Black African British	56-60	7	-	Care home	x	x	1, 3	3, 4
Amie	Mixed White and Asian	56-60	8b	-	Care home	1, 2	2, 3, 4	3, 4	x
Lucy	White British	51-55	6	-	Community	x	x	1, 2	x
Fiona	White British	46-50	6	-	Community	x	x	1, 2, 3	1, 2, 3
Maddie	White British	36-41	2 to 4	Student	Community	x	x	1, 3	1
Sophie	White British	46-50	6	Redeployed	Community	1, 2	2, 3	2, 3	2, 3
Edie	White British	61-65	5	-	Community	x	x	3	x

[1] In the UK nurses have standardised grading with band 5 the entry level for registered nurses and band 6 for many registered midwives. Nurses who work at higher grades have achieved a higher level of seniority and greater pay.

Submitted 09/01/2022 – Accepted 09/11/2023

Tilly	White British	41-45	8c	-	Community	x	x	2	1
Gaby	White British	56-60	6	Redeployed	Community	3	1	1	2
Tanu	Black Caribbean	56-60	6	-	Community	x	x	1	2
Sue	White British	46-50	8a	-	Community	1	2	3	4
Jess	White British	61-65	2 to 4	-	Community	x	x	2	1
Lizzy	Mixed White and Asian	56-60	5	-	Community	2,3	x	x	x
Lily	White British	51-55	5	-	Community	x	x	1	3
Mia	White British	56-60	6	-	Community	1, 2	2, 3	3	4
Ellie	White British	31-35	7	Redeployed	Hospital	1	2, 3	4	x
Caitlin	White British	41-46	2 to 4	Student	Hospital	x	x	1, 2	3, 4
Jo	White British	31-35	8a	Redeployed	Hospital	1	1,2	3	4
Sherie	White British	51-55	6	Redeployed	Hospital	1, 2	2, 3	2,3,4	2,3,4
Mary	White British	51-55	7	Redeployed	Hospital	1, 2	1, 2, 3	1, 2, 3	1, 2, 3
Sandra	White British	41-45	7	Redeployed	Hospital	1, 2	1, 2, 3	3, 4	3, 4
Saffron	White British	51-55	8c	-	Hospital	1, 2	1, 2	2, 3, 4	2, 3, 4
Lara	White British	56-60	5	-	Hospital	1, 2	1, 2, 3	1, 2, 3	1, 2, 3
Eve	White British	36-40	2 to 4	Student	Hospital	x	x	1,2, 3	2, 3
Laura	White British	31-35	6	Redeployed	Hospital	1, 2	2, 3, 4	3, 4	2, 3, 4
Camila	White British	46-50	7	Redeployed	Hospital	1	2, 3, 4	3, 4	3, 4
Isla	Mixed ethnicities	36-40	6	-	Hospital	1	x	2	3
Tessa	White Irish	46-50	7	Redeployed	Hospital	2	3, 4	3, 4	x
Isabella	White British	51-55	7	Redeployed	Hospital	1, 2	2, 3	2, 3, 4	3
Annabel	Black African British	26-30	5	-	Hospital	x	x	1,2	3
Rachel	White British	31-35	7	Redeployed	Hospital	1	2	3, 4	3
Amelia	White Other	36-40	6	Redeployed	Hospital	x	x	1	2, 3
Zoe	White British	51-55	6	-	Hospital	x	x	1, 2	3, 4

Submitted 09/01/2022 – Accepted 09/11/2023

Sarah	White British	26-30	5	Redeployed	Hospital	1	1, 2	3, 4	3
Amber	White British	56-60	5	-	Hospital	x	x	1	3
Ria	Black African British	56-60	8b	-	Hospital	x	x	1	3
Bethan	White British	31-35	7	-	Hospital	x	x	1,2	3
Peter	White British	20-25	6	Redeployed	Hospital	2	2, 3, 4	3, 4	3
Sephy	White Other	20-25	2 to 4	Student	Hospital	x	x	2	x
Catherine	White British	46-50	9	Redeployed	Mental health	1	1, 2, 3	2, 3	2, 3
Alison	White British	46-50	8a	Redeployed	Mental health	1	1, 2	3, 4	3
Julia	White British	56-60	8a	Redeployed	Mental health	1	2,3, 4	3, 4	3, 4
Helen	White British	46-50	7	-	Midwife	1	2,3	2, 3	x
Elizabeth	White British	41-46	7	Redeployed	Midwife	x	x	1, 2	2, 3
Louise	White British	46-50	8b	Redeployed	Research	1	2, 3	3	3
Kiya	Asian British	36-40	7	Redeployed	Research	x	x	1	3
Becky	White British	46-50	9	-	Social Care	1	1	3	3

‘

i) Undoing’ the derealised state: Constructing the hero discourse

For the nurses in this study, the start of the COVID-19 pandemic signified a shift in public discourse, from one where nurses were regarded as invisible, unhuman, or derealised, to one where they were suddenly recognised and treated as heroes. ‘Signifying economies’ operated, in which subjects were signified through norms that fix differences between people and categories of person (Riach et al., 2016: 4). During the first wave of the COVID-19 pandemic in the UK, the signifying economy became one in which nurses credibly performed the role of a heroic, angelic, courageous and dutiful nurse, with the public expected to perform the reciprocal role of gratitude for health professionals and be ‘good citizens’ by following COVID-19 guidance. Governmental and media discourses portrayed unity and solidarity in the fight against COVID-19, with nurses expected to perform their professional duty to care for the sick and the dying whilst the public had a civic duty to ‘stop the spread’, ‘flatten the curve’ and ‘protect the NHS to save lives’ (British Academy, 2021). War-time metaphors were used by Government and mass media and these messages were also repeated in the metaphors the study participants used to describe working during the pandemic: ‘A war mentality in terms of (…) that Dunkirk spirit’ (Sue, community rehabilitation hospital); ‘It's our call to arms’

Submitted 09/01/2022 – Accepted 09/11/2023

(Isabella, redeployed Intensive Care Unit (ICU)); '[Putting on PPE was] like putting your armour on before going to war' (Laura, redeployed ICU). The effects of these metaphors were to construct nurses as heroes, a process that rendered them visible and provided recognition for their edgework. Although the hero discourse rendered nurses visible, it is import that is viewed as a matrix of control, one in which the dominant belief and values were celebrated and other forms of belief were denigrated and censored (Mohammed et al, 2021; Kelsey, 2016).

The highly performative hero discourse (perhaps most notably embodied by the weekly 'clap for carers' that was enacted every Thursday evening during the first wave of the pandemic in the UK) effectively undid normative matrices of power that rendered nurses derealised. Nurses were elevated in society thus making them highly visible and valued by the public:

> The whole clap for carers thing, I was very appreciative of it, like, it was very much in that sort of first wave sort of almost like war mentality spirit. (Sue, community rehabilitation hospital)

> For the first time it felt people really appreciated what the NHS was in this country and that hopefully it would lead to more support […]. And that was really positive (Sandra, redeployed ICU)

From the above quotes it seems that the majority of the public the nurses encountered during the first wave of the COVID-19 pandemic adhered to the signifying economy of the nurses as heroes discourse. For Butler (2009) being realised in normative discourses involves being treated as human. During the first wave of COVID-19 nurses went from not being recognised in normative discourses to being elevated to a status above human; they were deemed to be angels or heroes, a status drawn from the signifying economy of mythology (Kelsy, 2016). We can argue that this process did, in fact, go beyond Butler's conception of what a 'realised' human is, elevating nurses to a status above human. On close examination it can be argued that, according to Butler's schema the elevation of nurses was actually a further, extended act of derealisation, because it is impossible for humans to consistently embody a hero / angel status over a prolonged period, and as such nurses' fall was inevitable. The elevation of nurses in this way also acted to make abuse and violence more likely and acceptable when they did fall, as was seen when hero discourses ceased to be constantly reinforced in media, and this is discussed in the third section of the findings.

At the time, the clap for carers performance was not uncritically praised by all nurses. Some deemed it unnecessary for the performance of being a 'good' citizen. In their narratives nurses highlighted citizens that were considered 'good' which involved doing their civic duty by compliantly following the national COVID-19 guidance; wearing face masks, socially distancing and staying at home for the greater good of the country. For example, Laura delineated a binary distinction between 'good' and 'bad' citizens, outlining the requirements of 'good' citizens by defining them in relation to what they were not, the 'bad' ones:

> The whole clap thing, I think it was lovely, but we don't really need that. We need people to comply with social distancing. We need people to support the NHS by staying at home (…) in July, like I'd go for a run and you'd see all like the mums hanging round in a group in the park and you'd just be like, 'oh my god'. (Laura, redeployed ICU)

Submitted 09/01/2022 – Accepted 09/11/2023

Therefore, 'bad' citizens were constructed by nurses as disobedient, defiant and selfish, they flouted the social distancing rules and mask mandates. Although occasionally present in nurses first interviews, these subject positions were referred to more frequently in later interviews. The boundary separating 'good' from 'bad' citizens enabled nurses in our study to identify the performativity of subject positions, a notion returned to later. Internalising their own 'goodness' brought the nurses stability, security and the feeling that they were able to positively affect society. Nurses categorised their own, and others' behaviour, as heroic if, in the face of the anxiety, they were willing to step up to the task and fulfil their professional and moral duty to care for their patients, regardless of the safety risk (Stokes-Parish, 2023). Many nurses talked about the need to support their colleagues by 'mucking in and getting on with it' (Ellie, redeployed to ICU, first interview). Indeed, the phrase 'mucking in' was used frequently:

> I think it was wanting to help. You're wanting to muck-in with your colleagues rather than be at home and have someone else doing the work. (Sandra, redeployed ICU)

Through standing in solidarity with their colleagues, with many nurses citing that obligation and moral duty compelled them to volunteer to be redeployed to the COVID-19 frontline, nurses can be viewed to have accepted the hero discourses in the signifying economy, no matter the risk to themselves:

> If you've been lucky enough to have the training to be able to help, then yeah, I do feel an obligation to use those skills. (Ellie, redeployed ICU)

> I'm fit, I'm healthy, I've got the skills necessary and yeah, I think morally I can't walk away. (Lara, ICU bank nurse)

As exemplified by Ellie and Lara above, in the first wave of the pandemic some nurses uncritically accepted their 'obligation' and moral duty to help and performed the role of the 'good nurse'. However, other nurses actively reflected upon the 'moral pressure' they felt through wider Government and media discourses in the form of 'propaganda'. For example, Eve who was a student during the first wave of the pandemic:

> I had a mix of emotions. I was worried about my health and then I was worried about how it would affect my course, but then I also, I guess I did feel, sort of, this moral thing because I think there was a lot of propaganda at that time (…) when the first lockdown started it was all very much, "The whole country's coming together to fight this virus," and there was, a lot of stuff in the media really about everyone helping out. So, yeah, I did, sort of, feel a bit of moral pressure to get involved. (Eve, student nurse)

For Eve, her role as the 'good nurse' was an extension of her role as a 'good citizen'. By accepting redeployment and further placements she was doing what was necessary to ensure

Submitted 09/01/2022 – Accepted 09/11/2023

the health of the population, notwithstanding the risks to her own health (these risks were not to be discussed). Many of the nurses were also engaged in 'othering' members of their own profession as they categorised nurses into one of two distinct camps: those that would fulfil their duty of care (good nurses) and distanced themselves from those who would not, which in some cases became those shielding (bad nurses).

ii) 'Redoing' the self in the liminal period: labelling 'bad' nurses

During the liminal period of the pandemic, to aid their self-performance of the good, heroic nurse, the participants' narratives were littered with allusions to the regulation of other (bad) nurses who may have tried to resist, or were perceived to be outliers of this morally dutiful heroic narrative. By othering 'bad' nurses, some of our participants can be seen to effectively derealise their colleagues as they became less human than themselves:

> I think there's two genres of staff. So I haven't had any time off from COVID-19. I haven't had a day off sick in the past, over a year. And then there's lots of people that have been off a lot and have been off a lot with very kind of (…) 2,000 reasons where you just like think, God, could any more of your family have a symptom of COVID-19? As you've literally been off continuously. So, there's some of us that feel exhausted and like we've taken the brunt of like keeping going, and then others that (…) are taking time off (…) for whatever reason and under whatever guise (…) some of us feel like, 'Oh good God!'. (Helen, midwife)

Helen had not had a day off sick in the past year, whilst the diametrically positioned 'others' had 'been off continuously'. By 'othering' colleagues Helen was able to boost her construction of the moral self by performing the heroic discourse, introjecting duty and responsibility and thereby visibly recognising her work throughout the pandemic, increasing her own visibility. Through this construction and erection of the binary boundary between 'good' and 'bad' Helen is able to justify her own frustration as she was the morally correct, 'good' nurse, working hard to provide the best care for patients, whilst others did not.

Helen's views were not unique and frequently appeared, predominantly in the narratives of those who were not redeployed. For example, in her first interview, Mia, noted that some nurses hadn't pulled their weight during the pandemic (shielding and/or distancing themselves from COVID-19 patients) and that she was not 'particularly impressed' by this. In her second interview Mia reported an incident that accentuated a schism within her team when thank you gifts, that were ordered by the team leader for staff that worked during the pandemic, were also given to those who had not carried out face-to-face work during the pandemic. She described the team leader as having ordered a:

> Thank you gift for being supportive, keeping the team going. But unfortunately, they didn't arrive before the other staff came back (…) our team leader said, 'I can't give half my team [the reward item] and leave the other half out', so she bought one for everybody. But the staff that hadn't shielded had accepted those [reward items] as a bit of a pride really, (…) it was a bit of a medal so (…) some of them felt [like they had received] a little bit of a kick in the teeth with it (...) And one of the staff, (…) [said in] an inappropriate jest, ,

Submitted 09/01/2022 – Accepted 09/11/2023

> 'Well, maybe you could put a white feather over the top of theirs', (…) and that went down like a lead balloon. (Mia, community nurse)

The white feather Mia described above again employs war metaphors as it refers to feathers which were given to perceived cowards during the First World War. Within nursing there is a strong expectation that team members should support each other (Traynor, 2017). Although Mia distanced herself from the white feather 'jest' by labelling it 'inappropriate' her narrative revealed her adoption of the prevalent signifying economy of the nurse as hero discourse, one where 'good' nurses worked at the frontline ('keep the team going') regardless of the risk of contagion to themselves and their families, whereas 'bad' nurses did not. By 'othering' bad nurses, nurses such as Mia can be viewed as enacting a form of derealisation as it became acceptable for symbolic and real violence to be enacted against the 'bad' nurses in the form of discrimination. This dehumanising action enables the 'other' to be subjected to violence; to make the cowards life ungrievable. Mia can be viewed as performatively 're-doing' her own identity, in order to cope with the stresses and anxiety of the liminal period of the pandemic, and in doing so she excludes others and reinstates a new boundary. Moreover, these identity struggles appear to involve contestations over nurse professionalism with many of our participants suggesting that their approach to nursing was the only way to nurse during the pandemic. Thus the imperative for nurses to construct themselves as hard-working and dutiful in the face of anxiety, to assimilate the prevalent 'nurse as hero' discourse and signifying economy, to reduce their own anxieties, meant that they had to ideologically erect boundaries from those who were viewed as avoiding work, or not caring enough about patients or about other members of their team. However, not all nurses' performances of self were binary during this liminal period and this is a notion we return in section iv. The next section explores the change in the signifying economy as, after the first wave of COVID-19 in the UK, nurses returned to their derealised position.

iii) From hero to derealised

During the first wave of the pandemic, the UK public's performance of the signifying economy of nurses as heroes was pervasive. However, the end of public displays of clapping for carers on Thursday evenings, which finished by June 2020, seemed to signal a shift in public feelings as the performative display of gratitude gradually fractured under the continuing burden of COVID-19. The signifying economy changed as the gratitude that nurses had enjoyed shifted, as the public's belief that the NHS could save the nation from the pandemic waned and optimism drained away:

> The whole clap for carers thing, although I was very appreciative of it, it was very much in that sort of first wave sort of almost like war mentality spirit. And the reality is that I think, that we're going to have to learn to live with COVID-19, because it's not going away, we're no longer frontline heroes because (…) the whole country is now being brought down by the burden of COVID-19, because what's happened is that the health service, although it has been brilliant, I think, it hasn't solved the problem. And that's what people think is, you know, give me a magic pill or injection and let me get back to my normal life. So, I think there is a sort of frustration that that's not happened. So, I don't think we'll ever go back to clap for carers or anything like that because you've lost that initial wave of, of optimism. (Sue, community rehabilitation hospital)

Submitted 09/01/2022 – Accepted 09/11/2023

For Sue, the public's position of gratitude was borne of the hero discourse which encapsulated a 'war mentality spirit' and a sense of optimism. Sue conveyed her perception of the public shift from the previously widespread performance of extreme gratitude, to questioning a perceived 'lack' in what nurses, and the NHS, had been able to offer, to solve the COVID-19 problem. Sue identified that what the public wanted was a quick fix, a magic pill or injection to return to normal. Therefore, the 'magic injection' (vaccinations) can be viewed as replacing the nurse's hero status. Through their awareness of the public's frustration nurses had been returned to their derealised status, and as such symbolic or real violence is unchecked, even acceptable, because within their derealised status, nurses' lives are ungreiveable (Butler, 2004; Varman and Al-Amoudi, 2016). For example, in their second wave interviews, nurses referred to the patients and relatives perceived deficits or 'lack' in levels of care, and an increase in 'demand' for care as usual:

> The general public now are coming back with their demands. You know, the first few months of the first lockdown, it was very much support the NHS, lots of services were, you know, were reduced down to minimum. That was reflected in our patients. Whereas now the patients it's like, 'Well, sod COVID-19, come and see my mum, my mum's not well, you know, she needs a nurse' (…) so we've sort of gone back to normality in a sense, but we're still working flat out (…) that's where the pressures are coming from different angles, really. And some staff are feeling really, really naffed off with it, to be fair, you know? (…) there's lot of people that are tired. (Mia, community nurse)

Mia noted the shift from her patients' positioning as supporting 'the NHS' as part of the hero discourse signifying economy, to a return to expectations of 'normality' where neoliberal discourses of healthcare (for example of efficiency and consumerism) are prevalent in patients', and their relatives' interactions with nurses with associated demands to meet needs and expectations (Nagington et al., 2013). Mia recounted her patients' and their relatives' articulation of discourses of consumerism of healthcare where the patient and their relatives are at liberty to complain when they believe the care they receive is not in-line with their wishes (Nagington et al., 2013). The proliferation of the consumption of healthcare in this manner can be viewed as a product of nurses' derealisation as nurses again became treated as a product to be consumed, rather than as human beings working in very difficult circumstances. COVID-19 increased the workload of nurses exponentially. The gratitude the public felt during the first wave of COVID-19 and their willingness to accept the disruption of services, led Mia and her colleagues to feel increased pressure with the public's return to a neoliberal consumption of healthcare, where patients complained because services, such as operations, were delayed or cancelled due to the pandemic. Therefore, on top of their levels of exhaustion, 'working flat out' left them feeling 'naffed off' (upset). This return to neoliberal discourses of healthcare left individual nurses and their care-work invisible, they were again derealised within normative matrices of power. The change that nurses perceived in the public's feelings also occurred closer to home. Nurses referred to their friends and family also shifting from the performance of overt gratitude to that of ambivalence, ingratitude or overt criticism indicative of symbolic violence. For example, Lara, a retired nurse who worked as a

pIJ/Volume 10 – Issue 2 ISSN: 2499-1333

Submitted 09/01/2022 – Accepted 09/11/2023

bank[2] nurse in an ICU, throughout the first and second waves of the pandemic, described her brother's attitude towards the 'lacking' NHS and its services and resources:

> On social media you can see a lot of people criticising the NHS now (…) the wards are short-staffed, people can't get into hospital for their operations, they're being cancelled again and again (…) certainly, my brother, he was talking about somebody who'd had an accident in his work, fractured his leg and the bone was sticking out. And I think they had to wait over three hours for an ambulance (…) my brother now, he hates the Ambulance Service (…) and the NHS is being criticised in the same breath, these stories are hitting the media far more than the positive stories we had back in April (…) people are just so tired and run down and fed up of the rules that they're going into self-preservation mode, and saying 'we're doing what we want to do' regardless. (Lara, ICU bank nurse)

Notably, nurses such as Lara were unable to separate their performances of self from their organisations. Therefore, criticism of the NHS was taken as criticism of their own identity and that of their colleagues. For Lara, the shift in her brother's, and the public's opinion, was entwined with shifting media discourses, which acted to again derealise nurses and their work by dehumanising them, leaving them open to symbolic and real violence. Gone were the 'positive' news stories associated with the start of the pandemic with more reporting of negative experiences of inadequate or poor care and cancelled operations. The shift Lara presented in the prevalent public discourses embodied a public attitude of 'do what we want to do'. Therefore, the unity embodied in the war narratives and the gratitude expressed and performed by the public at the beginning of the pandemic split into self-interest and a return to neoliberal consumerist notions of healthcare as a right (Nagington et al., 2013). The patients, who were deprived of routine NHS 'goods' or services during the pandemic, believed they were deserving of, and entitled to receive access to healthcare the same as pre-pandemic. The gratitude the nurses experienced from prevalent discourses and the public during the first wave of the pandemic were less prevalent and no longer provided by the public.

Most nurses tended to give quite emotive accounts of this shift although the ways nurses dealt with their return to derealisation seemed to vary depending on how exhausted they felt and whether they had immersed themselves in the prevalent hero discourse or resisted this performance (see Julia below). For example, for Caitlin, the shift in public attitudes towards nurses was embedded in a framework of 'fatigue' and 'mistakes' and being 'taken for granted' again:

> Yeah, I think that fatigue has set in now. Everyone's over the initial crisis and they're now looking at all the things that were missed, mistakes that were made, things that weren't done, tests that weren't done and everything and forgetting, quite easily forgetting what we went through (…) we're quite despondent because we were heroes and then suddenly we've gone back to just being taken for granted, which is quite hard when you've had that little bit of being a hero. (Caitlin, student nurse)

[2] Bank nurses are a register of staff who can come in at short notice to cover shifts. They have control over the shifts they work.

Submitted 09/01/2022 – Accepted 09/11/2023

Nurses were forced to re-construct their selfhood as they were no longer heroes and had to return to an unrecognised or 'unhuman' status; an 'ungrievable' life (Butler, 2004). After the first wave of the pandemic in the UK, conspiracy theories and the idea of the pandemic being a hoax began to surface with the result that nurses were turned from heroes into 'monsters'. Jo, had witnessed the consequences of this change in attitude towards NHS staff:

> One of the things that really surprised me in the second wave was the negativity that turned on to the NHS and that really hurt. You know, we were heroes through the first wave and in the second wave we were monsters, we were killing people or, COVID-19 wasn't real, we were all part of a massive conspiracy and it took me a long time to get over that negativity and just think, well, I've got to just get on with it and do it myself (…) it broke my heart, the people (…) chanting, 'COVID-19 is a hoax.' The poor nurses coming out of a shift and hearing that (…) I never got to know security before, now we've got hundreds of them (…) Yeah, and that was really, really tough to handle. I just didn't understand how people just turned so quickly (…) all of a sudden, we're monsters. That's the negative. (Jo, redeployed ICU)

Jo's narrative referred to the emotional toll taken by the shift from 'nurse heroes' to derealisation of nurses where they were again treated as unhuman and it became acceptable for members of the public to label nurses 'monsters'. Like, Lara, Jo's identity is closely bound with that of her organisation and the NHS as a whole and her narrative expressed solidarity with other nurses and the NHS. Even though Jo had experienced trauma through having worked with COVID-19 patients during both waves, and had nursed many who had lost their lives, she declared the change in public attitudes as the primary negative feature of the second wave of COVID-19. It is notable that neither nurses' position as heroes or angels or their positioning as monsters can be viewed as constitutive of being human (Butler, 2009). Varnman and Al-Amoudi (2016) argue that by negating, criminalising or pathologizing unrecognisable identities derealisation is '*in itself an act of violence*' operating at the symbolic level due to derealised subjects' deprivation of the ability to give an account of themselves as human beings. Derealization also increases the acceptability of further violence, as falling outside dominant categories is perceived as a subversion of the social order which may necessitate violence. For the nurses we spoke to, being recognised during the COVID-19 pandemic and working through extremely stressful realities, then once again being derealised and treated with symbolic violence was extremely challenging. As the pandemic progressed and the prevalent hero discourse began to wane, some nurses' anxieties heightened. Several nurses interviewed disclosed rising levels of anxieties resulting in increases displays of vulnerability in their private and public lives. The next section examines some nurses' revelations of vulnerability, vulnerability which Butler (2009) conceptualises as resistance to normative matrices of power.

iv) Resisting by revealing vulnerability

Not all the nurses adhered to their subject positions determined by the signifying economy of the hero discourse with some participants describing feeling like 'cannon fodder' (Isabella, redeployed ICU) as they realised that some lives mattered less than others (Maben and

Submitted 09/01/2022 – Accepted 09/11/2023

Bridges, 2020), further aiding dehumanising processes (Butler, 2009), and therefore, were aware of the perfidious nature of the hero discourse:

> So, I did feel a sense of duty to assist my colleagues (…) and to do the best that I could but maybe I didn't (…) although it was very moving, all the clapping and things it was very moving, I just thought no, I'd rather be safe. They build somebody up and they put them on a pedestal and like they're really they're going to be great and then they're not great because they're normal and it's, they fall and then the person completely decompensates, and things all get split and it felt a bit like that could happen within, on a systemic level that we're built up as these *wonderful, fantastic angels* who are going to do everything and we're not. (Julia, redeployed other)

For Butler vulnerability is conceptualised as the 'struggle with the norm' and, as such, exposes the struggle for which bodies are recognised and are worthy of being attended to (Butler, 2004 13; Lloyd 2007). Nurses' struggle for recognition in the context of the on-going pandemic led many to 'reveal their vulnerability'. Whilst Julia admitted to having an emotional response to the clapping (being 'moved') at first, she indicated her awareness that the public's gratitude would not be sustained, suggesting the inevitability of the toppling of the 'angels'. For Julia, and other nurses that questioned Governmental and media discourses, they resisted, or took back some autonomy over their own emotions, moving through the liminal space.

In our data it became apparent that progressively, as the pandemic went on, nurses reported increasing occurrences of emotional vulnerability. For example, Tessa related feelings of being forced into redeployment and therefore that the subject position of heroic key worker had been foisted upon her. At the very beginning of the pandemic Tessa, had wanted to go and refresh her ICU skills so that she could be redeployed confidently. However, her managers did not allow this, and she was very unhappy with the manner in which she was redeployed: at short notice, with minimal training. After months of redeployment Tessa recounted revealing her vulnerability:

> There were definitely days when you think, 'I don't want to do this anymore.' I've had months of hating going to work, and that's the bit that's really hard, when you see people lauding you as a hero. And you think, 'You don't understand that I hate going to work. I hate this with a passion. I'm scared and I hate it.' But you do it every day because it's what you're trained to do, it's who you are, but you wish you weren't (…) and you feel that you were supposed to feel proud of your profession and proud of what you could do. But actually no [I don't]. (Tessa, redeployed to ICU)

Tessa expressed extreme anxiety and distress, which left her unable to live up to the performance directed by the signifying economy of the prevalent hero discourse. The decline in her mental wellbeing left her unable to continue in her role and, at the time of her first interview, she was several weeks into, what turned out to be, a six-week period of sick leave due to workplace stress. Tessa can be viewed as rejecting the hero discourse and her role within that, but by challenging the processes through which claims are neglected or negated, she resisted her identity as a nurse which made it harder for her to perform her role as a nurse. The conflict Tessa experienced between emotions that are experienced and those she was

Submitted 09/01/2022 – Accepted 09/11/2023

required to conform (Kinman and Leggetter, 2016) made her realise she could no longer perform her role as a nurse and she took sick leave whilst accessing emotional support.

As the pandemic progressed many nurses referred to the diminishing of the hero discourses, which were no longer consistently reinforced in the media, and a subsequent change in public opinion. Nurses referred to their workload becoming again 'unseen' or returning to their derealised status. As such the public began to reveal more negative attitudes towards healthcare staff, and nurses frequently gave examples of the abuse and violence they encountered at this time. The intense stress brought about by the altered working conditions from the pandemic alongside frustration with the public resulted in Camila's own slippage from enacting the heroic caring nurse discourse led some nurses to reveal their vulnerability to challenge the matrices of power:

> The sheer ignorance and stupidity of a lot of people in the public who either won't wear masks, say it's a hoax, don't want to social distance, don't want to stay indoors, don't want to stay away from people and I just find that feels like an absolute insult and kick in the teeth to what we've been trying to do (…) I was getting really angry in... in supermarkets and telling people off (…) then I kind of got to the point I thought Oh, what is the point, there's no point? At the beginning when we were thinking it could become a second wave (…) it just started to really affect me psychologically (…) it's not fair (…) I felt it was sheer selfishness and stupidity of a lot of people just so, so upsetting. There's been quite a few times now where I've thought about COVID-19 and what's been going on and it's just had me in tears, but I think some of that's been where I've been so tired, that my defences haven't been as strong. (Camila, redeployed ICU)

Camila's vulnerable state can be seen to be indicative of her wishing to grieve for herself as she realises the disparity of the situation. The revealing of Camila's emotional vulnerability put her nursing identity at risk as her emotions were not concordant with caring nursing values prescribed by normative matrices of power. Camila positioned the public who label COVID-19 a hoax or refuse to follow social distancing rules as 'stupid' and 'ignorant' and refers to the public's enactment of violence against her and her fellow nurses ('kick in the teeth'). To Camila the public who perform this 'ingratitude', and their refusal to accept the social distancing required by law, initially made her angry which resulted in confrontations, but eventually resulted in her breaking down in 'tears'. Camila described her angry outburst in public in more detail during her first interview:

> I saw a guy in a shop with clinical gloves on (…) I walked up to him, "Excuse me, you realise you've just touched your face with your gloves on?" He went, "Oh yeah, I did, didn't I." I thought, "You idiot." (…) I was actually starting to confront people and get quite angry. (Camila, redeployed ICU)

It is striking that in her second interview Camila no longer felt able to become angry, even though the rate of the public's perceived misdemeanours had grown (with the rise of COVID-19-deniers and anti-vaxxers). Instead, Camila referred to being very 'upset' because of the 'sheer selfishness' and 'stupidity' of people and expressed her view that she had been 'psychologically' affected. Camila's frustration and display of vulnerability was heightened by viewing the 'bad' members of the public who did not compliantly follow governmental

Submitted 09/01/2022 – Accepted 09/11/2023

COVID-19 guidance and therefore did not perform the role of 'good citizen' propagated in media and governmental discourses. The public's lack of knowledge of infection control is the last straw, and her revelation of vulnerability can be viewed as resistance to the matrices of power that keep her in her subject position whilst allowing others to escape theirs. However, fatigue prevents her from continuing her fight.

4. Discussion

Drawing upon Butler (2004, 2009) our findings illustrate firstly the 'un-doing', through nurses being elevated to a hero position, and then the 're-doing', through nurses becoming seen as monsters, of subjective derealisation of nurses during the liminal period of the COVID-19 pandemic. The dynamics involved in the 'un-doing' and 're-doing' of the nurses' derealisation highlighted the chaotic reconstructions of positions in relation to shifting boundaries that delineated valid subjecthood, along with an active reproduction of these boundaries (Kenny, 2018). It is clear that a matrix of control which was 'oppositionally and hierarchically defined through the compulsory practice' (Butler, 1990, p. 151) ascribed the nurses' elevation. At some points this was reinforced by the nurses through their labelling both of bad nurses and bad members of the public. At other points, particularly as the pandemic progressed, this imposed identity was resisted by nurses, as some were no longer willing to embody the ideal of the good nurse. The angel or hero status ascribed to nurses was drawn from the signifying economy of mythology (Kelsy, 2016). This positioning process did, in fact, go beyond Butler's conception of what a 'realised' human is, elevating nurses to a status above human and as such can actually be viewed as an extension of the derealisation process. This is because, arguably, no human can maintain a 'superhuman' persona over a prolonged period and therefore nurses' fall from this position can be viewed as inevitable. Therefore, this paper's contribution has been valuable in extending Butler's concept of derealisation whilst exploring how derealisation can become malleable and fluid in liminal periods, such as the COVID-19 pandemic.

Similar to Mohammed et al. (2021) who argued that the hero discourse was a tool, we argue that it was purposively deployed by government and healthcare organisations to limit the ability of front-line nurses to agentically control the conditions of their work. 'Good' nurses got on with it and did not mention safety, risk and working conditions during the extreme edgework type conditions of the pandemic (Ward, 2020). This was easier to reinforce when, as we have seen in the data presented, nurses policed each other's behaviours through the creation of a boundary between themselves and others as they endeavoured to negotiate the fluctuating signifying economies and processes of realisation/derealisation that existed in the liminal period of the COVID-19 pandemic. Indeed, this research has highlighted the 'dynamics of derealisation' as, during the liminal period of the COVID-19 pandemic, nurses were encouraged to adopt the new economy of signification of the nurse as hero discourse. Although this article has referred to this position in terms of having 'un-done' nurses derealisation, it perhaps went further than that, as to be a hero or an angel is not constitutive of humanity – it is more than *human*. At the end of the first wave as the hero discourse economy of signification retracted and the derealisation of nurses was once again resumed, nurses seemed subject to possibly more widespread symbolic and real violence than they had endured before as they became monsters who were preventing the public from accessing

Submitted 09/01/2022 – Accepted 09/11/2023

healthcare. The reinstatement of the denial of recognition sometimes resulted in chaotic subject positions leading to an unravelling of nurses' sense of self. This article contends that nurses in this research were able to use boundarying to separate themselves from 'others' as nurses noted both the characteristics of 'good' citizens as opposed to 'bad' ones and also contrasted themselves to 'bad' nurses who had oftentimes managed to escape from nursing at the frontline during the COVID-19 pandemic. Thus, the experience of derealisation prompted a 're-doing' of the self which involved setting up and reinforcing new boundaries that differentiated a moral self from an unmoral other (Kenny, 2018).

Significantly, this research has revealed that for many nurses, being recognised, even for the short period that they were (during the first wave of COVID-19 in the UK), enabled them to better undertake the extremely difficult work in the 'edgework' type conditions of the pandemic, and therefore the signifying economy of the hero / angel myth can be viewed as effectively fulfilling its function. Post COVID-19 pandemic, there is a current shortage of nursing staff across the world, approximated at a six million shortfall (Ball et al., 2021). Commentators have argued that for nurses, not feeling recognised or valued whilst working in edgework type conditions, makes it extremely hard for nurses to remain in such work (Maben et al., 2023). This article makes contributions to contemporary debates surrounding nursing by highlighting the symbolic and often real violence that exists within neoliberal discourses which emphasise patient access to healthcare and patient rights over nurses' psychological wellbeing. This research has shown how symbolic violence can go unchecked because of processes of derealisation and also offer insights into how invoking vulnerability, can further rock nurses' performances of self, leaving them questioning their identity as a nurse and considering alternative careers. Unlike many other roles in the public sector, such as teaching, nursing work tends to be associated with low levels of collective union action. However, many of the participants referred to taking future political action with the issue of pay most frequently raised as a sticking point. During 2023 nurses have taken strike action in the UK, and this action represents a real departure from UK-based nurses' traditional viewpoint against collective action and, as such, can be viewed as a consequence of the impact of their work during the COVID-19 pandemic. This article has deepened our understanding of undoing and redoing derealisation, symbolic and real violence, resistance and highlights the social responsibility of nurses' employers and the government to ensure that nurses are made visible and that their status as 'ungrievable lives' is not accepted.

It is useful to reflect on the unique contribution qualitative longitudinal data can make to the production and analysis of temporal data as it is able to show the complexity of fluctuations and how they are differently experienced and interpreted by the people involved (Shirani and Henwood, 2011). An 'understanding of the cultural context and interpersonal processes' (Marsiglio et al., 2000: 1179) can be provided through the use of longitudinal qualitative methods. One proponent of the use of qualitative longitudinal methods, Saldaña (2003), differentiates between change over time, which is conceptualised as a before-and-after approach emphasising differences between 'then' and 'now', with change through time, which illuminates the process of change whilst detailing the complexities of the journey. Qualitative longitudinal methodology has allowed a more complex and realistic understanding to be developed of individual lives, transitions and meaning-making (Thomson, 2007). This methodology enabled follow-up on themes introduced in earlier interviews providing a more detailed, dynamic view of lived experiences of nursing at this liminal time, and respondents' thoughts and feelings about it, as it changes over the life course. The ethos of walking

Submitted 09/01/2022 – Accepted 09/11/2023

alongside people through time as their lives unfold (Neale and Flowerdew, 2003) allowed the exploration of the temporal dimension of experience, based on a theorisation of the dynamic, processual element of human life (Holland, Thompson, and Henderson, 2006; Shirani and Henwood, 2011). The concept of liminality has allowed reflections on how far from normal the working conditions were during COVID-19 for nurses and how very differently they were portrayed in the signifying economies which accompanied the pandemic.

5. Limitations

A limitation of the research is that we did not collect data with the nurses prior to the COVID-19 pandemic so we were not able to detail their contemporaneous experiences of the differences between public and healthcare organization discourses prior to the COVID-19 pandemic. The way in which our research was funded resulted in two samples of participants. This can be viewed to be a further limitation of the work and future work should aim to ensure that all participants are recruited at the same time. The nurses did work in different contexts, were from different grades, different geographical locations, different ethnic groups and age ranges which we would argue is an advantage of the study, as we agree with Kindsiko and Poltimäe (2019), that heterogeneous samples in qualitative research do not allow deep analysis into the specified area, especially when the research is founded on a constructivist or interpretive paradigm.

6. Future Research

Future research might build on existing work to focus in more depth on the translation of these findings across other staff groups, to generate an extended understanding of what, where and how value and recognition can exist within discourses surrounding healthcare. We call for more research to be conducted into retaining nurses and how a culture of valuing nurses, both in wider culture, and in healthcare organisation cultures, may be implemented in practice. Considered systemic support to be delivered and consistently provided to nurses and other healthcare workers to ensure the future of nursing, good retention of all healthcare workers and the security of society is essential. The avoidance of a mass exodus, and any further deepening of recent UK and global nursing workforce shortages, depends on getting the right support in place now.

7. Conclusion

This article has revealed the complexity of the dynamic subject positions and boundaries that shifted according to what delineated valid subjecthood as set by the signifying economies of prevalent Government and media discourses. The shifting discourses during the COVID-19 pandemic have illuminated the multifaceted and complex nature of nurses' caring work which was already under strain pre-COVID-19. The data discussed in this article suggests the need to avoid extreme positioning in future political and media discourses. The 'building-up' of nurses through the hero discourses made nurses fall harder and experience greater emotional strain when these discourses were retracted. The data discussed in this article ultimately

Submitted 09/01/2022 – Accepted 09/11/2023

shows how significantly nurses' psychological wellbeing was impacted by the COVID-19 pandemic and that war metaphors and the language or heroes further added to the COVID-19 challenges nurses faced.

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