CHALLENGING IDEAS IN PSYCHIATRIC NURSING

liam clarke

Challenging Ideas in Psychiatric Nursing

Psychiatric nurses comprise the largest group of mental health professionals and the most divided. Ongoing preoccupations with the nature of mental illness, the relative efficacy of treatments and professional identity undermine calls for unity and divert attention away from the pressing needs of patients.

Challenging Ideas in Psychiatric Nursing arose out of the author's concern for the state of psychiatric nursing and its effect on patient care. Focusing on the basic assumptions which currently underpin education and practice, Liam Clarke calls into question the validity of 'holism' as an alternative knowledge base for nursing, the wholesale acceptance of Rogerian principles and leanings towards a reductionist approach. His book is an attempt to refocus attention on finding practical ways of helping the mentally ill to live in society rather than in conflict with it.

Challenging Ideas in Psychiatric Nursing will be an essential and thought-provoking read for nurses and other mental health professionals who want to develop as critical practitioners.

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For my wife
Johanna Clarke

Contents

Preface

This book is concerned with psychiatric nursing. I use this term, rather than mental health nursing, because many of the issues and controversies which concern this group of nurses arise from the nature of mental illness and the manner in which it has historically been responded to by psychiatry. As the book unfolds issues will arise which may be of some relevance to nurses generally and, of course, related professionals such as doctors, psychologists and social workers are welcome to speculate on the implications which this discussion might have for them.

At first sight the range of topics included in the book might appear daunting. However, a small number of themes organises these topics into what I believe to be the central concerns of psychiatric nurses today. A major theme is the evolution of holism and its connection with the influential theories of Carl Rogers. Holism has played a significant role in determining the nature of much current care. Its influence has been evident not only in psychological theories but also in current nurse education and its emphasis on health rather than illness. These aspects of the holistic influence are addressed in chapters 2, 3 and 9. Another theme of the book is the nature of psychiatric nursing. In chapters 7 and 8 I review specific counselling approaches and a certain kind of humanistic philosophy which have come to characterise psychiatric nursing for some. For others, the issues are not so clear cut and chapter 4 worries again at a timeless bone of contention in psychiatric nursing, namely custodialism versus the caring role. Chapter 5 looks at the fashionable theme of postmodernity. Whilst some might regard this chapter as a mere 'flight of fancy' it is important in respect of the comparative relevance of postmodernist 'theory' and the question of moral judgements in nursing. In addition, in chapter 6 I try to disentangle the emergence of some of these ideas and their continued relevance to a troubled nursing profession. Finally, in my opening and closing chapters I have tried to weave these topics into a tapestry which shows that there can be no resolution of what psychiatric nursing means without regard to a moral perspective which takes account of the patient's experience and the role of the carer in representing that experience to others. Such a perspective places the psychiatric nurse *outside* the usual concerns of professional practice: in effect, he or she may even oppose such practice on behalf of patients. At the same time, it is hoped that the reader will absorb the tension which runs

through these chapters, especially where opposing viewpoints strive mightily for just such a professional evidence-based practice.

In order to impose a framework on the discussion the book sets out to find answers to a series of questions. The main question is one which has bewitched, bothered and bewildered nurse 'philosophers' for some time, namely 'what is nursing?', or more specifically for our purposes, 'what is psychiatric nursing?' Too many people rush to judgement on this, at times ending up in an abstract soup in which they flounder and sometimes drown. We shall proceed carefully, dutifully giving weight to various aspects of the arguments. This exploration invokes a range of issues which others have already examined in different contexts, but as nurses have not been conspicuous in their contribution to ideological, political or historical debates until recently, the presentation of some of these issues within a psychiatric nursing context may prove refreshing.

In asking 'what is psychiatric nursing?' it is anticipated that some of the answers which come about will relate to nursing as a whole. Recent developments in nursing generally, such as the tendency to equate nursing with this or that concept of caring, the stress on individualism, or the much vaunted entrance of nursing into the ranks of 'learned' professions are issues which affect all branches of the profession. We naturally shall concentrate on how psychiatric nursing relates to these developments so as to elicit differences as well as similarities between both arms of the profession. One warning before we start: the purpose of this book is to provide one point of view and not a balanced consideration of different or opposing positions. For example, it will be asserted that nursing of any kind cannot be a scientific discipline, in any normative sense of the word. However, this does not mean that in searching for answers, equal status will not be accorded other positions en route. It is high time that nurses came to conclusions about some things: we have been searching for a sense of 'who are we' and 'where are we going' for too long. Such lengthy inquiries are hardly problematic for most philosophical inquiry. However, their connection with practice places some obligation on nurses to declare themselves on some of the key issues.

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1 Psychiatric nursing

Illusion and reality

Connections

Client care is central in discussing what psychiatric nursing is. The manner in which theories are used becomes important whatever the validity or otherwise of a particular theory. Let us examine this in relation to the question of science. Since the Enlightenment, we have grappled with two dimensions of science. One is the undoubted advances which (medical) sciences have brought to our understanding of the body and its ills. The second is the repeated abuses which science permits (for instance the gratuitous leucotomies of the 1950s and 1960s) and it is this second aspect which obliges us to look carefully at what people *do* with science. This particular discussion is apt in the light of recent calls (Gournay 1995; McFadyen and Vincent 1998) for psychiatric nurses to re-adopt a medical view of psychiatric disorder. That contention is refuted here by the simple counter-point that it is what nurses *do* with clients which matters rather than the rights or wrongs of any particular view. Psychiatry is a practical business and the theoretical basis of a treatment may not be pertinent. For example, few deny the efficacy of behaviour therapy for phobic disorders as opposed to psychoanalysis even if the latter seems 'made' for the high symbolism of the phobias. However, it hardly follows that behaviourism takes philosophical precedence over psychoanalysis as an account of human behaviour: clearly it does not. This disjunction between theory and action is actually a main plank in psychiatric history. Compare the way in which the assertions of R.D.Laing, produced during a period of high social unrest, exerted as much influence as his written work. As Joseph Berke remarked at the time (Clare 1996), 'Laing put the person back into the patient' and that is why he made a difference. After him, the stigmatising did not stop but it was now easily seen for the smear tactic it was. Today, Laing's anti-psychiatry stands accused of naïvety; his supposed unwillingness to engage with the biological data is seen as a mistake. This misses the point, however, which is that irrespective of their biology, schizophrenic patients (by whatever name) were asking to be recognised as people and Laing responded appropriately.

What reductionism in science can do is further delineate the neurological correlates of schizophrenia and other physical states. What nurses must do is guard against that degeneration by which biological/genetic models lead—as indisputably they did in the past—to mental illness being seen as inborn and irredeemable to the extent that patients become undervalued as people. When psychiatric drugs fail to work—even their strongest advocates acknowledge that failures occur—there is a noticeable withering away of psychologists and psychiatrists from the social world of schizophrenic patients and their nurses. It is at this juncture that psychiatric nurses can enter the social worlds of schizophrenic people, engaging their desires, hopes and ambitions.

Genetic and technological investigations are important in that they may ultimately provide predictive clues to the likelihood of schizophrenia in the newborn. However, the nurse's role is not to embrace 'the new genetics' but, working in tandem with schizophrenic people, to judge its worth relative to the overall quality of living which schizophrenic people *currently* enjoy.

Hippocrates states: 'It is more important to know what sort of patient has a disease than what sort of disease a patient has' (in Lloyd 1970). In the light of this, asking the question 'what is psychiatric nursing?' can allow us at least to say what it is not. It is not, for instance, about the theoretical correctness of scientific as opposed to experiential concepts of mental illness. By experiential concepts I mean any account which has as a part of its description the narratives of the person with the presumed condition. Rather, it is more concerned with interventions which take the form of social engagements with patients. It may seek an understanding of genetics, biochemistry, structural functionalism (to pick just one sociological concept) or even Rogerian therapy but only insofar as these *inform,* not define, the way in which one works with clients. This is, of course, not something about which all psychiatric nurses necessarily agree and, as we have observed, the 1990s has seen the re-awakening, in some circles, of technologically inspired attempts to define schizophrenia in biological terms, and to revive psychiatric nursing as a supportive agency within a dominant biomedical culture. Yet, to risk overstating the point, it is an historical 'truth' grounded in the testimony of those who were there (Martin 1984) that the asylum/hospital conditions which directly stemmed from medical constructs of illness and its treatment led inexorably to the doldrums of institutionalised nursing. This was a nursing comprised of hierarchies, rules, uniforms, the omnipotence of doctors, an obsession with illness and, especially, the 'death by boredom' of shift systems. There existed a slavish obedience to received ideas, especially within nurse training departments, whereby patients simply withered on the vine of concepts of chronic illness. In far too many cases these attitudes led to a slippage into abuse and neglect.

This sort of nursing practice, incapable of dealing with patients outside medical constructs, persisted within such settings until as recently as fifteen years ago. The issue is therefore about how nurses, who do not themselves play a large part in the development of medico-psychiatric constructs, interpretthose constructs in delivering care to the patient and the extent to which they allow their actions to

be governed by them. An uncritical acceptance of illness models leads to beliefs about incomplete recoverability and it is this kind of thinking which also fosters custodialism and despair.

The new technocracy of care

Recently, whilst reviewing a paper (Gournay and Brooking 1994) with a view to discovering something about its methods and design, it became apparent that the paper's quantitative methodology, whilst being described in terms of its investigative merits, was in addition being proselytised as a superior approach to research. It seemed that a sub-textual propaganda was afoot. From my initial concern with methodology I became fascinated by the furtive deployment of language against qualitative studies which, according to this paper, were failing in their refusal to genuflect before the high altar of statistics.

The paper addressed various aspects of community psychiatric nursing. It described the random assignment of groups of clients to different therapeutic conditions and outlined the different client outcomes for these conditions, some surprising and some not. However, as the paper proceeded, it began to display a progressive displeasure that some Community Psychiatric Nurses (CPNS) were describing their work as 'counselling'. The paper made no attempt to find out what they might have meant by this but concentrated instead on the absence of controlled trials in support of counselling effectiveness. Surprisingly, in the absence of such trials, the authors conclude anyway that counselling appears not to be effective (1994:236). This is quite a neat shift coming as it does from psychiatric writers who would appear to pride themselves on specificity, measurement and control: for, in effect, they correlate the absence of controlled studies with assumptions about the effectiveness of that which has not been studied. Absence of evidence, in other words, becomes evidence of inefficacy. This paper is an example, par excellence, of what Hanfling (1978) calls a 'science has shown' argument, or to put this another way, discourse which seeks to show that scientific discoveries are as irresistible as progress itself.

The literature shows a growing interest in controlled trials of the 'experimental science' type and it is indeed remarkable how more and more psychiatric nurse researchers have adopted such experimentation without questioning its relevance to analysing patient relationships. What this sort of scientism ignores is the absence of any necessary connection between validity and fact. Simplistically, it impugns truths arrived at by different (that is, non-quantitative) means. Yet it is important to recognise that this re-colonisation of psychiatric nursing as a medico-scientific concern is itself a value-laden exercise. It has as one of its determinants a desire to take psychiatric nursing away from concepts of democratic practice where *everyone's* voice would merit attention and to re-orient it towards precepts which are objective and measurable. If we are to contradict this scientism then we need briefly to look at how science works.

The appliance of science

Most applied scientists operate within a conventional mode of science, working out problems and seeking solutions to questions of acknowledged significance. They rarely venture near the indeterminacy of the 'new physics' nor do they seek to concurrently disprove that which they are actively researching. Hugh Dudley (1996), in this instance, makes a distinction between science and scientific advance, by which he means that whilst most scientists work within conventional boundaries of testing their hypotheses, when scientific conclusions arrived at logically are at odds with underlying theory, they will remain sceptical and be prepared to shift their ground. They will balance 'the facts' against theory. What they will not do is use 'the latest findings' as a battering ram against colleagues who choose to differ and, of course, from a Popperian perspective, this would be a decidedly unscientific thing to do. The Gournay/Brooking paper, for example, masquerades as dispassionate writing, whilst implicitly condemning research which either relies on literary discourses or patients' narratives of their experiences. One would expect truly objective papers to concentrate on the significance of what leaves the laboratory bench, letting the findings speak for themselves, and it is therefore surprising to find that they are as politically motivated as any other kind of work. Although the full implications of their rhetoric are not spelt out, it does appear to hold that medical concepts of illness are fundamental: people have illnesses; these illnesses require treatments which can either be physical treatments or of a type which rely only minimally on human discourse and so, by their nature, produce measurable outcomes. The twin branches of psychoanalytic and humanistic therapies are rejected.

How is psychiatric nursing defined under these conditions? In addition to the provision of treatments it may also be about connecting nursing actions to beliefs about 'enduring and serious' mental illness with diminishing emphasis on 'problems' that are difficult to classify as illnesses. Interventions requiring lengthy contact time or the kind of interactive relationships which are difficult to quantify because they are unique will be sidelined. In short only that nursing which can produce evidence for what it does—specifying interventions and outcomes discretely—may be deemed worthy of inclusion.

Defining nursing

My purpose is not to attack approaches based on concepts of illness nor to castigate the kinds of research and treatments they appear to warrant. Rather my challenge to those who espouse these approaches, is that they identify the bits which comprise *nursing* and defend their position within a nursing context. The problem for them is that in using serious and enduring illness as a starting point, interventions are either going to be cognitive-behaviourist in nature, thus edging nursing towards a psychological mode

of practice, or they are going to be of a nature which will return nurses to the role of interminable second-fiddle to a medical speciality which enduringly controls diagnosis and prescription. In fact, the positions spearheaded by writers such as Gournay (1995) and Ritter (1997) are only viable in connection with medicine although they might point to initiatives such as the Thorn Programme (Gamble 1995) to refute this. Whilst anything that helps disabled people is to be welcomed, I am persuaded that Thorn programmes are as valuable to professional ascendancy as they are to patient care. An analogy can be made here with the introduction of phenothiazine drugs in the 1950s whereby these too heralded such high optimism that a feedback loop occurred in which higher and higher dosages of them were given. Since one imagines that the aim of pharmacology is to get the greatest benefit from the lowest dosage of a given drug it is surprising how rare this has been in psychiatry where drugs have often been used excessively and sometimes punitively (Breggin 1993). The same applies to Thorn where a modest package of psycho-social interventions has become regarded as a veritable 'magic bullet', which it is not. What Thorn does allow are interventions capable of producing measurable outcomes with schizophrenic patients, the unacknowledged caveat being that observable improvements in socially deprived schizophrenic patients within short time periods are not difficult to achieve anyway.

What Thorn fails to take account of is the person's right to refuse such treatment. Indeed the problem with 'packages' like this is their inability to recognise the intransigent nature of chosen lifestyles as well as their tendency to respond to refusals of treatment in ways which iron out the possible complexities involved rather than engage with them. The role which the unconscious life might play in refusing help or even in courting despair is anathema. Similarly, the manner in which some people find comfort in drifting into vagrancy is inexplicable other than as some 'idiosyncratic' choice. It is therefore debatable whether Thorn, or anything like it, could bring about long-term change and even more questionable whether it could provide a substitute for the necessary social and political redress of injustices visited on psychotic people.

Thorn's defenders point to the 'evidence' of its success and use this in turn as a further endorsement of the randomised control method. Gournay, for example, states that 'those who are responsible for funding projects and making public policy view such trials as the ultimate test. Mental health nursing should ignore this method at its peril.' (This in itself is an interesting 'disclosure' of who nurses should see as their significant audience.) The problem with controlled analysis, however, is that its subject rarely extends beyond single items of behaviour and is usually cleansed of both individual experience and psycho-social influences such that any explanatory power which these might have is lost. In addition, quantitative studies take very little account of the narratives of their subjects (something on which much of physical medicine relies). What this leaves, in effect, is a definition of nursing that does not admit quality of interactions as a primary element and