



FEATURE ARTICLE

Myth of mental health nursing and the challenge of recovery

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ABSTRACT: *Although the concept of ‘mental health nursing’ has grown in popularity over the past 35 years, it remains a myth. People believe that they know what it is and value it highly, but cannot describe or define it other than in vague terms. This paper briefly charts the rise of ‘mental health nursing’, emphasizing its political implications, and in particular, the drive towards an embrace of a person-centred, recovery-focused approach to care. If nurses are to realize such ambitions, they must resolve their historical association with psychiatric nursing. The concept of the ‘mental health nurse’ might signal the emergence of a new vision for human services, but might also signal the need for ‘mental health nurses’ to negotiate a formal separation from the traditional ‘psychiatric’ family.*

KEY WORDS: *ethic, mental health nursing, psychiatric nursing, recovery, standard.*

INTRODUCTION

Mental health nursing is a discipline with no obvious ‘purpose’, or at least not one embraced by all who might lay claim to the title. What are the needs of people, their families, or society at large that are met by nurses, and are not otherwise provided by psychiatrists, psychologists, various other ‘therapists’, social workers, or other ‘unqualified’ helpers? This question was first asked over a decade ago (Barker *et al.* 1999). Would the answers that then emerged fit ‘mental health nursing’ today?

Over a century ago, ‘mental’ or ‘psychiatric’ nursing was created by physicians to provide them with particular forms of support in caring for people in asylums (Walk 1961). Since the 1950s, psychiatry has changed dramatically, and nursing has adapted, slowly becoming more expert and expressing ambitions for a genuine professional identity (Nolan 1993). However, today, in almost every country worldwide, the nurse’s primary functions remain much the same as a century ago: to keep people (and others) safe; to express medical treatment; and in

hospital settings, to ‘manage’ the physical and social environment’: the stereotype of the ‘housekeeper’.

This might sound like a harsh assessment, since it is clear that nurses are almost indispensable; most services can function even when major gaps appear in medical, psychological, or other therapeutic disciplines, but risk collapse without nurses, or at least the support of someone offering what nurses traditionally offer. Most nurses today also possess university degrees. Many have completed supplementary training, qualifying them to deliver different ‘therapies’ or even to prescribe psychiatric drugs. However, to what extent do these developments reflect an extension of ‘nursing’ per se? Are these ‘extended roles’ merely examples of nurses becoming more adept at fulfilling roles once the preserve of other disciplines, such as medicine or psychology?

The Australian Congress of Mental Health Nurses (ACMHN), later to become the ‘College’, was founded in 1975 (Martyr 1999), making it one of the first organizations to use the title ‘mental health nurse’ officially, and therefore, worthy of specific acknowledgement with regards to the issues raised in this paper (J. Chesterson, pers. comm., 2010). Almost 20 years later, this title was recommended officially for nurses working in the community, hospital, or day services in England (Mental Health Nursing Review Team 1994). Since then, ‘mental

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Accepted December 2010.

health nursing' has spread around the globe, although in Europe, Horatio still remains an association of 'psychiatric nurses' (Horatio 2010). However, the difference between 'mental health' and 'psychiatric', or 'mental nursing', still remains unclear (Cutcliffe & Ward 2006, p. 22). In a very important sense, 'mental health nursing' is a 'myth', in the classic sense, reflecting how nurses would 'like' to be: a professional aspiration, rather than a practical reality. Most of the writing and talking about 'mental health nursing' is mere 'ideology': the collected ideals and social aspirations of some sections of the traditional 'psychiatric nursing' discipline (Chambers 2006). However, if nurses brought this ideology to life, their purpose might become clearer.

MERCURIAL NATURE OF MENTAL HEALTH NURSING

As ideology, 'mental health nursing' provides a linguistic means by which practitioners can feel better about themselves. In England, Norman and Ryrie (2004) suggested that this might be its only function:

In part this change in terminology would appear to reflect a desire by nurses to establish their profession as distinct from the discipline of psychiatry and also to find a more positive identity as people who can help people who are mentally ill [sic] become mentally healthy. (p. 67)

Despite its international popularity, the ideological shift towards 'mental health nursing' is often blurred by blending 'psychiatric' with 'mental health nursing'. For Cutcliffe and Ward (2006), this terminological confusion was key to all the theoretical and philosophical debates in the field, leading Collins (2006) to argue that it might be 'time to consider whether psychiatric nurses are nurses at all'. Such a radical stand would, however, require nurses to split from their historical roots: 'free from the influences of the "medical father" and the "nursing mother"' (Collins 2006, p. 50).

'Mental health nursing' implies something more meaningful, more egalitarian, more 'health promoting', and therefore, more liberating than traditional psychiatric nursing. This was signalled in the Australian College of Mental Health Nurses' (2010) definition:

(A mental health nurse) holds a specialist qualification in mental health. Taking a 'holistic' approach, guided by evidence, the mental health nurse 'works' in 'collaboration' with people who have 'mental health issues', their family and community, towards 'recovery' as defined by the individual. (p. 5. Emphasis added)

In contemporary international practice, the terms 'psychiatric' and 'mental health' nursing are used almost interchangeably. Nolan's (1993) groundbreaking 'history of mental health nursing' referred, in the main, to 'psychiatric' nursing, since the concept of 'mental health' nursing was introduced officially into the UK only a decade before the publication of his book. However, as Chambers argued: 'Logically . . . those nurses working with the mentally ill should, at the very least, be called "mental illness nurses" or even "nurses of the mentally ill[sic]"' (Chambers 2006, p. 44). If 'mental health' nursing is not simply rebranding – a piece of linguistic cosmetic surgery – then it must refer to something different from 'psychiatric' nursing.

In an ongoing study, we asked mental health nurses to provide brief, concise descriptions of what is 'psychiatric and mental health nursing?' and 'how do nurses 'practice' it?' (Barker & Buchanan-Barker 2008) We offered two-line definitions of medicine, psychology, and social work, drawn from Web dictionaries, to act as a guide. Two-hundred practitioners, leaders, researchers, and educators from around the world were invited to 'define' and 'describe' their discipline in a way that 'could be understood by the layperson'. Many admitted that these were 'difficult questions', finding it hard to offer definitions and descriptions that were not jargon-ridden summaries of eminent theorists. This led us to wonder how recruitment is encouraged, if prospective mental health nursing students cannot be offered a simple definition of its purpose and function.

Only a few respondents distinguished between 'psychiatric' and 'mental health' nursing. One professor of nursing from the USA said that the field was divided into two 'camps'. The first was:

A subservient discipline and an extension of psychiatry's social control mechanism(s) for the policing, containment, and correction of already-marginalized people, which carried out a number of defensive, custodial, uncritical, and often iatrogenic practices and treatments, based on a false epistemology and misrepresentation of what are, by and large, 'human problems of being', rather than so-called 'mental illnesses'.

The second was:

A specialty craft that operates primarily by working alongside people with mental health problems; helping individuals and their families find ways of coping with the here and now (and past); helping people discover and ascribe individual meaning to their experiences; and exploring opportunities for recovery, reclamation, and

personal growth, all through the medium of the therapeutic relationship.

People considering undertaking nurse training might wonder if they have a choice to join 'either' the first 'or' the second of these 'camps'. By contrast, a distinguished nurse leader from the UK said that mental health nursing covered:

A broad and moveable spectrum of roles, responsibilities, and practices defined by the economics, institutions, and policies of the day, which meant that this particular branch of nursing could not be defined.

PATERNALISM AND THE HISTORY OF PSYCHIATRIC NURSING

Clearly, there are risks in being defined by the 'economic', 'institutional', and 'political' influences of the day. The nurses who participated in the mass involuntary euthanasia programme during the Holocaust were merely conforming to the social and political standard of national socialism (Benedict & Kuhla 1999). The countless number of nurses in psychiatric hospitals who participated in electroshock, psychosurgery, enforced sedation, the application of wet packs, restraints, and seclusion were also conforming to an image of nursing practice set for them by someone in authority (Peplau 1994). If nurses do not define themselves professionally, they risk being defined and directed by others who might have very different agendas. Arguably, nurses' uncertainty over defining themselves and their inclination to serve almost anyone in authority lies in their history. In the mid 19th century, the physician, John Connolly, famously remarked:

All (the physicians') plans, all his care, all his personal labour, must be counteracted, if he has attendants who will not observe his rules. (Connolly 1856, p. 37)

Such attitudes led to the development of training programmes for attendants, created by physicians, largely to meet the physicians' needs (Walk 1961). In Cohen's (1981) view, medical patronage had long been nursing's biggest problem: 'Nightingale defined the nursing role as handmaiden to the physician, and it has remained so. Handmaidens are not professionals' (Cohen 1981, p. 140). Doubtless, most contemporary 'mental health nurses' would lay a strong claim to professional status. However, this only makes the inconsistencies and uncertainties over the definition of the discipline all the more intriguing.

Few psychiatric-mental health nurses give their history more than a casual glance, which might be reasonable, since it is not an attractive story. When trained nurses replaced Connolly's untrained attendants at the beginning of the 20th century, they continued the attendants' custodial function, but also provided more technical support to physicians, becoming the administrators of various 'patient management' methods, most of which had disastrous effects on the people concerned (Whitaker 2001). Given their 'medical-expressive' role (Barker 1990; Peplau 1994), nurses were either responsible for, or assisted in, the delivery of all such 'treatments', the validity and usefulness of which they never questioned, since they carried the stamp of medical authority. Unmodified electroshock, insulin coma, and lobotomy might be history, but forced drug administration continues, as does the widespread practice of disinformation and deceit often involved when nurses try to encourage people to take psychiatric drugs, which they do not want, or interpret their problems from a psychiatric perspective (Jackson 2005; Lakeman & Cutcliffe 2009).

A recent Irish study provides a fitting example, where nurses avoid telling people of the likely effects of certain drugs for fear that they would stop taking them (Higgins *et al.* 2006). Although defended as 'caring concern', this was paternalism writ large. The many 'side-effects' of neuroleptic and antidepressant drugs are well known and include pseudo-Parkinsonism; shrinking of brain mass; increased risk of impotence, obesity, seizures, and diabetes; enlarged breast tissue in men; dulling of the intellect; and heart problems, which might result in death (e.g. Wikipedia 2010). Before offering or recommending such drugs, any health-care professional should provide the person with a full explanation of all such risks. Failure to do so would be dishonest, unethical, dangerous, and illegal. It is only surprising that there is not more litigation related to the kind of 'paternalistic' practices described in Higgins's study.

PSYCHIATRIC MYTHOLOGY AND PSYCHIATRIC NURSING

Misplaced compassion is part of the paternalistic medical tradition: doing things, allegedly, in the patient's best interests (Breeze 1998; Szasz 1998), and nurses might have embraced this tradition even more fervently than psychiatrists. However, it has become clear that much of the paternalistic 'wisdom' concerning 'mental illness' and its 'treatment', especially by drugs, is grossly exaggerated where it is not complete mendacity. Whitaker (2010) noted:

For the past twenty-five years, the psychiatric establishment has told us a false story. It told us that schizophrenia, depression and bipolar illness are known to be brain diseases, even though . . . it can't direct us to any scientific studies that document this claim. It told us that psychiatric medications fix chemical imbalances in the brain, even though decades of research failed to find this to be so. . . . Most important of all, the psychiatric establishment failed to tell us that the drugs worsen long-term outcomes. (p. 358)

The idea of the 'chemical imbalance', first developed in the 1950s (Valenstein 1998), became the most popular myth related to of the causation of different 'mental illnesses', providing a fitting rationale for drug treatment. The 'myth of the chemical cure' was then sold as a scientific fact to patients and the public alike (Moncrieff 2009), despite the fact that no evidence existed to support the idea that 'schizophrenia', 'bipolar disorder', or 'depression' arose from such an 'imbalance'. (Our use of 'scare quotes' reflects our belief that these 'disorders' are not legitimate forms of bodily disease or illness.) Moncrieff (2009) and Whitaker (2010) illustrated how drugs offered as a solution became, for many, a cure that was worse than the hypothetical 'disease'. Hyman, the eminent US neurologist, was Director of the National Institute for Mental Health when, with a colleague, he first described how 'all' psychiatric drugs threw the brain into a state of chemical chaos, creating 'perturbations in neurotransmitter functions' (Hyman & Nestler 1996). Hyman's view that prolonged use of such drugs resulted in 'substantial and long-lasting alterations in neural function' showed that any 'chemical imbalance' that might exist in the brain of people with 'mental illness' was produced by long-term usage of psychotropic drugs, 'not' by some putative 'mental illness'.

Whitaker's (2010) review of the scientific literature on the development of psychotropic drugs formed the basis of his thesis, that through its rash and unscrupulous advocacy of such drugs, psychiatry had nurtured an epidemic of 'mental illness'. Many of today's 'mental health nurses' are either unaware or choose to forget that recovery rates from so-called 'serious mental illness' were far better 'before' the introduction of psychiatric drugs in the mid 1950s than they are today. It is commonly believed that the deinstitutionalization programme was made possible 'only' through the introduction of neuroleptics. This is psychiatric mythology. As Healy *et al.* (2005, p. 28) noted, few people are aware that the asylum population in Japan 'quadrupled' following the introduction of chlorpromazine, rather than leading to the closure of the institution. More importantly, numerous longitudinal studies (e.g.

Harding *et al.* 1987; Harrow & Jobe 2007; Jablensky *et al.* 1992) demonstrated that people with diagnoses of 'schizophrenia' and 'bipolar disorder' fared better in the long term if they 'did not' receive psychiatric drugs or gradually 'discontinued' their use. Despite this evidence, the European Convention on Human Rights, for example, exempts people with mental illnesses from its protection (Warne *et al.* 2010), with the result that, in most countries, people with 'serious mental illness' can be forced by law to take psychiatric drugs, which might cause them permanent and disabling physical damage.

Many mental health professionals would argue that drug companies have delivered 'new and improved' drug treatments, especially those who have developed sophisticated programmes to nurture adherence to drug treatment regimes, who argue, for example, that 'poor adherence increases morbidity and reduces a patient's quality of life' (Anderson *et al.* 2010, p. 341). This is not the place to rehearse these arguments in any detail. However, Lakeman and Cutcliffe (2009) have at least prefaced the case against 'pharmaco-centrism' which bedevils contemporary 'mental health nursing'.

'Schizophrenia' and 'bipolar disorder' are frequently characterized as 'malignant' forms of 'mental illness', requiring prompt medical intervention through drug treatment, usually for the rest of the person's life. If evidence existed that a significant number of people with physical malignancies, such as carcinomas, could recover 'without' either surgical or drug treatment, then the scientific and public view of cancer would change irrevocably. Yet a significant number of people 'recover' from 'schizophrenia', 'bipolar disorder', and drug and alcohol 'addictions', either through the 'administration' of social support or simply by 'talking' about their problems. Despite this evidence, the received view endures that these states are manifestations of 'illness' or 'disease' requiring medical treatment. It is difficult to counter the argument made by Whitaker (2010) and Mosher *et al.* (2004a), among others, that the 'pharmaco-centrism' in contemporary mental health services is a function of successful marketing by drug companies, rather than deriving from scientific research.

Although much of this emergent critique of psychiatric practice is focused on psychiatrists, it implicates psychiatric nurses, without whom the machinery of psychiatry could not operate. Where psychiatric nurses are not active advocates of Lakeman and Cutcliffe's 'pharmaco-centrism', they appear to display little in the way of active resistance. This might well be typical of their traditionally conservative outlook. As Nolan (1993) observed, psychiatric nurses 'have embodied traditional values of

subservience to the system and preservation of the *status quo*. Theirs has been a 'victim role' and by deflecting responsibility for the failures of psychiatry onto doctors, patients, or the institution, have made themselves, some would claim, obstacles to progress' (p. 159).

PERSONS AND RECOVERY

Much of the traditional discourse on psychiatric–mental health nursing remains focused on the treatment or management of 'patients'. Having coined the term 'nurse–patient relationship', in her last major paper, Peplau (1995) turned her attention away from 'patients' to the subject of 'persons':

Nurses claim that advocacy for patients, and consideration of their needs and interests *as persons*, having dignity and worth, are primary values inherent in the design and execution of nursing services. In keeping with these claims, it would behoove nurses to *give up* the notion of a disease, such as schizophrenia, and to think exclusively of patients as *persons*. (p. 2)

Peplau might be the most cited author in the nursing literature, but few nurses today practice what she preached at the end of her life. The most cursory trawl of any psychiatric–mental health nursing journal reveals that many nurses are reluctant to give up the notion of 'patients', 'diseases', or 'illnesses', such as schizophrenia. However, Peplau might have anticipated the 'person focus' of recovery (Barker 2001), only beginning now to be embraced, officially, by mental health nursing. In a highly-significant development, the *Standards of Practice for Australian Mental Health Nurses 2010* articulated five core values underpinning practice. These included:

... acknowledging the personal experience and expertise of the individual, supporting their potential for recovery and assisting them to achieve optimal quality of life. (ACMHN 2010, p. 5)

This implies that at least one purpose of nursing is to help people live their lives in the way they see fit. This is developed further in Standard 3:

... the Mental Health Nurse develops a therapeutic relationship that is respectful of the individual's choices, experiences and circumstances. This involves building on strengths, holding hope and enhancing resilience to promote recovery – later defined as a subjective experience, defined by the individual. (ACMHN 2010, p. 10)

GRASPING THE NETTLE OF THE RECOVERY ETHIC

Although necessarily vague, the ACMHN standards represent important examples of attempts to articulate the 'purpose' of mental health nursing. We singled out for consideration some of the ACMHN standards, since they represent the expressed views of members of the discipline itself, rather than ambitions made on behalf of the discipline by politically-elected or otherwise politically-motivated groups called upon to conduct 'reviews' of nursing, as so often prevails in other countries (e.g. Department of Health 2006). Moreover, the ACMHN standards also appear to distinguish 'mental health nursing' from the traditional practice of 'psychiatric nursing'. This is expressed most perhaps by the emphasis on 'values'.

The ACMHN concept of 'mental health nursing' appears focused on helping people live their lives 'on their own terms', echoing Barker's concept of 'trephotaxis':

Although we may help people to change in some way, we do not change people directly. Certainly we do not heal people, or otherwise make them whole . . . I have come to accept that while helping people always involves change, it never involves a return to previous functioning: it is always a forward change. I have called this approach *trephotaxis*, which in the original Greek would mean the 'provision of the necessary conditions for the promotion of growth and development. (Barker 1989, p. 138)

This contrasts starkly with 'psychiatric nursing', which appears to be focused primarily on the management of some hypothetical 'mental disease' or 'illness', and usually involves 'treating' the person by some medical means, and if necessary, by force. In this sense, 'mental health' and 'psychiatric' nursing could not be more different.

The ideal at the heart of the 'mental health nursing' 'ideology' embraced by the ACMHN standards, reflects an understanding of nursing in its purest sense. The English word 'nursing' derives from the Old French 'nourice', meaning to nourish. Therefore, nursing implies the provision of the conditions necessary for a person to thrive, grow, and develop (Barker 1989), using whatever resources are available, complemented by the nurse's compassionate support (Barker 2000).

We searched the psychiatric–mental health literature for models of practice that met the criterion of 'nourishment through interpersonal caring'. The examples that exist are more often than not provided by psychiatrists and psychologists who have moved beyond the limits of their core discipline. Arguably, the most famous example

of 'nourishing nursing' was Loren Mosher's work with the Soteria project in California in the 1970s and 1980s (Mosher *et al.* 2004b). Mosher showed how compassionate caring, without the use of psychiatric drugs, could help people grow and develop through the experience so-called 'schizophrenia'.

Another psychiatrist, Ed Podvoll, was the inspiration for the Windhorse projects in Colorado and Massachusetts, which realized what Podvoll called a genuine nursing of the mind (Podvoll 1991). Distressed people were helped to live ordinary everyday lives with nothing more than careful support of caring companions.

In Finland, another psychiatrist, Yrjo Alanen, developed his needs-adapted model in Turku, which also demonstrated that careful listening, without neuroleptic drugs, could help people reveal the meaningful stories embedded in so-called psychotic states, and in so doing, helping the person construct a new 'self-narrative' for going forwards (Alanen 1997). Alanen's work has been developed further by Jaako Seikkula in his 'open-dialogue' approach (Seikkula *et al.* 2006). Like the others, Seikkula embraces the virtues of humility, respect, and careful attentive listening. All three are examples of 'trephotaxis', although Mosher and Podvoll chose to work with staff chosen for their human qualities, rather than professional nursing qualification.

The ACMHN standards and their underpinning values signal an ambition to reinforce, or perhaps establish officially for the first time, a different kind of nursing for people experiencing the problems in living, commonly called 'mental illness'. This initiative is laudable, but not without potential problems. As Glover (2005) noted, it is one thing to embrace the recovery ethic, and quite another to shift towards a recovery-based paradigm. In the context of the ACMHN's expressed ambition to locate 'recovery' at the heart of 'holistic' mental health nursing practice, a number of questions might be asked. These might include the following.

Could a 'mental health nurse' fulfil the ACMHN standards 'and' be involved in:

- The administration of psychiatric drugs or any other form of treatment 'against' a person's expressed wishes?
- The use of coercive or constraining practices, such as 'control and restraint' or 'seclusion'?
- Any programme that encourages individuals or their families to adopt a psychiatric view of their 'symptoms' of 'mental illness', rather than assist people to develop their own understanding of their problems in living?

CONCLUSION

Over 20 years ago, Barker (1989) said that his articulation of 'trephotaxis' served: 'little other function than symbolic protection from those who would define our art for us' (p. 140). Perhaps the ACMHN standards represent a significant advance on that 'symbolic protection', as the College seeks to mould the discipline in the image of the ideas it values most. However, the emphasis given to valuing the active 'person focus' of partnerships, personalized notions of recovery, and respect for human rights might fly in the face of contemporary forms of 'evidence-based practice', which remain 'patient focused' and paternalistic, where they are not actually coercive and dehumanizing. The ACMHN standards appear to represent an important step forward in clarifying the fundamental purpose of mental health nursing. However, that step might also require the discipline to reconsider its relationship to 'psychiatric' nursing, if not also the traditional family of psychiatry, which might not share the value base of mental health nursing.

Five years ago we surveyed 100 colleagues in different countries around the world. Our question was simple: Could someone with a 'conscientious objection' to 'any' form of coercive practice, train 'and' qualify as a mental health nurse? The unanimous response was 'no'. Several educators said: 'Such a person could study and qualify, but if they confessed such a view at interview, they would be unlikely to gain employment in "mainstream practice"'.

We are not sure if the people who framed the ACMHN standards intended to make a radical statement about mental health nursing and mainstream practice. At least on paper, the standards raise many challenging questions about the relationship between the College's vision for the future of mental health nursing, the shadow cast by psychiatric nursing of old, and their common roots in the mental health field. Whatever its potential, however, 'mental health nursing' remains a 'myth' in the sense that the concept reflects how nurses would 'like' to be: a professional aspiration, as expressed by the ACMHN standards perhaps, rather than a widespread contemporary reality. What is clear, beyond dispute, is that the days where nurses debated what to call themselves appears to be over. Now nurses appear to be begging the question: 'What do we "do?"' to merit the title 'mental health nurse' and 'Why do we do this, rather than anything else?' The answers to such questions signal a future form of practice that might differ significantly from the conservative traditions of the psychiatric nursing past.

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