CHAPTER ONE: INTRODUCTION

1.1 Background to this study

Over the past few years, policy documents from the Department of Health as well as empirical research studies suggest that acute psychiatric admission wards are experiencing difficulties in managing clients in their care. Amongst these difficulties is an increasing reduction of in-patient beds nationally and the increasingly complex problems that clients present on admission.

The acute admission wards in the Queen Elizabeth Psychiatric Hospital (QEPH) are clearly experiencing the same type of problems as other facilities nationally.

Bowers and Park (2001) state that one of the unfortunate and unintended consequences of the deinstitutionalizing of mental health care by shifting care out of the old Victorian asylums into the community [1], has been the relegation of acute in-patient care from the centre to the margins of mental health services. In their view economic and philosophical objections to hospital care have resulted in great uncertainty about the contemporary purpose of in-patient services and thus of the role of psychiatric and mental health nursing within that context.

On the other hand, they assert that adequate alternatives to in-patient services have not been developed. The result is that psychiatric hospitals are now paradoxically almost entirely associated with containment. The assumption that they can be appropriate places of refuge has virtually disappeared.

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[1] See *Caring for People: Community Care in the Next Decade and Beyond* (DOH 1989).

According to a recent Sainsbury report (1998) [2], patients [3] tend to experience their stay in acute wards as non-therapeutic. There is little individual care planning and the environment tends to be custodial in nature with little quality. In addition to this, working on acute in-patient admission wards 15-20 years ago was a relatively high status position for psychiatric nurses who worked with patients considered to be amenable to both intervention and care. This is no longer the case.

What used to be the jewel in the crown of psychiatric services has become the rump. According to Quirk & Lelliot (2001), acute wards are now places of risk, violence, restraint and custodial care where the quality of care has been compromised or is under threat. They are perceived to be relatively low status or dead-end work environments. Nurses who work on acute wards in comparison to their community colleagues are paid less, tend to be less well educated professionally and have fewer opportunities for career advancement. The result is that the least able and the least experienced nursing staff care for the most acutely distressed patients[4] . According to Quirk & Lelliot (2001) –

"Nurse patient contact has declined; and patients are critical of conditions on the ward and view life there as both boring and unsafe".

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[2] See *Acute Problems: A Survey of the Quality of Care in Acute Psychiatric Wards*, The Sainsbury Centre for Mental Health (1998). London. The Sainsbury Centre for Mental Health.

[3] In this paper the term '*patient*' will be used interchangeably with the term '*service user*', '*client*' and '*person*' Historically doctors and nurses have spoken in terms of having *patients*, social workers, counsellors and psychologists in terms of having *clients*, profit making business in terms of having *customers*, managers of service industries in terms of *service users* and ex-users of mental health services in terms of being *survivors* of those services

[4] According to Quirk & Lelliot (2001) - *"...Nurse patient contact has declined; and patients are critical of conditions on the ward and view life there as both boring and unsafe.* ". In addition to that, acute wards are characterised by rapid staff turnover, extensive use of bank and agency staff and low morale.

In addition to this, they state that acute wards are characterised by rapid staff turnover, extensive use of bank and agency staff and low staff morale. The improvement of the quality of care on acute admission wards is thus a major on-going concern for the Department of Health (1999, 2002, 2003), which, in a recent Policy Implementation Guide (2002), openly admits that:

"In-patient services are not working to anyone's satisfaction"

According to Allen & Jones (2002), with acute mental health care in such a crisis we should consider every mental health nurse who works in the acute in-patient setting as a key resource for change. Until this view is adopted, many nurses who see themselves as seriously ill-equipped for the strenuous demands placed upon them in the acute setting, or undervalued because of a lack of relevant training and support as well as underpaid, will continue to leave acute in-patient work for less stressful, more prestigious and better rewarded jobs in the community.

As a result of this state of affairs, this study seeks to give a wide-ranging picture of the full context in which these problems have developed, in order to more effectively identify those nursing practices, and the theory underlying them, which will substantially improve the therapeutic experience of clients. By doing so it seeks to examine, in depth, a current issue of great concern to the Department of Health and to the nursing profession, an issue that has important implications for all the acute in-patient facilities at the QEPH and the way in which these impact on in-patient service users.

1.2 Looking inside the black box

Quirk & Leliott (2001), in their discussion of previous studies on the nature of current psychiatric in-patient care, point out

that there is actually very little known about the quality of care being provided on UK admission wards. Despite various studies about daily life on acute wards, what is left is a patchy, inconsistent picture and a very opaque window looking in on how in-patient care is currently experienced by its recipients and by the nurses who work on acute wards. In the authors' words:-

"*There is a sense that hospital care is a black box, with people being admitted and discharged, but with little known about what happens to them while they are there*".

According to Higgins et al. (1999) patients report feeling bored, filling in time by sitting on their own doing nothing, watching television or talking with other patients. 40% of patients according to national survey undertaken by the Sainsbury Centre for Mental Health (1998) reported having undertaken no social or recreational activity while on the ward. Another survey undertaken by Ford et al. (1998) reported that most patients had little to do all day and the nursing staff took little interest in them unless they were making a disturbance.

This study seeks to take a look inside at least one black box in the hope that by obtaining data as well as testimonies on the way things actually are on the acute wards at the QEPH, a real transformation of nursing practice can begin to impact on the wider vision for building and nurturing organisational change and developments already underway within the Birmingham and Solihull Mental Health NHS Trust (BSMHT).

1.3 Tolkien Ward

Tolkien Ward is one of four adult acute in-patient wards at the Queen Elizabeth Psychiatric Hospital (QEPH), which is in Edgbaston, Birmingham, United Kingdom, serving a population of approximately 450K. The QEPH provides in-patient care for the South of the city. In addition to the four

acute wards the hospital contains an Intensive Care Unit, three Speciality Wards, three Elderly Care Wards and offers other services such as Neuropsychiatry, Psychology, Psychotherapy and Day Service Care. The QEPH has 93 acute in-patient beds within the four adult wards plus 10 on the ICU.

Tolkien Ward has 22 beds and its catchment area covers the Bourneville, Kings Norton, Cotteridge, Kings Heath, Billesley, Brandwood, Hall Green, Fox Hollies and Acocks Green areas of the city of Birmingham.

At the time of the implementation of the Tidal Model there were four area-based Consultant Psychiatrists whose patients were on Tolkien ward. There was also a Neuropsychiatry Consultant who had the use of two-three of the beds.

The nursing establishment for the ward during the project was:
One x ward manager (Grade G)
Two x deputy ward managers (Grade F)
11 x qualified nurses (Grades D/E)
11 x nursing assistants - mixture of full and part-time (Grade A)

CHAPTER TWO: LITERATURE REVIEW

2.1 The state we're in

According to the report *Acute Problems* by the Sainsbury Centre for Mental Health (1998), acute admission work in England is in great difficulty today. This is due to a number of inter-related reasons. Some of these are historical and economic and are directly related to a lack of investment in in-patient services over several decades, as both policy focus and resources have been re-allocated to the community. In addition to this, there has arisen a correspondingly inadequate system for training and educating nurses in ways appropriate to the very specialised nature of acute care at a time where there is an ever-increasing pressure on the in-patient system due to bed shortages [5].

Not surprisingly, under such circumstances, service users tend to experience their stay on busy acute wards as anxiety provoking and non-therapeutic. This is, in part, related to the fact that there is little skilled therapeutic involvement of nurses with patients on acute admission wards. The reason given for this by nurses is that they are just too busy doing other things like administration, answering the phone, writing up notes, attending meetings and dispensing

[5] The Sainsbury report makes ten recommendations in relation to these problems*:*
(1) Patient-centred care should be adopted as the fundamental principle underpinning the planning and delivery of acute care. (2) Care should be individualised, comprehensive and continuous. (3) A range of therapeutic resources must be available within acute care, based on the needs of patients. (4) The hospital environment must be designed to deliver a relaxed and secure atmosphere. (5) Wards should be organised as optimally therapeutic units. (6) Providers must review their provision to ensure that it meets the needs of women. (7) Staffing levels and skill mix must be geared to the provision of effective care. (8) Training in evidence-based practice is required for all clinical staff. (9) Each provider must designate a senior lead clinician or manager to take overall responsibility for bed management. (10) A range of crisis services should be available of which hospital - based care is one component.

medication. Much of the current literature into acute psychiatric care highlights a system under increasing stress [6].

Although acute admission wards are not currently in fashion within the NHS, a body of evidence is emerging that they are not only needed, but can potentially be a very effective type of intervention for some people under some circumstances. Nevertheless, according to Priebe and Turner (2003), skilled nurses[7] and planners are attracted away from acute in-patient work to community-based work because that is where the resources are and where nursing career opportunities lie. This leaves fewer resources to create and develop effective in-patient services.

In addition to this, nursing as a profession has developed a degree of autonomy and respect within the community that it does not have within more medically dominated and

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[6] Just a few of the many papers and articles which discuss these issues are: Beech, P., & Norman, I.J., (1995); Bowers, L. & Park, A. (2001); Breeze J A, Repper J (1998); Cambell P (Sept 1999).; Davenport, Sarah (2002).; Ford, R., Duncan, H., & Warner, L., Hardy, P., Muijec, M. (1998); Goodwin, I., Holmes, G., Newnes, C & Waltho, D. (1999); Higgins, R., Hurst, K., & Wistow, G, (1997); Hummelvoll and Severinson (2001; Langdon, P. E., Uaguez, L. Brown, J. & Hope, A. (2001; Parsons, C. (2002).; Rix, Susannah & Shepherd, Geoff. (2003).

[7] **Nurse**: According to the dictionary a 'nurse' is a person trained to care for the sick or infirm or (outdated) a person employed or trained to take charge of young children. Historically nursing has often been the 'poor relation' amongst the professions in that nurses are not, according to Waters (1999) *" really distinguished as having an autonomous helping and enabling role ,but as extenders and monitors of the treatment of others - this in spite of the rhetoric to the contrary. Nurses are considered useful and caring ,but I am not sure if they are considered to take an active therapeutic role or to undertake a therapy that is of any real value according to the prevailing and powerful medical model*". Waters goes on to pin point what in fact is the crucial issue facing mental health nurses today. " *Who decides on the focus of nursing services within the context of a whole coordinated service for those experiencing the life-altering effects of mental illness? I agree with Barker that we must define for ourselves the proper focus of nursing, or continue to have it defined for us by the other mental health disciplines who have the power to dictate their agenda of the funding bodies and planners of MH services.*"

poorly resourced NHS hospital settings. This tends to place acute in-patient nursing staff on the defensive. They tend to see their nursing role as subordinate and ancillary to that of the medical staff in the context of what is, often, a custodial environment.

According to Forrest (1994), one of the biggest problems in attempting to study or to improve acute in-patient services is how best to measure, understand and to work within their very complex dynamics in order to transform nursing practice. In reviewing the therapeutic day, Ehlert and Griffiths (1996) looked at the social environment and social activities on acute wards and found that many were poor and had little to engage anyone undergoing a severe mental health crisis. They also found that both nurses and patients held unfavourable views about the ward. They complained about inadequate staffing levels, the lack of support for staff and patients, the lack of patients' involvement in their own care, and the lack of therapeutic activities available for patients during the course of a day. Some patients stated they were unable even to have a cup of tea when they wished; others said they were bored most of the time and that there was little or nothing for them to do or read, and a few stated that they had no opportunities to involve themselves in activities that would enrich them spiritually.

Consistent with the Sainsbury report are the findings of the Standing Nursing & Midwifery Advisory Group in *Mental Health Nursing: Addressing Acute Concerns* (June 1999). The SNMAC also highlights the severe problems acute in-patient services are experiencing nationally. For effective reform of the acute in-patient system to take place, according to the report, what is clearly needed is a *'change in therapeutic culture'* within the acute in-patient setting [8].

[8] Concern is expressed by the Department of Health in the report about the present standards of care provided in in-patient settings, particularly patient's dignity and access to therapeutic interventions. Amongst the factors which need urgent attention are:

But, such a change is clearly dependant on broader systemic and institutional changes within the mental health system as a whole, such as those recommended by the NHS Modernisation Agency booklets on developing and nurturing

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- *A Deficiency of acute in-patient nursing skills:* The first section the report seeks to account for changes in the demands on the clinical skills of acute mental health nurses over the last few decades and the second reviews the policy framework, which provides the context for future developments in mental health nursing.
- *Pressure on beds:* Along with the Sainsbury Report, the DOH draws attention to the dramatic reduction in the number of in-patient beds since the closure of the large hospitals and the development of community care. In-patients are now much more likely to be severely ill, have a dual diagnosis, and have greater social needs. "*The complexity of the care that patients require is much greater than in the past and yet little attention has been given to the clinical skills and resources that nurses in in-patient facilities require in order to provide care this level."*
- *Nurse training and education:* The training and education of nurses has failed to take this situation into consideration. According to the report. " *In recent years the focus of education, training, status and career opportunities have all shifted from acute in-patient mental health to the community and specialist services. Acute in-patient care is seen as an area attracting specialist expertise despite the increasing complexity of care that in-patients typically require*"
- *Research base and nursing culture*: The poor research base of mental health nursing must be improved to make possible the development of evidence-based guidelines and polices. Research on the components of a therapeutic culture and the skills on the acute mental health nurse should be given priority. Education consortia need to ensure a balance of university-based and work-based courses on all grades of nursing staff in the specific skills that are required to car for patients in the acute phase of illness. Trust and Health Authorities are specially encouraged to review ward staffing levels, skill mix, training and clinical leadership to ensure that staff have the resources they require to provide high quality care.
- *Recommendations: "SNMAC recommends investigation in acute mental health nursing to enable educational opportunities and develop a career structure.*
    - *The poor research base of mental health nursing must be improved to make possible the development of evidence-based guidelines and policies.*
    - *Research on the components of a therapeutic culture and the skills on the acute mental health nurse should be given priority.*
    - *Education consortia need to ensure a balance of university-based and work-based courses for all grades of nursing staff in the specific skills that are required to care for patients in the acute phase of illness.*
    - *Trust and Health Authorities are specifically encouraged to review ward staffing levels, skill mix, training and clinical leadership to ensure that staff have the resources they require to provide high quality care".*

an 'improvement culture' within the NHS as an organisation [9]. It must become more collaborative and facilitative in its way of operating if it is going to deliver a more client-centred type of care. The way in which decisions are actually made at the management and operational levels will also need to change if a genuine transformation in therapeutic culture is to take place.

Quirk & Lettiot (2002), after looking closely at the available in both historical and sociological context have come to the conclusion that:

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[9] According to the Improvement Leader's Guide to Building and nurturing an improvement culture (NHS Modernisation Agency Series 3 (2004). *"More and more we have realised the importance of building a culture of improvement. However transforming the culture of huge organisations like the NHS and social care with millions of staff is very complicated and will take a long time."* The HSS Modernisation Agency booklet lists a number of factors which make up 'the culture' of an organisation. These include*:*

- *A Culture is about how things are done within your workplace.*
- *The way things are done within your team is heavily influenced by shared unwritten rules*
- *Cultures reflect what has worked 'well' in the past.*

According to the booklet, working in a culture that does not promote improvement would include:

- *Slow and unresponsive decision-making processes that are not understood*
- *Not getting even the basics sorted out*
- *Not sharing information*
- *Seeing training and development as a cynical way of ticking 'the empowered workforce' box*
- *Acceptance of inefficient systems that someone tried to change five years ago: 'There's no point in mentioning that, nothing will happen;*
- *Keeping your head down and doing the minimum required of you.*

Characteristics of an improvement culture would include:

- *Patient or client centeredness.*
- *Belief in the power of human potential*
- *Innovation and change are encouraged*
- *Recognition of the value of leaning*
- *Effective team building and working*
- *Good communications*
- *Honesty and trust*

- *Despite the development of community care and associated processes of de-institutionalisation, the hospital remains the hub of mental health services in the UK*
- *However, previous quantitative and survey research indicates that quality of care in acute psychiatric admission wards has been compromised or is under threat and points to a bleak experience for people who are admitted. Indicators of this include that there have been increases in admission rates, the proportion of compulsory admissions, and bed occupancy rates*
- *There is also evidence of violence, sexual harassment and substance misuse in this setting, accompanied by rapid staff turnover, low staff morale, and an increasing proportion of 'difficult patients' (especially young men with schizophrenia)*

The authors, both nationally respected researchers, emphasise the fact that although nurse/patient relationships are perceived to be one of the most important aspects of care, yet nurse/patient contact has declined dramatically on acute in-patient wards over the last decades; and patients are now critical of conditions on acute wards and tend to view life there as both boring and unsafe.

2.2 Childhood abuse, psychosis, & the dynamics of containment, control and milieu toxicity

Complicating the issue of 'why' managing care on acute in-patient words is now so dangerous and difficult are three interconnected factors, which often, according to Davenport (2002), tend to converge and support each other on acute wards:

1. The relational dynamics of 'adult' survivors of childhood sexual and physical abuse
2. The nature of custodial in-patient care on acute wards
3. The dynamics of psychotic mental states

Along with Davenport (2002), Wurr & Partridge (1996) also maintain that there is a high incidence of people on acute wards today, with various medical psychiatric diagnoses, who have experienced sexual and physical abuse in their childhood. More recently, Hammersley et al. (2004) have highlighted the growing clinical evidence that there is a strong link between childhood abuse and subsequent psychosis in later life [10].

Typical relational dynamics associated with a history of childhood sexual and/or physical abuse would include post-traumatic stress disorder (PTSD), psychological dissociation ('splitting'), drug and alcohol abuse, a pattern of re-victimisation and re-traumatisation, difficulties within relationships in which there is an imbalance of power and the over sexualisation of relationships in general.

According to Davenport (2002), the relationship between patients, many of whom have this history, living together on an acute admission ward in an intimate, but unsafe environment where there are outbreaks of violence and verbal abuse is easily sexualised and vulnerable to exploitation. This dynamic has a confusing impact upon nursing staff, who are normally not trained to deal with these phenomena and who thus get caught up in situations with little if any insight into what is happening. Relationships on the ward are thus easily subverted within a victim/perpetuator dynamic. According to Hammersley (2004) [11]

Some patients become powerless, while others are seen as predatory. Women patients are most often adversely

[10] See also Mullen P et al (1993); Read J (1997); and Read J, and Argyle M (1999)

[11] According to Hammersley (2004): "*I have personal experience as a nurse in both in-patient and outpatient settings of disclosures of childhood abuse being made by psychotic patients being dismissed, ignored or marginalised on the grounds that discussion of such issues will make symptoms worse.*"

affected. Staff find it particularly challenging to handle these difficulties with sensitivity; they can contribute to poor outcome, characterised by treatment dropouts, lack of meaningful therapeutic relationships and acting-out behaviour. For staff, the outcome is equally poor, with lack of job satisfaction, a high staff turnover and high sickness rates.

According to the now classic paper by Menzies Lyth (1988), a recognised feature of many hospital wards are institutionalised nursing practices and management attitudes that strengthen nursing staff's psychological defences against the experience of anxiety. One aspect of these defences is the *avoidance of patient contact* under plausible pretexts.

The Menzies Lyth study concerned general nursing, but Davenport (2002) convincingly applies the findings to acute psychiatric wards. Within this context, at any given time, a number of patients on the ward will be in the midst of a psychotic episode. Aspects of their behaviour and the way they relate to staff and others will be driven by the dynamics typically underlying psychotic states.

Davenport's (2002) thesis is that the dynamics of past abuse in individual patients when brought together with a custodial style of nursing care built upon nursing defences against anxiety, as well as the bizarre behaviour of some psychotic patients, makes the development of a therapeutic culture on acute wards exceedingly difficult. These three dynamics tend to work powerfully together to create a toxic or anti-therapeutic milieu based on denial rather than on trusting therapeutic relationships open to feelings, insight and new learning. The three tables below illustrate how these three dynamics often interact within acute in-patient settings:

Table 1: The dynamics of abuse

IN THE PRESENT	DYSFUNCTIONAL DYNAMIC
Difficulties in establishing trusting relationships with staff.	Manipulation of an unequal power relationship between parent and child for adult gratification leads to long-term difficulties in negotiating trusting relationships.
Poor personal boundaries	Violation of the child through a sexual act may lead to long-term difficulties recognising and maintaining personal boundaries
Re-victimisation syndrome	Early experience creates a strong on-going expectation of repeating the cycle of abuse in the present.
Low self-esteem, self-disgust and self-loathing	The original experience of abuse instils a sense of abuse, both past and present, being deserved
Sexualisation of therapeutic relationships	Early experience of a sexual relationship with a care giver creates the on-going expectation that future care giving relationships will also be sexual or become sexualised
Transference and counter-transference difficulties between staff and patients	Working with survivors of sexual abuse may evoke powerful feelings of rage, disgust and hatred, which may be displaced by the patient and experienced as disabling, confusing or frightening by staff.
After Davenport (2002) adapted	

Table 2: The dynamics of in-patient care on acute wards

IN THE PRESENT ON THE WARD	DYSFUNCTIONAL DYNAMIC
Ritual nursing tasks and procedures performed each day	Ward routine lends stability and consistency to nursing task performance and avoids excessive decision-making, but the progression to compulsive anxiety avoidance-ritual can depersonalise care, reinforce depersonalised ways of relating to patients and to the avoidance of engagement with them.
Resistance to change	Familiar ways of thinking and working are adhered to even when they are dysfunctional, making both patients and staff feel peripheral to and powerless within the routine process of institutional care.
Nursing detachment and denial of feelings	The necessary professional detachment and maintenance of personal boundaries becomes extreme and is characterised by therapeutic withdrawal, poor handovers, rapid staff turnover, failure to follow through care plans and the avoidance of difficult patients.
Collusive redistribution of social roles, e.g. scapegoating	Specific individuals are unconsciously chosen to fulfill a role for the ward and then act upon that role as assigned.
After Menzies Lyth, 1988 adapted	

Table 3: Dynamics of psychosis

THE INDIVIDUAL PATIENT	IMPACT ON WARD DYNAMICS
Psychological splitting	Nursing staff and patient groups are artificially split into good v. bad, us v. them, or victim v. perpetrator
Grandiose omnipotence	Patients (or staff) feel entitled to act as if they are all-powerful or all-knowing
Pathological projective identification	Parts of the self are experienced as intolerable and are projected out into others; others unconsciously respond in accordance with this projection. As patients often project intolerable aggression or rage, staff may be perceived as dangerous.
Persecutory states	Potentially good or popular figures are regarded with intense suspicion.
Inhibition of symbolisation (failure of verbal linking)	The use of pathological projective identification may disrupt rational thinking and good decision making and lead to disordered interpersonal behaviour.
After Davenport (2002) adapted	

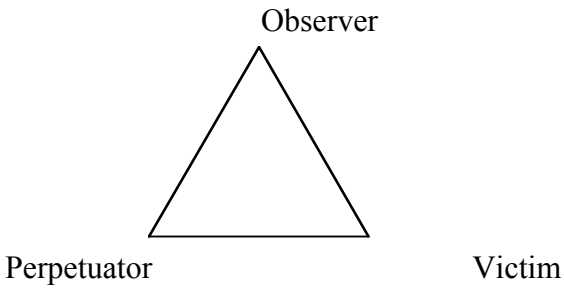
The three dynamics described in the above tables can be aptly described as 'toxic' rather than healing or recovery-oriented. Stated briefly, the metaphor of *relationship toxicity* alludes to any interpersonal context within which verbal or physical violence/abuse (either as a perpetuator, victim or silent witness [12]) takes place on a regular basis, as well as to

[12] According to Ney and Peters (1995) the typical abuse situation is not a dyad ,but actually a triangle involving the abuser, the abused, and a silent witness to the abuse or bystander who 'does nothing' to stop the abuse.

those institutional environments where relationships are characterized by denial, lack of trust, manipulation, defensiveness, poor personal boundaries, and depersonalisation [13].

By way of contrast, *genuinely therapeutic dynamics* are characterised by the core conditions necessary for personal growth, originally identified by Rogers (1951,1961 and 1980), such as mutual positive regard, trust and respect, clear boundaries, openness and honesty, willingness to learn and congruity of thought, feeling and behaviour [14].

TRIANGLE OF ABUSE



According to Ney and Peters "*..the observer, the supposedly innocent bystander who is not innocent and often is not simply one person*" is a key component of the dynamic of abuse. Current research suggests that the triangle or triqueta of abuse and neglect can rotate with different circumstances and through time with the people occupying different roles in turn.

[13] See also Kurtz (1979/1991), Friel & Friel (1990), Kellogg (1990), Beattie (1987/1992), Twerski (1990) and Schaef (1986).

[14] Carl Rogers, the originator of what is today known as the *person-centered* or *client centered approach* to care, undertook, with his colleagues, a massive research study in the 1950s to determine what were the 'core therapeutic conditions' of personal growth and recovery. The conclusion of the study was that the school of therapy to which the helper belonged or the specific psychological techniques used bore little relationship to the outcome of counseling. What related more significantly to the positive outcome of counseling and psychological therapies *was the quality of the personal relationship, which developed between the client and the therapist, counselor or person offering help*. The key finding was that human beings become increasingly trustworthy *once they feel at a deep level that their subjective experience is both respected and progressively understood by others*.

The metaphor of relational toxicity has been used for a number of decades in the addictions-recovery movement pioneered by Alcoholics Anonymous in the 1930's (See Kurtz 1979) [15]. It has facilitated a worldwide self-help movement, which has developed very clear concepts about the kinds of relationships, thinking and behaviours that tend to promote recovery from both addiction and relationship disorders and those that do not. The mental health service user/survivor/recovery movement employs similar perspectives on personal growth in conjunction with a hard-won practical wisdom that has many analogues within the self-help addiction and co-dependency recovery movement.

These analogues are instructive and are gradually transforming our understanding of mental health issues, but also the role of service users in developing health-care policy and models of recovery absent from the conventional psychiatric model, which has tended to think primarily in terms of disease/cure in which the helping professional is in charge of the whole process.

However, the weight of the responsibility of the 'cure model' in the mental health field is, according to Olthuis (2001), absolutely immense [16]. In reality, this responsibility is just impossible to bear. It also tends to support a dependency and victim mentality in service users by undermining the need for people to take personal responsibility for their own lives, actions and recovery. Over-burdened by their sense of total responsibility for both the behaviour and the recovery of those they seek to cure, many helping professionals tend to see their role primarily in terms of controlling their clients and not in terms of sharing responsibility equally with them in a spirit of collaborative problem solving.

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[15] See Alcoholics Anonymous (1939/1976) and Narcotics Anonymous (1983)

[16] Olthius (2001) is writing primarily from the perspective of a psychotherapist and counsellor, ,but the issues of cure versus care in the field of counselling and psychotherapy are the same as that within the 'mental health' field.

Within this 'control-cure paradigm', according to Olthius (2001), helping professionals naturally tend to interpret situations in such a way that if things go wrong (as they often do), the professional offering the service or 'cure' cannot be blamed. Blame will then be shifted on to colleagues or to the service user and to his or her intransigence. Applied to nursing within this paradigm, one-to-one sessions with patients often become battles of will between the nurse and the patient in which the nurse seeks to ease his or her conscience by pointing at the service users bad behaviour, and failure to co-operate.

And for their part, service users – saddled with the feeling that it is their duty to get better in order to save the nurses' ego – can end up over-complying with whatever help is offered as treatment, by saying and doing exactly those things designed to win the approval of the nursing and medical staff. This is how a 'good patient' should behave. Service users, especially those who have a history of childhood abuse, can thus be profoundly patronised and intimidated by the acute in-patient treatment setting, causing them, in turn, to either close down emotionally or to 'act out' in protest.

So, for Olthius (2001), if we are to overcome such non-therapeutic relationships and treatment environments, the premise is clear. The 'cure paradigm' of control should be replaced with a 'care paradigm' of caring-with. Olthius thus advocates a recovery-oriented and client-centred model based on a partnership between the person in need and those offering help. In addition to this, the responsibility for recovery lies ultimately with the service user not with the helping professional.

Table 4, following, Olthius (2001), contrasts two models or paradigms: the cure paradigm of control-over service users in contrast with the partnership paradigm of caring-with service users. In terms of the discussion above, it is clear

that what Rogers (1951 and 1968) first identified as the core personal characteristics necessary to form therapeutic relationships (congruence or genuineness, unconditional positive regard and accurate empathic understanding) are most likely to flourish within the caring-with paradigm based on partnership than it is within the more dictatorial cure-control paradigm.

Table 4: Cure Model of Control versus Care Model of Compassion

CURE PARADIGM OF CONTROL	CARE PARADIGM OF COMPASSION
Power Over	**Power With (Mutual Empowerment)**
Cure	Caring-with
The Expert	The Helper
Technique	Personal- interaction
Detachment	Involvement/Engagement
Impersonal	Personal
One-Directional	Multi-directional
Instrumental Reason	Imagination/Empathy
Dictative/Dictatorial	Collaborative/Partnership
Compliance	Empowerment
Uni-Vocal (Only One Voice Heard)	Multi-Vocal (Many Voices Heard)
Institution-centred	Client-centred
When I Feel Responsible For Others, I……..	**When I Feel Responsible With Others, I……..**
Talk a lot	Listen a Lot
Tell People What to do	Invite
Fix Things/ Withdraw	Attune and Stay With
Protect	Encourage
Rescue	Share
Control	Go With the Flow
Carry Other Peoples Feelings	Show Understanding
Interpret Others Thoughts and Feelings	Encourage Self-Understanding
Make Decisions For Others	Encourage Responsible Decision-Making
After Olthius (adapted)	

2.3 Why don't nurses talk to patients any more?

Davenport's (2002) thesis concerning how the inter-relationship between childhood abuse, psychosis and the dynamics of containment impacts nursing practice on acute wards, when brought together with Olthius' (2001) contrast between a 'cure' versus a 'caring-with' model of interpersonal relations helps explain why nurses tend to avoid patient contact on acute wards even though they may be unaware that they are doing this.

Peter Cambell, a long-term survivor of the mental health system, gives a personal account of the frustration and anger many service users feel as in-patients, because of the fact that nurses claim not to have enough time to talk to them. His testimony is consistent with the current literature. According to Cambell (1999):

People with a mental illness diagnosis often say that they value relationships more than psychiatric drugs.

This coincides with nurses saying how much they value their relationships with their patients. Yet nurses also express frustration and anger as they explain how there is not enough time for them to talk to their patients or to establish meaningful therapeutic relationships with them on acute wards.

Part of this general frustration is compounded, according to the available research, by many nurses' acute *awareness* of the large gap that exists between, on the one hand, the stated values of their profession and personal vocation to be a caring person, and, on the other hand, the harsh reality of poor care experienced by both patients and their relatives [17].

[17] See Building and nurturing an improvement culture (NHS Modernisation Agency Series 3 (2004).

The Department of Health's (1994) mental health nursing review declared:

'The work of mental health nurses rests upon the relationship they have with people who use services. Our recommendations for future action start and finish with this relationship'

But, one could ask, what is the real possibility for developing this kind of partnership between nurse and patient within present acute in-patient settings when nurses do not spend quality time with their patients or talk to them except in summary ways?

According to Cambell (1999), the professional and research consensus is that interactions between service users and nurses have generally improved in the community over the past few decades. The barriers that power imbalances (between those who deliver mental health services and those who use them) used to place along the pathway of therapeutic relations in the past are now generally understood today.

In the more distant past, the role of psychiatric nurse was, according to Sainsbury (1974), clearly defined in terms of a rigid institutional hierarchy in which the patient had the lowest place. Orders were passed down the line. According to Sainsbury (1974)

There was a relationship of authority-submission between nurses and patients, and nurses were expected to direct and manage patients in all their activities. The criterion of the nurse's efficiency was the quietness and tidiness of the ward, rather than the therapeutic atmosphere and the quality of their relationship with their patients.

Cambell reminds us that things have improved considerably since then. Service users are much more powerful today

than they were during the high Victorian era and more powerful then they were in the 1960s and 70s. Nevertheless, serious problems and dilemmas still remain within the hospital setting today. According to Cambell (1999)

One of them is why mental health nurses in in-patent settings will not talk to us. Service users clearly expect nurses to talk to them – we may get diagnostic interviews from psychiatrists and group therapy from psychologists, but we expect nurses to talk to us. Ostensibly, that is also what mental health nurses intend to provide. Professor Altschul (1972) has written of the importance of interaction, saying: 'it has meaning, is mutually beneficial and has purpose'*, but how much of such interaction do we get and is it becoming more or less common? Unfortunately, patient contact is not a significant priority in the traditional psychiatric hospital*.

2.4 The dislocation of appearance and reality on acute wards

Sociological research into the nature of knowledge has demonstrated the many ways in which our knowledge and perception of reality is, in the words of Berger and Luckmann (1966) 'socially constructed'. This has enabled a more self-aware and self-critical appraisal by nurses today of their role within the mental health system of both the past and present and the *historical and ideological factors* which have influenced both the theory and practice of nursing as well as the theory and practice of psychiatric medicine, counselling and psychotherapy. There is, according to Lynch G (1998),

…..an increasing recognition that the cultural and intellectual world that we now inhabit is very different to the one in which therapy originated

The discrepancy between the *stated values* of client-centred care and service user involvement within the nursing profession and the *present reality* of nursing care on acute wards is thus one of the first painful issues that needs to be faced in any serious effort to change nursing practice on acute wards. Contemporary psychiatric nursing in particular is fraught with many dislocations of reality and appearance, which reflect the inner tension between the Victorian and early 20th century origins of psychiatric nursing and its present very different historical context. Contemporary mental health care nursing is thus rife with often unacknowledged philosophical disagreements over the proper focus of mental care, and thus ethical strife.[18]

Ethical strife, according to Lakeman and Curzon (1998) is generated when nurses *strive towards understanding the individual in our care rather than simply relying on psychiatric or diagnostic labels*. Philosophical conflicts (say, over what it means to be a human being) surface where there are sharp disagreements over the proper focus of nursing care. This is especially the case when nurses see their nursing practice compromised or undermined by institutional and administrative practices which they see are clearly disempowering both patients and themselves, practices that are extremely resistive to change or reform. In the literature consulted [19], nurse clinicians and academics as well as service users complain that the gap between nursing theory and practice has never been greater than it is today.

There are complex reasons for this. Peters and Chiverton (2003) observed that where there was focus on a patient's progress this tends to be conceptualised primarily *in medical terms*. In other words, it tends to be constructed in terms of

[18] See Barker and Davidson (ed) (1998

[19] For example, see Nolan P (1999); and Hall B (1996); Horsfall J (1997); and Cambell P (Sept 1999)

purely medical treatments, new medication or referral to other medical specialities. The result is that doctors tend to dominate decision-making on acute in-patient wards and patients have few opportunities to say how they really feel about things except within formal medical ward rounds lasting about 10 minutes or less. During those few minutes patients must face their psychiatrist, junior medical staff, medical students, the nurse (and often nursing students), the social worker, occupational therapist and other helping professionals in a meeting which can involve up to eight to 10 people. Nursing practice, in such a context, tends to subordinate itself to medical interpretations of the patient and the patient's problems. Often the result is the loss of a uniquely nursing perspective.

According to Morrey (1998) Davidson (1998) and Berke (1989), nurses working on hospital acute wards tend to view and talk about the patient as if the person was a passive host of mysterious mental disease processes to be looked after by experts who 'always know best'. They also tend to assume that the patient's own interpretation of his or her experience and symptoms has no or little relevance to their treatment and that 'insight' means agreeing with the doctor or the nurse about the meaning of the patient's symptoms and diagnosis. It is then the job of the nurse to help control or suppress the patient's symptoms of distress, often whilst ignoring the patient's own interpretations or version of events [20].

[20] According to Morrey (1998). - *'Such attitudes are an essential part of the very strategy of professionalism. Professionalism seeks to maximise the amount of social distance between producers and consumers of services and to create conditions of both dependence and uncertainty on the part of consumers, thus being able to control and manipulate them. Laying claim to esoteric knowledge (and the skills which are claimed to follow from this) offers a powerful means of dominating a producer-consumer exchange, and being able to impose what are to be the conditions of exchange.'*

According to Jourard (1971), much of the professional expertise of psychiatric nurses working in hospitals tends to involve the nurse's

….ability to get patients to conform to the prescribed roles they are supposed to play within the social system of the hospital, so that the system will work as smoothly as possible

Although Jourard was writing over 30 years ago the situation he describes is still current within many hospital settings today, as evidenced by Moorey (1998), Nolan (1999), Hall (1996), Horsfall (1997), Barker et al. (1997) and others. Within a 'containment' or custodial style of care the emphasis falls primarily on the *management of risk* rather than on the recovery of the person in care. Nursing practice in this context tends to value various methods of suppressing symptoms and controlling disturbed behaviour more than learning from the patient about the patient and the nature and meaning of this patient/person's distress from the patient's perspective.

In such an environment, according to both Bray (1998) and Horsfall (1997) the uniqueness of each person receiving care tends to disappear behind diagnostic labels. The person's own voice is easily silenced under such conditions by the authority of professional or bureaucratic language. When that happens, it is more or less inevitable that the relationship between nurse and patient will be a depersonalised one, a relationship which follows a predictable, institutionalised, stereotyped, pattern, not conducive to therapeutic relationships or to genuinely therapeutic conversations.

2.5 Conflicting perspectives on the appropriate focus of nursing care.

Having raised the difficult issue of the 'social construction of reality', it is appropriate for this study to examine briefly those philosophical perspectives which impact on contemporary nursing practice at ward level and on the way in which patients are actually understood and treated. The institutional dislocation between appearance and reality on acute in-patient wards tends, in the view of many clinicians, researchers and academics involved in the mental health field, to recapitulate at the institutional level incompatible conceptions of what it means to be a person as well as conflicting views about the appropriate focus of compassionate care and thus of the nursing task. The literature discussing this issue is extensive [21].

The problem can be expressed in the form of a series of related questions. Should nursing be understood primarily as a reflection of, or an auxiliary to, psychiatric medicine, and work within the parameters of the 'hard sciences'? Or should nursing develop its own methodology and make its own unique contribution to care outside of (but working alongside) the natural sciences? Should mental health nurses be working more (but not exclusively) within the parameters of the social sciences?

Although some nurses still prefer to work within the categories of traditional psychiatric medicine, others are seeking to pioneer a more humanistic and collaborative

[21] See also Barker, P et al. (2000) and Barker P (1999); Beech I (1999); Beer, Jones and Lipsedge (2000); Bonell C (1999; Drevdahl D (1999); Fabrega, H (2000); Foucault, M (1965); Glaser and Stauss (1967); Grafanaki and McLeod (1999); Hohr, W. K. (1999); Holdsworth N (1995); Horsfall J (1997); *Improvement Leader's Guide to Working in Systems* (NHS Modernisation Agency Series 3 (2004); Keen TM (1999); Kinach, Barbara M. (1995); Kylma J and Vehvilainen-Julkunen K (1997); Leon, Tasman, Lopez-Ibor Jr.,et al (2000); Mohr W (1999); Olthuis, J.H., (2001); Parse RR (1995); and Prior J (2001).

approach to care which privileges the patient's narrative, concerns and problems (as perceived by the patient) over any professionally constructed 'diagnosis'. According to Barker et al. (1997) nursing care should be located within the context of everyday life and thus be focused on the person's relationship with self and others within the context of their interpersonal world. Nursing practice should be focused on helping people address their human responses to psychiatric disorder, rather than the disorders themselves, which are, by definition, professional constructs.

But, in order for people to do this, nurses must begin to learn to trust the capacity of persons in their care to explore and understand their own troubles, and mental health problems and to resolve these in a climate of warmth, acceptance and understanding. In the absence of such a climate, genuinely therapeutic conversations are, of course, unlikely to happen.

2.6 Contradictions within current mental health nursing theory

Epistemology [22] is that branch of philosophy that deals with the theory of knowledge. In terms of the present debate going on within the theory of nursing, epistemology is the study of our right (or lack of right) to the beliefs we have as nurses about what constitutes good nursing practice. *Ethics,* particularly, the ethics of belief, involves the rules used in evaluating different kinds of beliefs, in this case, beliefs about the nature of human beings and the nature of care.

According to both Horsfall (1997) and the various contributors to *Psychiatric Nursing Ethical Strife* (1998) [23] incoherence in nursing theory arises when the nursing

[22] See Honderich, T (ed.) (1995), The Oxford Companion to Philosophy, Oxford University Press.

[23] See Barker P and Davidson B (eds) (1998). *Psychiatric Nursing: Ethical Strife*. Arnold. London

emphasis on care in which the nurse and patient are seen to be 'interdependent' and to be working in collaboration with each other in the context of a personal relationship runs at cross-purposes to materialist epistemologies which see the ideal knowledge situation as depersonalised and entirely objective. When medical understandings of the mind and mental health problems become reductive in this sense (which is not always the case) and are then incorporated uncritically within nursing theory and practice these become riddled with deep epistemological and ethical contradictions, contradictions that have been identified and discussed within the philosophy of mind for over 50 years [24].

In point of fact, Michael Polanyi (1958), the Scottish philosopher John Macmurray (1957 and 1961) and the

[24] The modern conflict between personal and impersonal forms of knowledge is discussed, at depth, by Bernstein, Richard (1983) *Beyond Objectivism And Relativism: Science, Hermeneutics, And Praxis, University of Pennsylvania Press, Philadelphia, USA*; and Nagel, Thomas (1986) *The View From Nowhere*, Oxford University Press, New York; and Searle, J (1999) *Mind, Language and Society: Philosophy in the Real World*, Weidenfeld & Nicolson, London. Searle in particular argues with persuasive examples that most theories of the ideal knowledge situation are beset with a mind/body dualism that entangled in logical contradictions. He identifies the very terminology used in the field (philosophy of mind) as the main source of trouble. He observes that it is a mistake to suppose than an ontology of the mental is objective at all and that the methodology of a science of the mind must concern itself exclusively with directly observable behaviour or a study of neurobiology. He also argues that it is a mistake to suppose that we know of the existence of mental phenomena in other people only or exclusively by observing their physical behaviour. Human behaviour or causal relations to behaviour are not essential, according to Searle, to the existence of mental phenomena. It is inconsistent with what we already know about the universe and our place in it to suppose or to assume that everything is knowable by us or can be known by us. The modern problem of the relationship of a supposedly non-physical 'mind' subject to a law of freedom to a purely physical body subject to a strict cause and effect relations at the bio-chemical level goes back at least to Descartes (1596-1650). According to Bernstein (1983 page 17) *" Few philosophers since Descartes have accepted his sustentative claims, ,but there can be little doubt that the problems, metaphors and questions that he bequeathed to us have been at the very centre of all philosophy since Descartes – problem concerning the foundations of knowledge and the sciences, mind-body dualism, our knowledge of the 'external ' world, how the mind 'represents' this world, the nature of consciousness, thinking, and will, whether physical reality is to be understood as grad mechanism, and how this is compatible with human freedom."*

philosopher of science Thomas Kuhn (1962) have all shown in different ways how the conflict between personal and impersonal forms of knowledge remains counter-productive and is no longer supported within the history of science itself [25]. In its broadest terms it can be seen as a conflict between two irreconcilable life and world-views, that of a basic humanism which is holistically and deeply integrated with basic human ethical values versus a science, which claims complete value and ethical 'neutrality'. This claim can be traced back to the legacy of a particular 19th century philosophical movement called positivism.

Positivism is historically associated with the philosophy of Auguste Comte (1798-1857) [26] who said that the highest form of knowledge is simple description of sensory data and that all that is worth knowing can be reduced to such descriptions [27]. Positivism, in its bio-medical form, seeks a complete account of mental events and human behaviour,

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[25] See Polanyi, Michael (1958). Polanyi in particular has argued that the tendency to make knowledge impersonal in our culture has split fact from value and science from humanity. Polanyi seeks to substitute for the objective, impersonal ideal of scientific detachment an alternative ideal, which gives attention to the personal involvement of the knower in all acts of knowing.

[26] See Urmson, J & Ree, J (eds.) (1991)

[27] Comte had a specific view of positivist science and rationality in mind, which he felt was superior to theology and to philosophy and for this reason, had superseded both in history. Belief in the emancipation of reason from tradition and from religious texts and ecclesial authority made it possible to pioneer a fully modern secularised world with utopian ends in line with the rhetoric of the European Enlightenment. Positivism is thus closely allied with the prestige of scientific empiricism, which denies that there is any knowledge (properly so-called) outside this class of observables. Both positivism and empiricism are inherently reductive in so far as they claim that nothing really worthwhile can be known beyond the senses or beyond that which appears to correlate very highly with observable, measurable data. In other words for positivism *'knowledge' is associated purely with the hypothetical-inductive method of reasoning and denied to other approaches to knowledge.* In our culture the historical connection between positivism, rationalism, empiricism and reductionism is clear at least from the time of the European Enlightenment and this 'tradition' of thought is becoming, as suggested at various points in this paper, increasingly problematic across all academic disciplines since the so-called 'postmodern turn' of the late 20th century.

including mental health or illness [28], in terms of purely physiological bio-chemical events. However, it is easily shown that a general deterministic theory of the *physiological causation* of human consciousness is philosophically inconsistent as a theory as well as unsuitable as a foundation for an ethical belief system, which could provide a controlling framework for nursing practice as a science of care [29].

Firstly, according to Clouser (1991), who is a philosopher of science, *as a scientific general theory* all such reductionist explanations are self-referentially incoherent. In the specific

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[28] The arguments against reductive explanations of complex phenomenon are not merely theoretical ,but also practical. Yet the temptation to re-align mental health nursing within a bio-medical paradigm continues to be prevalent within modern psychiatry and has its convinced supporters. ,but as Barker at al (1997) point out-

" Although realignment of nursing within (again) biomedical orthodoxy would simplify the psychiatric service, this simplification might be at the cost of both the development of nursing and, more important, the satisfaction of the human needs of the people defined as the 'mentally ill'. Nurses should treat with caution any attempt to refocus nursing within a biomedical paradigm. The phenomena defined as mental illnesses are two complex to be 'explained away' completely by models of biological causation. Instead, nursing should continue its exploration of what Rosemary Parse (1995) called the 'whole lived experience' of the person in care. This exploration is predicated in the interpersonal process, involving both person-in-care and nurse, and the person and others. Nursing is concerned not to explain, however hypothetically, the origins of the person's mental distress, ,but to assist the many forms of growth and development that are core characteristics of 'being human'. Another perspective on 'the human focus' of psychiatric nursing was recently articulated by Smith (1994) -*' Assumptions that underpin psychiatric nursing [might include]: the nature of humans (the uniqueness of the individual and inalienable rights), society (regarding freedom), health (regarding the right of access to health care) and nursing (i.e. the focus of nursing is human beings). "*

[29] Controversies over the relationship between the mind and the brain (mind/brain dualism) as well as over the nature of consciousness are by their very nature philosophical in nature. Many studies of the 'brain' claim to be studies of the 'mind' without defining how the two are synonymous. According to Barker et al. (1997)-

'If the notion of the 'whole person' is accepted, such distinctions [between mind and brain] become redundant. The use of such distinctions becomes significant, however, when one comes to consider the content of phenomena such as auditory hallucinations. The content of voices saying 'don't act stupid' must surely, in Peplau's view, 'have their origin not in the brain cells ,but in words used by persons in the patient's interpersonal milieu'. All current scanning experiments appear to 'tell us is where the brain does some of the mental stuff'. See Foder, J (1995).

case of bio-medical reductionism, the inconsistency is due to the fact that purely biomedical explanations of human cognition do not and cannot explain the origins and nature of the theory itself. In other words, those who hold to such a theory are normally unwilling to say that the theory itself is simply the product of the electrical and chemical functioning of their own brains. This would clearly undermine and reduce to absurdity the entire basis of the theory itself, as a credible general scientific theory [30]. And yet logical coherency would require that they say exactly that.

Secondly, *in terms of the ethics of belief*, one cannot posit the physical brain as the exclusive locus and cause (without remainder) [31] of human consciousness, self-awareness and

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[30] See Clouser R. (1991). According to Clouser, who is a philosopher of science, straightforward logical inconsistency between statements of a scientific theory is not the only type of incoherence. For example, a theory might include a claim, which, while not inconsistent with another statement of the theory, is in some way incompatible with its own truth. In other words a theory must not make any claim that would either cancel out the possibility of its own truth, or cancel out the possibility of KNOWING its truth. If a claim does either of these two things it becomes incoherent when applied to itself. *An example of the first type is the radical sceptical claim that nothing can be known*. Taken without qualification this is self-referentially incoherent statement since to say that 'nothing can be known' is to claim that one knows this statement to be true. The statement thus cancels out its own truth. *An example of the second type of self-referential incoherence is that of biomedical-reductionist theories of human cognition and behaviour*. Another classical example of this type of self-referential incoherence is Freud's famous claim *that every belief is a product of the believer's unconscious emotional needs*. If this claim were to be universally true, it would also have to be true *of itself* since it is the belief of the individual Sigmund Freud. It therefore requires itself to be the product of Freud's own unconscious emotional needs and drives. This would not necessarily make the claim false, ,but it would mean that Freud could not claim to it to be true. The most it would allow him to do would be to admit that he could not help ,but believe it because her was *compelled to believe it because of his own unconscious needs and drives*. And since *the truth of this claim would require that everyone believes whatever they believe for exactly the same reason*, there would be no possible way left for Freud or anyone else to discover whether this particular belief was really true in any meaningful sense or not – including the belief that all beliefs are simply the products unconscious, irrational drives, wish fulfilment, the electrical activity of the brain and so on.

[31] Modern materialist biomedical epistemologies hearken back to Democritus and ancient Greek 'atomism' (see Honderich, (1995). in which '*the fortuitous agglomeration of*

insight and thus of, non-organic mental health problems and *at the same time* advocate genuinely 'humanistic' person centred solutions to care and to the resolution of those functional problems.

Or at least one cannot do so without great inconsistency and without demonstrating a profoundly split and contradictory view of reality, the nature of human being and mental health. Of course this in no way minimises the usefulness of psychiatric medication in the treatment of some conditions or as useful tool to be used in the control or self-management of distressing symptoms of mental disorder (whatever the cause) but that is a different issue.

2.7 Impact of the psychiatric medical model on current nursing practice

According to Clouser (1991) no theory, practice, or institution is neutral with respect to core beliefs. Descending from theory to practice it is clear that what we as individuals believe about human beings will determine to a large extent how we will behave towards ourselves and other people and how, as helping professionals, we will conceptualise the nature of the care we offer to others. Several papers address this issue, especially the need for nursing to establish itself as a form of knowledge (embodying its own values, theory-base and methodology) in its own right alongside other types of knowledge [32] so that nursing

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elements or of atoms accounts for the origin of each individual, and the agglomeration disperses totally at death. The breath of life is attri,buted to the phenomenon of the heating and combustion of air, and thought is attri,buted to a spark generated by the 'beating of the heart'. This mechanistic explanation reinforces Gk theories hostile to the reality of the soul, at the same time countering biblical doctrines with its ironic image of the 'breath in the nostrils' (see also The New Jerusalem Bible, The Book of Wisdom: 2: 2 note c.)

[32]Broad scientific 'general theories', say, the theory of evolution or theories about the relationship between the mind and the body are always philosophically laden; so much so, that they tend to judge in advance what is and what is not to be considered a 'fact'. These theories are, to that extent, examples of circular reasoning, which is more or less

practice is informed by its own conception of the meaning of care and is not side-tracked or distracted away from its proper focus within the domain of compassionate care.

In their attempt to formulate standards of good practice psychiatric nurses have often been impeded by the beliefs, assumptions and conceptual parameters of medical psychiatry in ways that have, until recently, evaded conscious awareness. For example, Hall (1996) argues that nursing still uncritically incorporates assumptions of the psychiatric medical model into its own understanding of the human person and care. The medical model, although appropriate for doctors, is not appropriate for nurses and has not, to date, resulted in any effective *nursing*

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unavoidable at that level of abstraction. They are not the same thing as more narrowly defined *specific theories*. And 'in fact' even so-called sensory data is already a theoretical construction, as we have no normal everyday experience of 'sensory data' as such ,but our everyday experience is both integral and pre-theoretical. Contemporary philosophy of science now recognizes that different aspects of the world (i.e. matter and energy, the biological, social, psychological and other aspects) each have their own different epistemologies, different research methods and research criteria. For example, mathematics uses deduction etc., physical sciences use experiment, psychology uses a different type of experiment, using control groups etc., social sciences use surveys, interviews, and the like, to obtain people's interpretations and views. The methods of one science should not be forced on other sciences. To assume that methods of the physical aspect should be applied to all sciences was the mistake the Vienna Circle (positivists) made. Though many academics and researchers have emerged from that misconception today, the general public has not nor have sections of the nursing or medical profession and current 'demands' that nursing practice should be evidence-based is often equivocal and handicapped by this mistake and now outdated misconception. The term '*scientific*' is too often used to mean *'rigorous to the point of being able to prove'*, and all 'science' is seen to be modeled exclusively on the physical sciences. Those methods are suitable for aspects of the world, whose laws are determinative, ,but not for those whose laws are normative, as in the social sciences ,but also within nursing theory and practice ,but also, to a degree, even medicine itself. Finally there is now a well established philosophical argument against materialist, reductionist descriptions of human knowledge and experience which can stand on its own independently of empirical evidence because it is not about empirical evidence at all, one way or the other, ,but about demonstrating (logically) faulty self-contradictory reasoning about empirical evidence. That any theory should be coherent is a prime requirement (amongst several) of good scientific method. If lack of coherency can be demonstrated the theory should be rejected as not meeting the accepted normative standards of sound reasoning.

approaches to the care of people with mental health problems.

Horsfall (1997) also reminds us that modern psychiatric nursing emerged historically under the patronage of Victorian psychiatry in a pre-existing organisational hierarchy in which the medical profession wielded ultimate power and authority over the patient's treatment (Wilson and Kneisl 1992). Thus, a materialist medical epistemology was absorbed uncritically by the nursing profession in its formative stages and became the foundation for much of modern psychiatric training and education. In fact, until recently, psychiatric nursing has, according to Horsfall (1997) more than any other mental health profession, been in thrall to mainstream medical theory. According to Horsfall

As the importance of objectivity, the mind-body split, and a material understanding of the person increased, the values of caring, holism, and self-expertise (of patients and nurses) diminished.

To this day, mainstream bio-medical epistemology proceeds on the philosophical assumption that the psychiatric patient has a disordered *mind* arising from a damaged or diseased *physiology* [33]. The aetiological sites of this malfunction are

[33] Briefly stated, biomedical reductionism in its more extreme or simplistic forms conceptually reduces

- The mind and emotions as well as interpersonal relationships to brain function and
- Disturbed (or disturbing) 'mad' behaviour to chemical or biological or purely genetic factors, and
- Mental health problems to the concept of 'disease' in analogy with physical or organic diseases of the body.

Within this paradigm, a diagnosis of a person's unhappiness and emotional distress is carried out by using standardized published categories, such as found in the latest edition of the DSM-IV which are then correlated with standardized chemical treatments to be found in the British National Formulary. The person's mental health problems then tend to get interpreted purely in terms of malfunctioning neurotransmitters for which groups of psychotropic medications are the designated treatment of choice. The continuing slide towards positivism is reinforced philosophically and under girded financially and

understood to be lie within aetiological neurotransmitter imbalance, possibly partially genetic in origin, which is to be corrected by means of a specific recourse to chemotherapy. Horsfall draws out several logical and practical consequences of this belief-

Such an orientation ultimately mitigates against the agency of both the psychiatric nurse and the psychiatric service user. What is a consumer to do about his or her terrifying experiences if his or her body is faulty and only medical prescription is offered? What is the nurse to do if mental illness is caused by neurotransmitter excess or depletion and the medication is meant to rectify the uptake at the receptor site? Materialist psychiatric epistemology has profound consequences for psychiatric users and nurses, beyond that of diagnosis and treatment by medication. A focus on the physical indicates a narrow view of patients and of oneself as a person and a nurse. The medical model seriously limits the patient's sense of competence, control, and responsibility. It also excludes or displaces the centrality of the nurse's interpersonal skills in supporting and improving patient resourcefulness and well-being.

Hall (1996) identifies several assumptions underlying the psychiatric medical model and questions these from a more humanistic perspective. She shows how using purely diagnostic medical explanations of the patient's 'problem' is inconsistent with good nursing practice. The author

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institutionally by the vast resources of the multi-national pharmaceutical industry, standardised treatments, political fashion, and alarmist, reporting by the press and media. It is also coherent with the increasing Government demand for effective 'cost effective treatments' within a health care market place. See Barker (1999); Hall (1996); and Nolan 1999b). According to Horsfall (1999). *'Cost effective treatment' in this context equals that treatment which will ensure the most rapid and the cheapest global 'reduction of risk', which will ensure that mentally ill people do not commit crimes or cause a public nuisance. These political and socially reactionary trends continue to encourage the reduction and confinement of in-patient psychiatric nursing to medication administration, assistance with electroconvulsive therapy, observation for medication 'side effects' and giving depot injections to severely mentally ill patients in the community'.*

describes the process of her own awakening to how conventional psychiatric thinking was undermining her relationships with patients.

She then offers suggestions for more appropriate nursing practices and strategies as does Evans (2001) who warns that the adoption of chemical therapies should not be employed in place of or at the expense of the holistic approach which is valued so highly by patients, carers and nurses.

The issue raised in different forms by these papers share an over-riding concern with the very real problem of dehumanising treatments and represent what could be called a search for the 'whole person' in care. They are therefore not anti-medical model in tone. As Barker (2003) says, returning to the pioneering work of Hildegard Peplau, medical psychiatric diagnosis represents a useful way of talking about groups of people with similar problems of living, but…

It is largely irrelevant to the consideration of what any individual might need, now, in the name of nursing care. We can answer that only be exploring the widest possible personal context, which will allow us to gain some insight into what is meaningful for this particular person, as opposed to what might be considered 'appropriate; for a group of 'patients'.

Barker (2003) goes on to say that for the past two decades in both the USA and in the UK mental health nurses have started to move away from the strict use of a medical-diagnostic model. Barker continues:

The voice of the nursing process movement urged all nurses to show concern for the person behind the patient label, reminding us to look for 'worth' amid what might seem like insurmountable problems…..

but, he warns:

-There is a grave risk [today] that nursing might drift back into a reductionist approach to care delivery, using medical diagnosis as the primary determinant for the design of care.

On a somewhat different track, Hummelvoll and Steverinson (2001) look at the source of some of the tensions and pressures nurses are experiencing on acute in-patient wards. Their analysis describes in more detail *how* the high-pressure and unpredictable environment of acute wards in combination with short hospital stays is impacting nursing practice. Nursing practice in such contexts tends to be tentative and summary. Nursing care under such circumstances is characterised by great 'therapeutic superficiality'. This constitutes a serious hindrance to nurses encountering the patient as a person. It also prohibits genuinely therapeutic conversations developing between nurses and their patients.

The proper focus of nursing care is distorted, Parse (1999) argues, when the medical specialty of psychiatry is practically and ideologically dominant in relation *to nursing care*. To conceptualise nursing theory and practice in terms of an applied science model, one that combines biology, physiology, and psychiatry but, strangely enough, has no specific knowledge base of its own, is to fail to grasp the true focus and domain of nursing care. Parse is not alone [34] in taking issue with the idea that an applied natural science model should be the template of choice for nursing theory and practice. Although the nurse needs to be informed by medical, biological, pharmacological and other kinds of knowledge these *forms of knowledge* do not and cannot in and of themselves define the heart or unique focus of care.

[34] See also Barker, P. (2001); Barker P and Reynolds B (1997); and Stevenson C (1998).

The preferred alternative is that nursing should be seen as a basic human science with its own unique conceptualisation and contributions to make, one focused on the whole person in relationship to others, to health and to illness. The key concept for Parse is that of 'human becoming' and the fact that people are always in a process of change. The significant structures relevant for nursing are the lived experiences of patents as described by the patients themselves.

Finally, Barker et al. (1997) seek to define the focus of nursing practice in such a way that it is fully outside the perimeters of medical psychiatry. Nurses should acknowledge that the phenomena dealt with by them in the act of care are human responses to various life problems. Nurses do not deal with now, and have never dealt with at any point in history, mental illness per se, as that has always been the psychiatrist's role.

2.8 The starting point of research and the problem of bias.

Although the research methodology of this study will be discussed in **Chapter Three**, the principles and rationale underlying the methodology will be discussed at this point in the literature review.

It has been an essential part of this study to ask the following questions:

- ⇒ How is this study connected to learning, to institutional change, and to nursing theory?
- ⇒ How has the project been effected by on-going operational difficulties within the QEPH acute in-patient service?
- ⇒ How has it been related to present Department of Health guidelines and directives?

- ⇒ How has it been related to the personalities, and experience of nurses in senior management, clinical or teaching positions who have welcomed the initiative?
- ⇒ How does this study relate to the personal bias of the authors of this paper and to their personal beliefs and past experiences of what works and does not work?

Such questions, once asked, according to Mark Fenton (2003), raise critical issues about the very nature of research itself and the evidence base, which should inform good nursing practice. This is especially true for any human science, which seeks to be reflexively self-aware of its commitment to keep its focus on care. Connected with this is the need for a *kind* of nurse training and education that keeps this focus clear and does not lose it.

One problem that besets conventional research as well as present nursing training and education is their relevance to the real world in which people actually live and work. Thompson and Dowding (2001) found that one of the most influential factors impacting nursing practice is the opinion, recommendations and practices of nursing peers and colleagues, rather than theory or research. In addition to that, nursing practice on acute wards tends to be dictated by what service users are prepared to accept, by the hospital's management and operational policies, by the local 'nursing culture" and by what a hospital is willing to pay for.

Simmons (1995) questions the following three assumptions

1. That decisions about research methods are ever purely objective (in the way usually claimed) or
2. Are ever informed exclusively by the pristine or 'scientific' nature of the research question itself or
3. That research questions ever automatically indicate in and of themselves what approach to use

These three assumptions vastly over-simplify the historical, social, and economic contexts within which all human enquiry and decision-making are embedded. This being the case, Simmons 'grasps the nettle' and recommends that research *bias* is always inevitable, not necessarily a bad thing, and should be harnessed in the cause of doing effective research [35].

One problem that besets nursing research in particular, according to Simmons, is that it usually has no impact at all on actual nursing practice. This is because *most nursing research does not set out to create change in the settings studied*. Researchers usually 'leave the field' unaffected by the research process itself, and this leaves nurses working in the clinical setting seeing little relevance to most research findings, and with little guidance on how to implement the findings even if they wanted to. Therefore Simmons recommends action research as the best way to address this particular problem.

2.9 A commitment to basic principles of action research

This study began as and remains an exercise in action research and grounded theory [36]. According to Newman

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[35] According to Hans-Georg Gadamer (1975).- '*The self-awareness of the individual is only a flickering in the closed circuits of historical life. That is why the prejudices of the individual, far more than his judgements, constitute the historical reality of his being…What appears to be a limiting prejudice from the point of viewpoint of the absolute self-construction of reason in fact belongs to historical reality itself. If we want to do justice to man's finite, historical mode of being, it is necessary to fundamentally rehabilitate the concept of prejudice and acknowledge the fact that there are legitimate prejudices*'. (pp 276-277).

[36] According to Haig, Biran D, (1995) "*Grounded theory begins by focusing on a specific area of study or concern and then begins gathering data from a wide variety of sources, especially 'interviews and field observations'. Once gathered the data is then 'analysed' and a number of theories are generated with the help of interpretive procedures, before being finally written up and presented. Ideally 'theory' slowly emerges over time from the data rather being made in advance of any data collection*".

(2000) and Reason and Bradbury (2001) a basic assumption of action research is that research cannot be divorced from real life. Action research searches for and questions the validity of different types of knowledge, institutional structures and practices, ways of relating and forms of existence. Action research can be applied to establishing and examining why when working in the helping professions, people can become so easily trapped in unhelpful and un-therapeutic contexts or 'negative circles' of relating and decision-making.

Action research initiates a focused well-informed course of action into such contexts and begins to reflect on the experience of whatever happens next. This process involves developing a spirit of co-operative inquiry in which all of those involved (nursing staff, managers, patients and service users) become co-researchers whose thinking and experience contribute to the emergence of solutions to the problems, which arise during the project's implementation. *Co-operative inquiry* is thus a form of research as well as a way of working and learning with others in the same organisation who have similar concerns and who, according to Haig (1995):

- Seek to understand what is a shared world in order to make sense of life and to develop new creative ways of looking at things and to learn from experience rather than just recycling all the old problems and explanations
- Want to learn how to act collaboratively with others in order to change things that need changing and to find out how to do things better

2.10 Abductive reasoning

The pragmatic American philosopher Charles Peirce (1839-1914) [37] talks of 'abductive reasoning' [38]. This is a type of reasoning that is prepared to accept a conclusion purely on the grounds that *it appears to satisfactorily explain what evidence is available at the time*. It is the pattern of reasoning most commonly used by ordinary people day by day and is used in both action research and grounded theory [39]. It does not seek to prove that (a) 'causes' (b) in the way typical of the natural sciences and in fact insists that the complexity of some situations prohibits 'proof' of this type.

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[37] See Honderich, T (ed.) (1995)

[38] **Abduction** or "inference to the best explanation "is a form of reasoning based on experience that follows a pattern like this:

D is a collection of data (facts, observations, 'states of affairs' personal testimonies, or 'accepted givens'),
T appears to explain **D** (or would, if true, explain **D**),
No other hypothesis, explains **D** as well as **T** does.

Therefore, **T** is *probably correct*;
or at least it is the best common sense explanation of **D** under the circumstances.

Abduction represents an alternative form of reasoning to the strict canons of RCT's. The strength of an abductive conclusion **T** depends on a number of factors, such as:

- How good **T** is by itself, independently of considering any alternatives,?
- How decisively does **T** surpass alternative explanations?
- How thorough was the search for alternative explanations of 'the problem' and its 'solution', and
- Pragmatic considerations, such
  - The costs of **T** being wrong and the benefits of it being right,
  - How strong is the *need to know, or to come to any conclusion or understanding at all*, especially considering the possibility of seeking further evidence before deciding to take any action on the basis of **T**?
- It is said that the strength of any abductive conclusion **T** depend on the above and other factors, and that it *should* depend on these and similar factors, and that insofar as we are intelligent creatures, our ordinary common sense conclusions based on personal experience will actually depend on factors such as these.

See the Abductive Reasoning Page @ < http://www.cis.ohio-state.edu/lair/Projects/Abduction/abduction.html >

[39] See Glaser and Stauss (1967).

Peirce calls this kind of ordinary reasoning '*inference to the best explanation available at the time'*. This type of reasoning is judged to be *adequate* to most of our purposes in life [40] including, it could be argued those mental health nursing practices, which facilitate good care. But, what would constitute an adequate 'theory' or explanation and justification of these practices? Glaser (1992) gives two basic criteria for judging the adequacy of any theory (or explanation) emerging from such reasoning: firstly that it fits the situation; and that it works –and secondly that it helps the people in the situation to make sense of their experience and to manage the situation better.

One question which arises in such a discussion is: What is adequate evidence and evidence for what purpose? For example, Williams and Garner (2002), two doctors, discuss the host of problems, which are generated when RCT (Random Controlled Trials) becomes the only 'gold standard' for what is considered 'good evidence-based practice' in medicine. Many *medical* practices just do not yield to RCT methodology, but should not, on that basis, be deemed ineffective, irrational or not evidence-based at all. The authors conclude that an exclusive emphasis on narrowly defined evidenced-based criteria drastically oversimplifies and undervalues the complex and interpersonal nature of effective care [41].

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[40] See Kinach,Barbara M. (1995)

[41] The key point, according to Williams and Garner, is that there are, even in the field of psychiatric medicine many limitations to all RCTs because of variables such as mixed or borderline diagnosis, variations in personality characteristics, social factors and personal history, all of which can and usually are excluded from most RCT studies. Additionally, randomised controlled trials only provide information about groups not about specific individuals. There is also what they call the *'file drawer factor'*. For any given research area one cannot tell how many studies, especially older ones, have already been conducted ,but are not being reported on or referred to or drawn to the attention of the relevant people and thus an excepted part of the discussion.

Abductive reasoning recognises that a distinction should be made between hypothesis testing (testing some big theory made in advance) and an emergent theory or understanding of a situation involving people in relationship which develops by increments over time. According to Dick (2002) the key to effective research is remaining open to what is actually emerging (in a very global way) once a project such as this gets underway, with a willingness to change course and adapt creatively to whatever does in fact happen within the larger institution as a consequence of undertaking the project.

The danger or temptation is always to move directly to 'premature closure' by forcing some theory on to the evidence generated by the study before any explanation is really warranted or justified at any level of inquiry. In order to remain open to what is actually emerging in the situation one needs, as a researcher, to learn to tolerate:

- A high level of confusion
- Feelings of powerlessness and inadequacy to the job at hand and so on

2.11 Qualitative and quantitative (statistical) evidence

This study seeks to examine *different types of evidence*, generated as part of an action research project undertaken at the QEPH in order to come to a number of conclusions and judgements about those nursing practices which clearly improve the therapeutic experience of patients in contrast with those that do not. So it is important to clarify the nature of this study and the nature of its conclusions and recommendations. According to Stevenson et al. (2002)-

Research into clinical effectiveness in health care is complicated and cannot mirror the processes of the natural sciences. Consequently, it is important to treat evaluation tentatively…….. Although the Tidal Model has theoretical

justification and fits with the recommendations of the National Services framework (DoH 1999), it nevertheless has to be subjected to an evaluation process in order to be classified as evidence-based practice [42].

Bonell (1999) recommends that ideally both qualitative and quantitative methods should be used together in designing any research study. He seeks to dispel the myth that qualitative research methods (such as action research, grounded theory, the use of interviews and focus groups) and quantitative research methods (statistical number crunching) are necessarily opposed.

Whether or not they are in conflict depends entirely on the assumptions and philosophies of the researchers [43]. Therefore the evidence base for this study includes of a mixture of quantitative and qualitative data such as QEPH nursing interviews, audits of nursing documentation of the

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[42] According to Phil Barker, (personal correspondence December 5th 2003) "*Speaking as a researcher with 30 years experience, I do not believe that it is possible to 'prove' in any absolute sense that 'systems' have direct effects on phenomena like 'length of stay' or 'untoward incidents'. All we can say is that there appears to be weak or strong correlations between certain systems and measures of such phenomena. A well-organized and careful evaluation will not be 'rocket science'. Such 'science' is impossible in the social sciences. However, such a careful evaluation will yield some information on what appears to be happening, and 'why' that might be happening. This will help management make decisions as to whether or not this is a good/bad/or indifferent thing. It is worth saying that services have been changed, adapted and modified (often massively) with recourse to nothing other than anecdotal commentary from HAS visitors or CHI inspectors. A careful evaluation may not be wonderful science, ,but (in the absence of major funding - say £300K) is probably the best that can be done in the circumstances* "

[43] According to Bonell, *Quantitative (experimental) research* is not necessarily positivist or reductionist so long as it is made clear that the epistemological assumptions are not absolutized or privileged over other forms of competing knowledge claims. *Qualitative research* needs the support of more experimental approaches if it is to establish 'what is the case' under certain circumstances and in certain contexts. Bonell gives an example of a recent study, which concludes on the basis of a range of specific quantitative outcome measures that care had significantly improved ,but that "*the measures used in the evaluation were informed by prior qualitative work and were properly piloted so that they reflected patients own conceptions and meanings.* 'Also, see Barker P and Davidson B (eds) (1998); Barker P, Reynolds W, Stevenson C (1997); and Simmons S (1995) .

Tidal Model following its implementation, and the personal testimonies of key people, including service users involved in the project as the process of implementing the Tidal Model on Tolkien unfolded. This evidence has then been examined in the light of the known literature and other studies, which addresses the same or similar issues [44].

2.12 Conclusion: In search of a non-reductive science of care

According to a number of authors, especially Barker (1999), Sullivan (1998) and Nolan (1999), alternative more humanistic approaches to mental health nursing need to be pioneered in the 21st Century or the problems currently facing NHS Mental Health acute in-patient services will continue to get worse. An essential feature of a balanced

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[44] The bringing together of both qualitative and quantitative evidence as part of an action research project and looking at this in relation to other studies of the subject is an example of triangulation. According to Thurmond V (2001) *The point of triangulation*, Journal of Advanced Nursing 33(3) pp -253 – 258: "*Triangulation involves the combination of at least two or more theoretical perspectives, methodological approaches, data sources, investigators, or data analysis methods and so on. The intent of using triangulation is to decrease, negate, or counterbalance the deficiency of a single strategy, theory or approach thus increasing the ability to interpret situations and findings usefully* ". Thurmond outlines various types of triangulation, its advantages and disadvantages. The basic disadvantages of triangulation are primarily practical including:

- *The increased amount of time needed in comparison to single strategies,*
- *The difficulty of dealing with vast amounts of data,*
- *Potential disharmony based on investigator biases and perspectives,*
- *Conflicts between theoretical frameworks or philosophical convictions, and*
- *Lack of understanding about why triangulation strategies are used.*

On the positive side,

- *The use of triangulation will never strengthen a flawed study; rather, it will expose it.*
- *Triangulation can also enhance the completeness and confirmation of findings in qualitative research.*
- *Specifically, the use of BOTH quantitative and qualitative strategies in the same study will strengthen research results and is therefore to be recommended.*

Significantly, for Thurmond: *"If different philosophic and research traditions will help to answer a research question more completely, then research should use triangulation."*

model of care is that it will be genuinely holistic, non-reductive, truly collaborative and respectful of the whole person in care and of that person's voice in the context of that person's life-narrative.

The meaning of the stories different people tell about themselves cannot be reduced to the way in which they are functioning (well or poorly) within the different aspects of their lives. The focus of nursing, it is argued, should thus be *upon these stories and upon caring interpersonal relationships located uniquely within the context of everyday life* [45]. But, as all the above authors point out, to re-focus nursing care in this kind of way will require a redefinition of what it means to be a mental health nurse. Such a change will also require major redefinitions of what it means to provide good care within the context of acute in-patient services. Thus, more rigorous attention will need to be given, argues Barker (1999), to nurse training and education for the development of –

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[45] Barker P, Reynolds W, Stevenson C (1997) argue that nursing needs to acknowledge more openly and clearly that fact that the phenomena dealt with by nurses are human responses to various life problems. Psychiatric nurses do not deal with now, and have never dealt with, mental illness per se. *" Concepts such as schizophrenia in particular, and what has 'down the ages' been called 'madness' in general, are no more than ideas about some people, their behaviour and their reported experience, formed through generalisations about the behaviour and reported experience of other people. Even if such ideas had validity, nurses have no responsibility to explain people by use of diagnostic concepts such as schizophrenia. Nursing's task is 'and has always been' to help people deal with the human problems they experience: their responses to what other people call various forms of mental illness. Given this focus, nursing needs to be promoted as a form of human inquiry, (in Paplau's words) ' to help patients [who] are embarked on a search for truth about themselves and their life experiences.* The author's interest in such human inquiry in nursing is linked to the work begun half a century ago with Peplau's theory of interpersonal relations applied to nursing. Nursing's exploration of the human context of being and caring is predicated in the potential for growth and development witch is inherent within each person-called-patient. In the author's view, being with and caring with people-in-care is the process which distinguishes nurses from all other health and social care disciplines, and needs to be recognized also as the process that underpins all psychiatric nursing*"*

a 'critical and informed' self knowledge with more sensitivity and compassionate awareness of the nurse being a fellow human traveller with her or his patients on life's sometimes strenuous, dangerous, but exciting journey into the unknown.

But, in order for this to happen, according to May (1990), nursing, as a profession, will need to make a more robust commitment to the reformation of the institutional context within which nurses are educated and trained and seek to practice if they are to provide a therapeutic environment of nursing care. This is not an easy task.[46] Root and branch reform is necessary to bring present institutional and professional practices in line with basic human values, human rights, and human duties/responsibilities.

One theme that stands out clearly in the papers reviewed above is that the nursing profession is seeking to extricate itself from the medical model not by being 'anti-medical model', but by insisting that nursing is not medicine and should be concerned with fundamentally different issues and practices than medicine. Nursing, in its central focus, is not concerned with 'cure' or medical treatments per se (as these are the concern of the medical profession) but with the person's relationship to health and illness.

According to Olthuis (2001) to dwell exclusively on 'cure' can focus the nurse so much on solutions, answers, and performance that there is little room for the listening, attending, and caring that is required for inner healing, which lies at the heart of therapy. Success in implementing real change in acute in-patient care, according to Griffiths

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[46] As May points out-*" patient difficulties and nurse responses are often mediated and impeded by health systems, hospital procedures, and ritualised professional interactions."* Horsfall (1997) is even more gloomy, saying- *"...a positive, caring, and egalitarian orientation towards others is not likely to emerge easily when both parties [patients and nurses] who should benefit from such changes are comparatively powerless in the face of medical dominance within psychiatric services"*

(2002) as well as Rix and Shepherd (2003) requires working in a genuinely collaborative way with commitment at all levels of the organisation including clinical leadership, management support and a wide range of stakeholder input. According to Griffiths:

The problems facing many acute wards may seem utterly daunting, but there does seem to be something in a systematic collaborative approach that can lead to rapid and significant improvements. It requires planning, enthusiasm and commitments. I know the solutions are out there because I have seen them.

Horsfall (1997), however, is not so upbeat:

Humanistic nursing care cannot apply revolutionary leverage to an ossified system. But, it can assist with changing nursing ideas, practices, and workplace cultures at the grassroots level for the benefit of psychiatric service users and nurses. Before humanistic nursing practice can be implemented, contradictory theoretical assumptions need to be uncovered.

Humanistic nursing remains committed to holistic conceptions of nursing care, which, in turn, are based historically on non-reductive views of the human person where the emphasis is on the importance of personal relationships, personal growth and development as well as spirituality and ordinary everyday life as the appropriate context of care [47]

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[47] **Non-reductive views of the human person as the foundation of a nursing science of compassionate care.**

The concept of a non-reductive view of the human person is ancient in origin with roots in the Judeo-Christian revelation of mankind being made 'in the image of God'. The specifically biblical origins of the science of compassionate care can be heard within the biblical commandment that we should love God and our neighbour as ourselves and that doing the will of God is the meaning of temporal, earthly life. ,but this concept also has

parallels within the other world religions such as Islam, Hinduism and Buddhism, where, according to the theologian Hans Kung (1990) human being are seen to be dependent in some essential way on what is ultimately divine, that is, we as human beings are dependant on '*That which all else depends, yet which does not depend on anything else for its own existence*" (Clouser 1991).

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The ideas of the non-reductive view of the person need not be a 'religious' conception at all, and can also be found in the secular tradition of the European Enlightenment in the moral maxim that human beings are to be treated, 'as ends in themselves' from which the entire secular liberal tradition of human rights as well as the concept of client-cantered care have their origin. Non-reductive conceptions of the human person usually rely on some idea of different levels of being. The classical statement of this can be found in E.F Schumacher's A Guide For the Perplexed (1977). Schumacher points out that the universe consists of different levels of being moving from what is 'lower' in the scale of being to what is 'higher'. Thus what is unique to the mineral kingdom (= m), what is unique to the sensitive vegetative life of the plant kingdom (=x), and what is unique to animal life and instinctual awareness (= y) and what is unique to beings as persons (= z) form four separate kingdoms. The higher levels cannot be 'reduced' to the lower. Each 'kingdom' higher on the scale is rooted within the kingdom below it and yet fully transcends it. Thus plants are higher on the scale than stones, animals from plants and human beings from animals. The four great Levels of being can be summed up as follows:

Humanity can be written (m+x+y+z)
Animal can be written (m+x+y)
Plant can be written (m+x)
Mineral can be written (m)

However, according to Schumacher (1977). A Guide For the Perplexed. Chapter Two:

"If, instead of taking "minerals" as our base line and reaching the higher Levels of Being by the addition of powers, we start with the highest level directly known to us--man--we can reach the lower Levels of Being by the progressive subtraction of powers [using the minus sign]. We can thus say:

Man can be written (M)
Animal can be written (M-z)
Plant can be written (M-z-y)
Mineral can be written (M-z-y-x)

Such a downward scheme is easier for us to understand than the upward one, simply because it is closer to our practical experience. We know that all three factors-(x), (y), and (z)--can weaken and die away; we can in fact deliberately destroy them. Self-awareness can disappear while consciousness continues; consciousness can disappear

while life continues; and life can disappear leaving an inanimate body behind. We can observe, and in a sense feel, the process of diminution to the point of the apparently total disappearance of self-awareness, consciousness, and life. ,but it is outside our power to give life to inanimate matter, to give consciousness to living matter, and finally to add the power of self-awareness to conscious beings.

What we can do ourselves, we can, in a sense, understand; what we cannot do at all, we cannot understand--not even "in a sense." Evolution as a process of the spontaneous, accidental emergence of the powers of life, consciousness, and self-awareness, out of inanimate matter, is totally incomprehensible. For our purposes, however, there is no need to enter into such speculations at this stage. We hold fast to what we can see and experience: the Universe is as a great hierarchic structure of four markedly different Levels of Being. Each level is obviously a broad band, allowing for higher and lower beings within each band, and the precise determination of where a lower band ends and a higher band begins may sometimes be a matter of difficulty and dispute. The existence of the four kingdoms, however, is not put into question by the fact that some of the frontiers are occasionally disputed. Physics and chemistry deal with the lowest level, "minerals." At this level, (x), (y), and (z)--life, consciousness, and self-awareness--do not exist (or, in any case, are totally inoperative and therefore cannot be noticed). Physics and chemistry can tell us nothing, absolutely nothing, about them. These sciences posses no concepts relating to such powers and are incapable of describing their effects. Where there is life, there is form, Gestalt, which reproduces itself over and over again from seed or similar beginnings, which do not posses this Gestalt ,but develop it in the process of growth. Nothing comparable is to be found in physics or chemistry.

To say that life is nothing ,but a property of certain peculiar combinations of atoms is like saying that Shakespeare's Hamlet is nothing ,but a property of a peculiar combination of letters. The truth is that the peculiar combination of letters is nothing ,but a property of Shakespeare's Hamlet. The French or German versions of the play "own" different combinations of letters.

The extraordinary thing about the modern "life sciences" is that they hardly ever deal with life as such, the factor (x), ,but devote infinite attention to the study and analysis of that physicochemical body that is life's carrier. It may well be that modern science has no method for coming to grips with life as such. If this is so, let it be frankly admitted; there is no excuse for the pretence that life is nothing ,but physics and chemistry.

Nor is there any excuse for the pretence that consciousness is nothing ,but a property of life. To describe an animal as a physiochemical system of extreme complexity is no doubt perfectly correct, except that it misses out on the "animalness" of the animal. Some zoologists, at least, have advanced beyond this level of erudite absurdity and have developed and ability to see in animals more than complex machines. Their influence, however, is as yet deplorably small, and with the increasing "rationalization" of the modern life-style, more and more animals are being treated as if they really were nothing

,but "animal machines." (This is a very telling example of how philosophical theories, no matter how absurd and offensive to common sense, tend to become, after a while, "normal practice" in everyday life.)

All the "humanities," as distinct from the natural sciences, deal in one way or another with factor y--consciousness. ,but a distinction between consciousness (= y) and self-awareness (= z) is seldom drawn. As a result, modern thinking has become increasingly uncertain whether or not there is any "real" difference between animal and man. A great deal of study of the behaviour of animals is being undertaken for the purpose of understanding the nature of man.

This is analogous to studying physics with the hope of learning something about life (= x). Naturally, since man, as it were, contains the three lower Levels of Being, certain things about him can be elucidated by studying minerals, plants, and animals--in fact, everything can be learned about him except that which makes him human All the four constituent elements of the human person (= m+x+y+z) deserve study, ,but there can be little doubt about their relative importance in terms of knowledge for the conduct of our lives."