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Article title: Queering the relationship between evidence-based mental health and psychiatric diagnosis: Some implications for international mental health nurse curricular development

Word count: 2024

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Introduction

On the basis of biomedical and post-positivist foundational assumptions, evidence-based (EB) healthcare is a current curricular imperative in UK nurse education policy. From the position of our engagement with Queer scholarship, we recently discussed and contributed to the sustained critique of the function of EB assumptions in repressing and marginalizing non-EB epistemologies (Zeeman et al, 2014a). Our current aim in this paper is to develop this critique further from a Queer paradigm position, with a specific focus on the association between EB mental healthcare and psychiatric diagnosis, and related concerns. This will enable us to sketch out some initial principles that will hopefully stimulate and contribute to the advancement of mental health nurse educational curricula internationally.

These principles will cover greatly increased levels of criticality about the existing, potentially and actually oppressive representational practices of institutional psychiatry; will recognise and develop emerging, non-medicalized, ways of engaging student nurses in responding appropriately and

sensitively to the increasing heterogeneity of life problems implicated in human misery, which bring people into contact with mental health services; and will ensure that mental health nursing curricula keep theoretical, disciplinary and critically reflexive pace with Queer theory and related critical approaches in the social and human sciences more broadly. In conclusion, we will argue that these principles must promote a curricular development that honours service users' lived-experience based narratives of distress. These will inevitably also include their experiences of frequently oppressive institutional psychiatric systems.

With the above aim and principles in mind, we will first necessarily but briefly recapitulate on some of the critical ground we have already covered in our work, by contextually locating the EB discourse in terms of its cultural and epistemological emergence, and its significance and dominance in both neoliberal healthcare governance and nurse and mental health nurse education.

EB epistemology

The increasing need to make western healthcare, including nursing and mental health nursing practice, evidence-based began in the early 1990s in the context of the Thatcher and Regan administrations in the UK and USA respectively. In this context, the EB discourse coheres with the neoliberal managerialist agenda that currently informs higher education in healthcare internationally (Grant, 2014a).

The EB discourse exerts influence on the shape and content of health policy, practice and service delivery, and UK nursing and mental health nursing curricula, with the asserted aim of improving healthcare outcomes. It does this according to a logic of rationality, whereby integrating clinical knowledge with rigorous, objective and supposedly culture-neutral quantitative-experimental evidence, and public and patient feedback and choice, is tempered by cost-effectiveness and efficiency. However, what constitutes 'evidence' according to this discourse is never neutral and objective. It is inevitably situated, time-bound, and imbued with assumptions that shift according to the values that specific scientific communities and related practice disciplines subscribe to. This inevitably results in cultural practices which privilege some ways of knowing over others.

Such privileging on the basis of rationality is not without its problems. EB mental health epistemologies informed by biomedical assumptions have recently been discredited on the basis of deeply flawed science (Grant, 2015; Johnstone, 2014; Thomas 2014). Despite this, the dominant systems of psychiatric

diagnoses from the American Psychiatric Association and World Health Organization have become increasingly instrumental in sustaining international norms around what constitutes 'mental illness' over the last six decades. Although discredited, our experiences as academics tell us that the cultural hegemony of psychiatric diagnostic systems in the UK is supported by the form and content of mental health nurse educational curricula and related mental health professional and institutional practice exigencies (Grant, 2015).

Such a state of affairs inevitably impacts on the experiences of mental health service users and survivors. Normative judgements are made about them on the basis of diagnostic labels that lack scientific validity and reliability (Grant, 2015; Johnstone, 2014; Thomas, 2014). Already reductionist in defining people in terms of specious pseudo-illness categories that fail to honour richness of individual identity and life-context, such judgements are, at worst, added to with a an overlay of stigmatising and othering lables that arise as a result of staff-service user intergroup dynamics (Grant and Leigh-Phippard, 2014; Grant et al, 2015). The net effect of all of this is that users can become trapped in negative, pathologizing and oppressive, life-defining narratives that are imposed on them as a result of their engagement with institutional psychiatric services (see eg Grant and Leigh-Phippard, 2014).

Queer epistemology

It is timely therefore that Queer Theory has recently emerged as a radical epistemological challenge to normative influences on mental health nurse educational curricula. Its scope extends to a critique of any kind of practice that leads to exclusion and marginalisation on the basis of identity (Hall et al, 2013; Zeeman et al, 2014b). In assertively resisting any form of knowledge, system or practice that attempts to privilege normative identity as 'natural' and identities that differ markedly from the norm as pathological, Queer scholarship makes visible the cultural and social assumptions and processes by which the natural and the pathological are produced.

In this regard, Queer epistemology is both distinguishable from, and advances, social constructionist epistemology and its related critique of biomedical power in key ways (Zeeman et al, 2014a,b; Hall et al, 2013). From a social constructionist perspective, knowledge is shaped by academic and professional communities of meaning making to the extent that it is eventually invested with norms and informal rules that govern what counts as 'the real'. In this context, social constructionist crique makes explicit the social process whereby some forms of evidence are more highly regarded than others, and troubles the biomedically nuanced EB stance of value neutrality (Zeeman et al, 2014a).

However, Queer epistemology takes this critique further in unpacking the normative epistemological foundations of EB practice. In so doing, Queer epistemology exposes the specifics of power relations and the ways in which power advantages some groups and individuals at the expense of other groups and individuals, in highly detailed ways (Zeeman et al, 2014b; Hall et al, 2013). Moreover, at a paradigmatic level, in distinction from social constructionist epistemology, Queer knowledge draws on and has co-evolved with poststructural and Foucauldian texts. Overall, this results in an epistemology that is both entagled with EB and constructionist epistemologies, and goes further in critiquing the assumed truths, causal relationships and epistemological coherence characteristic of EB epistemologies (Zeeman et al, 2014a).

In contrast to EB discursive epistemologies and related practices, Queer scholarship constitutes the ways in which a number of critical methodologies have cohered around a refusal to accept broad normative identity categories to define healthcare subjects (Zeeman et al, 2014b). In so doing, situated, contextual, un-finalised identities, difference, embodiment, and agentic self-determination are all simultaneously celebrated in both knowledge production and in different ways of knowing (Grant and Leigh-Phippard, 2014; Zeeman et al, 2014a,b).

At the level of normative identity categories, Queer scholarship should also be seen as distinct from the Antipsychiatry movement and Labelling Theory. These approaches arguably reify and thus essentialise binaried categories, often from a moral basis of distinguishing between oppressors and the oppressed. In contrast, Queer epistemology shows how the normative reproduction of *all* identity categories and related ways of knowing enables their regulation in broader agendas of social control (Hall et al, 2013; Zeeman et al, 2014a,b).

According to Queer Theory, normative social identities become visible in dichotomous thinking and labelling informing binary, paired oppositions, where the former term in each pair is privilege and the latter pathologised or disparaged. This can be illustrated by paired oppositions such as healthy/ill; mentally ordered/mentally disordered; heterosexual/homosexual; or, with reference to popular EB practice-related assumptions, objective-scientific/subjective-interpretive. These oppositions clearly exlude those who refuse to be positioned as, for example, either mentally ordered or mentally disordered, and who further refuse the epistemological assumptions underpinning such binaried

options. Such refusals have implications for identity politics, with regard to how people might then achieve viable identities outside of normative binaries.

Queer politics

Queer scholarship and politics moves beyond understanding of how exclusion occurs, to create spaces where resistance can take place or be imagined. This political impetus enables celebrating difference to disrupt the normative 'truths' of EB practice in the broader aim of contributing to radical social and material change (Grant and Leigh-Phippard, 2014; Zeeman et al, 2014b). With regard to mental health/nursing practice for example, 'mental health recovery' is not a neutral, a-political process. On the contrary, it is frequently characterised by power struggles between the authority of mainstream psychiatry and a need by many survivors of the institutional psychiatric system to critically re-define 'recovery' in existential rather than psychiatrized ways (Grant and Leigh-Phippard, 2014; Grant et al, 2015).

A Queer perspective in mental health nursing curricula helps clarify that normative identity is produced in particular politicised knowledge frameworks (Zeeman et al, 2014b). These frameworks are informed by normative assumptions around class, age, disability, race, ethnicity, culture, sexuality, gender, and ethnocentric biases in professional mental health practice around diagnosis and classification (Grant, 2015; Thomas, 2014). The social and professional processes of normative identity construction function both to police and restrict who can be regarded as viable subjects. When people are culturally acknowledged as viable by their relative conformity to acceptable norms around social identity, their lives are similarly recognised as being of value and thus 'liveable'.

Conversely, where and when people deviate from the norm, their lives can become increasingly inconceivable and illegible (Butler, 2004). From this perspective, a major political challenge for mental health nurse education is to initiate curricular changes that will make life more viable for people associated with or currently involved in mental health systems as service users. Many have been, and will continue to be, excluded, marginalised or represented as having unintelligible lives as a result of the normative practices of institutional psychiatry (Grant and Leigh-Phippard, 2014; Grant et al, 2015; Johnstone, 2014; Thomas, 2014).

A normatively-informed EB mental health nursing curricula arguably renders the lived experience of many mental health service users invisible due to its preferencing of the scientific, rational, objective and normative. Although this process is to some extent ameliorated by the emergence of public and patient involvement in health and mental health, as academics who privilege lived experience-based knowledge in our research and teaching, we regularly find that this form of knowledge is often disparaged as 'anecdata' by mental health professionals and quantitative-experimental researchers. Through such disparaging practices and processes, mental health service users are systematically disconnected from their rich and variable identities, histories and life contexts, and from the larger narrative structures informing their identities.

As a result of this – what might be reasonably regarded as normative violence – the lives of many mental health service users become invisible (Butler, 2004), in that their unique stories of the experiences and events contributing to their troubles are silenced and remain unheard (Grant, 2015; Grant and Leigh-Phippard, 2014; Grant et al, 2015; Johnstone, 2014; Thomas, 2014). An EB discourse-informed mental health nursing curriculum thus arguably plays a constituent part in trapping many mental health service users in reductionist institutional psychiatric biographies. This poses an ethical challenge for mental health nurse educators internationally, and, in related terms, mental health nursing practice.

Some Queer epistemological principles for revisioning mental health nurse curricula

Curricular changes to mental health nurse educational preparation should therefore include working towards 'breaking the grip' of current but outmoded representational practices (Grant, 2014b). These have sustained a decades-long oppressive exclusivity internationally in constructing and managing the defining narratives of people involved in mental health systems as service users. Curricular changes must urgently and necessarily envision different and new ways for nurse educators to engage students in the contemporary and increasingly heterogeneous life problems that bring users into contact with mental health services. This should be done in ways that challenge normative assumptions and practices, including psychiatric diagnostic practices, in a sensitive recognition of an increasing range of plurality and diversity in human identities. This will necessarily implicate the intersections of various markers of difference, such as gender, sexuality, ethnicity, race, and social class, to help make meaning of the complex processes that underpin adversity and human misery (Grant, 2015; Johnstone, 2014; Thomas, 2014).

As a hybrid discipline, mental health nurse education should therefore intersect with other ways of knowing in the social and human sciences to ensure that its theoretical developments maintain a necessary level of criticality and discipline reflexivity. This will help it move out of the parochialism and insularity that has for too long trapped it in a 'guilt by association' relationship with oppressive institutional psychiatric practices.

All of this will implicate and reinforce the welcoming of the relatively new emerging skill of *narrative competence* as crucial in mental health nursing curricula (Grant, 2015). This will help prepare student mental health nurses to respond to the contemporary demand for an empathically-attuned awareness and listening, to see and hear *difference* between people's narratives rather than simply assume normative categorical similarities among them. It will also help nurses respond non-defensively to the stories they hear from people in their care, about events and experiences carried out in the name of institutional psychiatry which have proved damaging to their narrative identities. Observance of the last principle will bring mental health nursing more in line with contemporary developments in narrative psychiatry (Grant, 2015; Thomas, 2014) and the policy-informed, thoroughly psychologically-evidence based, emergence in UK clinical psychology of *formulation* as an alternative to psychiatric diagnosis (Grant, 2015; Johnstone, 2014).

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Highlights

- We critique EB mental healthcare's relationship with psychiatric diagnosis from a Queer paradigm position.
- We sketch out some initial principles that will hopefully stimulate and contribute to the advancement of mental health nurse educational curricula internationally.
- This will help bring mental health nurse education more in line with contemporary developments in narrative psychiatry and formulation as an emerging alternative to psychiatric diagnosis in UK clinical psychology.