The corporate construction of psychosis and the rise of the psychosocial paradigm: Emerging implications for mental health nurse education

Introduction

A major shift is underway that is changing what counts as lay and professional knowledge of 'the psychoses', with the emerging psychosocial paradigm increasingly challenging longstanding biomedical understandings in this area. This places a demand on international mental health nurse education, in countries where biomedical understandings of psychosis inform dominant lay and professional assumptions and practices, to both clarify its moral purpose and consider emerging implications for pedagogic practice and curricular content (BPS, 2014; Grant, 2015; Read and Dillon, 2013). Inaction will maintain the status quo of nurse educators causing minimal trouble to often socially and personally damaging institutional psychiatric business-as-usual. At a more troubling level, it will signal continued complicity with the corporate construction of such extremes of human distress as *disease* (BPS, 2014; Mosher et al., 2013).

In what Healy (2013) and others describe as our current 'Pharmaggedon' era, successful drug cures in healthcare conceal tragedies. These include the social damage of drug-induced illnesses and deaths in the mental health field through the injudicious use of antipsychotic medication (Healy, 2013; Hutton et al., 2013). The relative lack of public and professional protest about this reflects a decades-long efficient colonisation of the psychological and social by the biological (Read et al., 2013). This has paved the way for the dominant shaping of the mental health care agenda by the pharmaceutical industry (Healy, 2013), mediated by this industry's use of multiple overt, covert and often morally dubious strategies (Healy, 2013; Mosher et al., 2013).

The corporate construction of schizophrenia

It is well known in the critical mental health communities that pharmaceutical companies use such strategies. Mosher et al. (2013) summarise these as: falsely claiming 'schizophrenia' as a proven brain disease requiring urgent drug treatment from its earliest signs, to the extent of treating pre-psychotic 'at risk' adolescents; vigorous marketing and sales; sponsorship of national and international symposia by field 'thought leaders' on the payroll of drug companies; selective publication of drug trial results, often 'ghost authored' by high profile researchers; endorsement of specific drugs by organizations who have a financial allegiance to drug companies; media hype and celebrity endorsement of specific drugs; lobbying of drug formulary publishers to include specific products; political campaigns to advance the interests of drug companies; shaping government policy

and public opinion around the nature of 'mental illness' and relevant drug treatments through the use of skilled publication relations experts; discrediting and harassing individuals who criticize drug companies and their activities and products; withdrawing funding from journals that publish material unfavourable to a drug company's interests; suing researchers for the publication of negative results of drug trials; and shaping psychiatric diagnosis – all of the contributors to the sections on 'schizophrenia' of the 5th edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders apparently had financial ties to the pharmaceutical industry.

As a result, this industry is implicated in the construction of mental illness and cures generally, at policy, academic, research, diagnostic, professional practice and lay and professional conceptual levels (Mosher et al., 2013). Biomedical psychiatry shares an elective affinity with pharmaceutical interests in that both co-exist in a symbiotic relationship of mutual gain. In consequence, 'schizophrenia as illness' assumptions have thoroughly saturated public and mental health professional consciousness. Biomedical constructions and related claims for the vital and logical role of drug treatment are omnipresent and drown out emancipatory and empirically supported advances in psychosocial understandings and interventions for psychosis. It is for this reason that Read et al. (2013) call for a *balancing* rather than a *balanced* account of this state of affairs, to lay bare both the dark side and spurious claims of the 'psychosis as illness' model and to argue for the psychosocial model as an already credible and evidence-based alternative.

Schizophrenia as illness

The biomedical paradigm supports a view of psychotic disorders such as 'schizophrenia' as chronic, severe and progressive illnesses with a genetic basis, and antipsychotic drugs as *the* cornerstone treatment (see BPS, 2014; Hutton et al., 2013; Read et al., 2013). Given the discussion so far, although many mental health professionals and the public accept this message in good faith, it does not sit well with the consensus among the critical mental health writers cited in this paper and elsewhere (see Grant, 2015). To recapitulate for emphasis, this is that, in keeping with their privileging of profit over ethics, pharmaceutical companies use the scientific evidence for their mental health products in immoral and fraudulent ways. Antipsychotic drug trials are constructed and disseminated in such a way as to produce data supportive of psychosis as an underlying disease process, with antipsychotics as the effective treatment for this. Trials with positive outcomes are far more likely to be reported than those without, and the effectiveness of antipsychotic drugs is misrepresented and over-estimated while their adverse effects are either minimised or not reported (Barker and Buchanan-Barker, 2011; Healy, 2013; Hutton et al., 2013). In this context, Barker and Buchanan-Barker

(2011) highlight evidence of the lack of discussion on adverse effects between nurses and service users. This serves strategically to maintain the latter group's drug treatment adherence, in relationships and environmental contexts characterised by control and compliance rather than collaboration.

The toxicity of antipsychotics

In addition to treatment induced deaths (Healy, 2013; Hutton et al., 2013) and brain volume reduction (Hutton et al., 2013), adverse physical effects of prolonged antipsychotic medication include but are not limited to neurological problems, such as akathisia or restless legs syndrome, and dyskinesia which results in muscle coordination and contraction difficulties (Hutton et al., 2013). These and other, related, neurological problems make daily living very difficult, and result in distressing emotional states, a markedly increased rate of suicide (Healy, 2013), and a substantial proportion of suicide attempts – most common among young people recently diagnosed and medicated (Hutton et al., 2013). Tardive dyskinesia involves uncontrollable movements in the face, hands and feet, and can progress to mouth infections, dental problems, muffled and unintelligible speech, impaired mobility and an inability to work. Unsurprisingly, all of this contributes to stigmatization, and the experience in some patients of guilt, anxiety, shame and depression (Hutton et al., 2013). Almost thirty years ago, the pharmaceutical industry admitted that tardive dyskinesia, a feature of brain damage described by Breggin (1983) as one of the worst medically-induced disasters in history, is irreversible in 75% of cases (Hill, 1986).

Problems with the idea of 'schizophrenia as illness'

The experiences and behaviours associated with psychosis are variously distributed among the general population (BPS, 2014), varying in intensity and type of clustering as a function of time, context and individual circumstance (Read, 2013). Further, the experiences and behaviours associated with the 'schizophrenic' diagnosis occur in other mental health problems. Equally, the experiences and behaviours associated with such other problems are also present in those diagnosed with 'schizophrenia' (Read, 2013).

The psychosocial challenge to such bio-pharmacological dominance thus begins from the premise that 'schizophrenia' does not exist (Read, 2013). This is not to deny the extremes of human misery and disturbance that those in receipt of this diagnosis experience and exhibit. In keeping with

the compromised scientific status of psychiatric diagnoses more generally (Johnstone, 2014), it rather points to the fact that the schizophrenia diagnosis is conceptually and empirically incoherent.

Moreover, the diagnosis fails to meet the normally accepted scientific requirements associated with identifying discrete illnesses. This includes the fact that schizophrenia has not been successfully shown to exist in nature in terms of bodily pathology, and that the diagnosis lacks the predictive utility normally associated with illnesses that have been shown to have such an established organic basis, aetiology, course and prognosis. Further, at a fundamental existential level, as is the case with psychiatric diagnoses more broadly, it violates human dignity and biographical integrity in stripping vital relational and contextual meaning from the experience of extreme distress (BPS, 2014; Johnstone, 2013; Read, 2013,). This includes acknowledgement of the personal histories of trauma, abuse, discrimination and deprivation implicated in the development of psychotic experiences and behaviour (Read and Dillon, 2013).

In consequence, following the lead of several international organizations, including the Division of Clinical Psychology of the British Psychological Society, Read (2013) calls for an end to the use of this uninformative, unscientific and unhelpful concept.

The psychosocial paradigm

The psychosocial paradigm places the *narrative subject* (Frank, 2015) at the heart of good mental health recovery practice. Like all users of healthcare internationally, mental health service users are narrative subjects to the extent that they are spoken or written about, and understand themselves, within the constraints and possibilities of competing discourses or 'master narratives' (Frank 2015). The biomedically-informed psychiatric discourse constrains users to comply with currently dominant understandings of their experiences and behaviour, in terms of accepting that they are 'mentally ill' and thus often in need of appropriate pharmacological treatment. In contrast, the more general discourse of *illness experience*, which includes users' experiences of the often damaging effects of institutional psychiatric practices (Grant et al., 2015), enables users to understand their psychological distress in existential terms. This offers them the possibility of using such understandings to engage in self-development and recovery community building work (Frank, 2015; Grant et al., 2015).

In summary, this discursive tension constitutes a divide between the meaning and significance of recovery in either biomedical or psychosocial terms (Kinderman 2014; Rapley et al., 2011; Read and Dillon, 2013). In terms of the latter, a new conceptual and categorical system for understanding psychotic experiences and behaviours is clearly needed. Read (2013) argues that a more fruitful alternative categorising approach would be to group people and their problems according to their

reported lived-experiences (eg hearing voices, having unusual beliefs). Such groupings can be further broken down into dimensional variables, such as duration, intensity and associated levels of distress. Work towards developing such an alternative categorising approach for understanding and working with psychological distress more generally has in fact been in progress for over 15 years (Johnstone, 2013). Co-led by Johnstone, this ongoing project aims to provide an evidence based, conceptually and empirically coherent alternative basis for research, planning and implementing services, and administration.

However, Johnstone points out that there are already existing viable alternatives to psychiatric diagnosis – all aimed at the restoration of personal meaning within a psychosocial context. These include, but are not limited to promoting the use of psychological formulation as one approach among several (see also Grant, 2015). Johnstone (2013) identifies the best practice characteristics of formulation. These include the need for mental health professionals and workers to: be collaborative and respectful of the views of service users; be clear about who has the 'problem'; exercise reflexive awareness around their own values and assumptions; use accessible language; include service users' strengths and achievements; consider the possible role of trauma and abuse in the development of problems; include the possible role of services in compounding users' difficulties (see also Grant, 2015); use formulation in a teamwork context; and include, as part of formulation, critical awareness of the wider societal context within which its ongoing process takes place.

There are a range of other, related, contemporary approaches which equally proceed from the value base of the centrality of personal meaning within a social context (see Read and Dillon, 2013 for a full discussion of these). These include capitalising on experts by experience in the development of a wide range of international evidence-supported user-led services which are all based on models of peer support rather than professional expertise. Within this area, the international hearing voices movement has an important role to play. Cognitive therapy to help people work with voice hearing and unusual, distressing beliefs would complement these approaches (Morrison, 2002), as would psychodynamic approaches and early interventions.

Notable among non-hospital, non-medication early interventions is the Finnish Open Dialogue approach. This highly evidence-based and effective approach recognises that the meaning of experiences is created in social relations and that the process of dialogue in social network meetings involving service users, their families and social networks are key to recovery (Barker and Buchanan-Barker, 2011; Read and Dillon, 2013).

Emerging implications for nurse education

The moral purpose of in-patient mental health nursing has long been articulated in a succession of nursing models and an allegiance with Humanistic principles down the decades. However, the

response of institutional psychiatric business-as-usual to all of this has arguably been one of indifference to such models and principles. Despite the innovations made by many mental health nurse leaders, Barker and Buchanan-Barker (2011) assert that the primary function of in-patient mental health nursing internationally, and by implication nurse education in terms of preparation for this, has remained largely unchanged over the last century. In their view this function amounts to 'housekeeping', in terms of the default role of nurses being mainly about managing the social and physical environment and ensuring adherence to prescribed psychiatric treatment.

The rise of the psychosocial paradigm for making sense of psychosis and other variants of human misery in the context of mental health recovery necessarily shifts the moral purpose of mental health nurse education away from implicitly servicing the organisational needs of institutional psychiatry. Notwithstanding ongoing obstacles to progress, including nurses having to work with legally detained psychiatric patients, nurse educators need to play a vital, lead-taking role in this task. Doing so will constitute a principled response to the Barkers' (2011) manifesto call, in shifting the curricular and pedagogic emphasis of mental health nurse education. This will be from complicity with a traditional form of psychiatric nursing that services the needs of biomedically-driven institutional psychiatry to a mental health nursing practice where the facilitation of recovery in psychosocial terms is paramount .

This will have clear, related, specific implications for changes to curriculum content. At a general level, as critical educational activity, mental health nurse pedagogy will demonstrate that the narrative identities of service users as 'experts-by-experience' are taken far more seriously than is currently normally the case. Such a pedagogy will more vigorously challenge dominant 'psychosis as illness' assumptions and practices, and will include reflexive engagement with *all* scientifically and morally questionable representational practices. In consequence, texts within which words and phrases such as 'symptoms' and 'mental illness' appear will be held to critical account.

In related terms, this enacted level of criticality will require nurse educators to both role model and teach narrative competence (Corbally and Grant, 2016), without using an illness vocabulary to do so. The careless use of terms and phrases such as 'severely mentally ill' and 'psychotic symptoms' in educational practice and in print gives a double message to students: this is that we need to cover alternative models and understandings of psychosis but we will continue to do so in the language of biomedspeak.

A revised mental health nurse curriculum will also need to more explicitly prepare students to be culturally as well as narratively aware and competent when talking with service users (Corbally and Grant, 2016), to the extent of developing best practice, person-centred and tailored formulation skills and associated knowledge (Johnstone, 2013), within which students use demedicalized neutral descriptive terms and phrases, such as 'hearing voices' or 'having unusual beliefs'. This will shift the

basis for such a dialogue from illness assessment to open-ended formulation; from 'what is wrong with you?' to 'what happened to you?'. In this context, following the logic of the psychosocial paradigm, nurses should be supported in avoiding colluding with institutional pressure on users to accept a hitherto dominant unitary framework for explaining and understanding their difficulties; that 'illness', whether used in a metaphorical or literal sense, is just *one* of several ways of understanding such difficulties.

Teaching on pharmacology modules needs to go beyond safe drug identification and administration (see Grant, 2015). In a critically pedagogic and curricular context, nurse educators should highlight the corporate construction of psychosis practices which give rise to the prescription of antipsychotics in the first place, and encourage students to find out more about these practices. Students should also be prepared to engage in full discussions with service users about the short and long term adverse effects of antipsychotic medication, and be given support to deal with the inevitable resistance to such dialogues from their colleagues in practice.

Finally, in preparation for their future partnership role, students will need help in working with experts by experience in community led services, and in playing a future key role in the expansion and development of these services. They will thus need to know the principles, strategies and associated skills that underpin initiatives such as the international Hearing Voices Network project, Open Dialogue, and related therapeutic approaches, including cognitive therapy for psychosis.

All of the above will contribute to the development of a more coherent pedagogic, curricular and moral direction for a mental health nurse education. This will be fit for the purpose of meeting the challenges and rewards of an increasingly strong and compelling psychosocial paradigm for understanding and working with people hitherto treated mostly within a biomedical framework. Such an undergraduate mental health nurse curricula will be far more focused, intensive, critical and challenging than it generally is at present. It will thus accord appropriate respect to the contemporary needs of service users and critically reflexive, evidence- and values-based, graduate practitioners.

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