Nurse Education Today 35 (2015) e50–e53

Contents lists available at ScienceDirect

Nurse Education Today

journal homepage: www.elsevier.com/nedt

Demedicalising misery: Welcoming the human paradigm in mental health nurse education

Alec Grant *

University of Brighton, School of Health Sciences, Robert Dodd Building, 49 Darley Road, Eastbourne BN20 7UR, East Sussex, United Kingdom

ARTICLE INFO

Article history:
Accepted 30 May 2015

Keywords:
Demedicalising mental health
Technological paradigm
Human paradigm
Mental health nurse education
Social justice

Introduction

In 2013 in the UK, the Division of Clinical Psychology (DCP) of the British Psychological Society released a position statement. This called for a paradigm shift in mental health 'towards a conceptual system that is no longer based on a "disease" model' (Johnstone, 2014, p15). The arguments for changed practice and understandings in this document are supported in contemporary critical mental health work at an international level (eg Bentall, 2010; Boyle and Johnstone, 2014; Cromby et al., 2013; Johnstone, 2014; LeFrancois et al., 2013; Thomas, 2014).

The authors of the DCP (2013) position statement do not deny the role of biology in mediating and enabling all forms of human behaviour and distress. They also acknowledge complex relationships between social, psychological and biological factors underpinning mental health problems (Cromby et al., 2013). Their key message is that there is a lack of empirical support for biology as a primary cause in what are currently commonly regarded as 'functional' mental health problems. Functional mental health problems, treated across the range of in-patient and community mental health services, are distinguishable from organic problems by an absence of signs of brain impairment.

To date, no genes, biomarkers or evidence for disease processes have been convincingly identified for functional mental health problems. Instead, accepting the importance of evolved human biology and cultural mediators in patterns of human emotional reaction, an overwhelming amount of evidence points to the causal role of social and relational adversities in their development (Boyle and Johnstone, 2014; Cromby et al., 2013; Johnstone, 2014; Thomas, 2014). These adversities can be roughly divided into two groups: *social circumstances* subsume various forms of social inequality, such as unemployment, discrimination, poverty, poor housing and living environments, adverse events in childhood and adolescence, and social isolation. *Relationship factors* include varieties of victimisation, emotional, physical and sexual abuse in childhood and adulthood, and loss and bereavement.

It should be emphasised that 'distress' in the above context does not mean 'disease' or 'disorder'. For this reason, the position statement and related critical literature make clear that a change of language is needed to understand, conceptualise, research and help in alleviating human misery. In moving from technological to human paradigmatic understandings, narrative-based approaches, including the central role of formulation, emerge as a more credible way forward.

The Technological Paradigm

The *technological paradigm* assumes that interlinked, faulty physiological, emotional and information processing mechanisms are key to understanding extremes of human misery (see Thomas, 2014). This assumption is reflected in an increasing colonization of human experience and behaviour by medical and psychiatric language. In various forms, biomedical understandings have generally dominated mainstream psychiatric theory and practice for 150 years (Thomas, 2014). Since the early 1950s however, psychiatric diagnosis has been more specifically spearheaded by the diagnostic development committee work of the American Psychiatric Association (Johnstone, 2014). This work is represented in successive editions of its Diagnostic and Statistical Manual of Mental Disorders, culminating in its most current, fifth, edition (APA, 2013).

The technological paradigm privileges and promotes pharmaceutical and related psychological interventions that fit with its medicalised assumptions. These interventions are by definition context-independent in regarding internal processes as causal in human distress. They can therefore be applied relatively independently of concerns about the impact of relationships or personal values — information conveyed by service users in their narratives of lived experiences. It is therefore not surprising that such narratives are often regarded as andecdotal and/or diagnostically symptomatic, and therefore irrelevant to mainstream institutional psychiatric treatment (Johnstone, 2014; Thomas, 2014).

---

* Tel.: +44 7813 332537 (mobile).
E-mail address: A.Grant@brighton.ac.uk.

http://dx.doi.org/10.1016/j.nedt.2015.05.022

The Human Paradigm

In contrast, the emerging human paradigm regards mental health work and recovery from distress as embodied moral practice, grounded in material and cultural circumstances and personal histories and relationships. It therefore values context and meaning as crucial in understanding human distress, and pays the utmost respect to how suffering people interpret and story their experiences of this (Boyle and Johnstone, 2014; Grant and Leigh-Phippard, 2014; Grant et al., 2015; Johnstone, 2014; Thomas, 2014).

The human paradigm rests on the simple idea of human life as narrative. The concept of narrative or storied identity emerged as a philosophical concern in the second half of the 20th century, in the work of philosophers such as Rorty (1989) and MacIntyre (1981), who argued that people's lives are inescapably grounded in their experiences of time. So like novels or plays, but in much more messy ways, human lives have beginnings, middles and ends, and plots and sub-plots along the way. Our life narrative behaviours, experiences and decisions are thus only understandable to the extent that they are embodied in historical contexts. To put this more simply, what guides our understandings of ourselves is knowledge of what stories we're in at any one point at time. Similarly, other people's understandings of us inform how they locate us in their accounts of what we're doing and our motivations behind our actions (Thomas, 2014). This has implications for what constitutes good mental health work: this arguably occurs when service user and worker stories about each other merge and chime sympathetically and in harmony, rather than jar in discord.

Problems with the Technological Paradigm

How well do psychiatric diagnostic systems fare as moral practices in storying lives from the perspective of the human paradigm and evidence-based scrutiny? They fall down as both a credible categorising and coherent system in two major ways. The scientific criterion of *reliability* refers to the consistency of judgements made about mental health service users' diagnoses. Diagnostic reliability emerges from the literature as consistently low, and influenced by such factors as different diagnostic preferences held by different psychiatrists (Johnstone, 2013; Thomas, 2014) and relatively unconscious judgements that reflect and reinforce white western norms about what constitutes culturally normal experiences and behaviours (Johnstone, 2013). As a result of these and related factors, ‘People typically collect a whole range of diagnoses as they progress through the (psychiatric) system, and are often prescribed a whole range of different medications on the basis of… guesswork’ (Johnstone, 2014, p23).

Psychiatric diagnoses also fail on the scientific criterion of *validity*, or describing what actually exists. Given that, as described above, there are no sites of functional ‘mental illness’ that can be seen in human bodies, diagnostic categories do not describe things in the real world. Instead, diagnoses are made on the basis of psychiatrists' and other mental health workers' observations of people's mood, thinking and related aspects of their subjective states (Johnstone, 2013; Thomas, 2014).

Having the status of social and cultural, rather than medical or evidence-based, judgements, it is remarkable that diagnoses have endured to date as fundamental to the work of mental health nurses and their colleagues. In this context, the medicalised language used in diagnostic understandings – replete as it is with terms such as ‘symptoms’, ‘illness’, ‘pathology’ and ‘prognosis’ – conceals an ideological rhetorical function. Reflecting and reifying lay assumptions, it is constantly accepted as *the* authoritative narrative, received and believed by many service users and their carers: that the former group are suffering from a diagnosable illnesses, perhaps caused by biochemical imbalances, best treated in hospitals, with medication prescribed and administered by doctors and nurses.

The Psychosocial Impact of Diagnosis

Also concealed is the fact that there are problems related to psychiatric diagnosis at the level of relationships in and between professional and user communities. These result in incoherent stories conferred on the latter groups (Johnstone, 2014; Grant and Leigh-Phippard, 2014; Grant et al., 2015). Johnstone (2014), for example, makes the point that when involved in mainstream institutional psychiatric services, service users are often caught in a double bind, reflected in the message that ‘although it's not your fault that you are ill, you are responsible for your illness. You must therefore make the effort to get better (so long as you do it our way as we are the illness experts).’

This, institutional-led rather than collaborative, recovery dynamic was further illuminated in a recent, internationally-focused integrative literature review of mental health service users' experiences of mental health care. Newman et al. (2015) describe a lack of user involvement in the care planning process as a major finding. These authors argue that this stems from limited opportunities reported by users to express their views about both their care needs and what should be included in their care plans. They report that where this is achieved, service user involvement is often rarely implemented, in spite of policy directives to the contrary.

This tension at the heart of care planning speaks to a related tension between the meaning of ‘recovery’ at institutional psychiatric and service user levels, and arguably gives rise to circumstances where users may be judged on the basis of how well they comply with the dominant narratives of institutional psychiatry (Newman et al., 2015; Stacey and Stickley, 2012). Thus, users can be perceived as being either too dependent or non-compliant, lacking in insight through rejection of a diagnosis or too reliant on it and avoidant of life responsibilities. Overall, this proves to be a no-win situation for many service users, which contributes to why some make a reasoned choice to use deceit and subterfuge to manage their relationships with the psychiatric services in the interests of their personal integrity (Grant and Leigh-Phippard, 2014; Grant et al., 2015; Johnstone, 2014).

A further problem has been described as the ‘treatment barrier’. This refers to how, according to the logic of a diagnostic model of mental distress, problems are located within individuals rather than in social or relationship difficulties (Johnstone, 2014). This gives, for example, abusive partners licence to avoid culpability, and also enables mental health services to blame individuals for the intractability of their problems, without these services acknowledging the extent to which involvement in psychiatric services has contributed to their development (Grant and Leigh-Phippard, 2014; Grant et al., 2015).

As mentioned above, if personal experiences are regarded as simply diagnostic symptoms, there seems little reason for mental health professionals to make too much of an effort to explore their meanings. As a result of this state of affairs, ‘…people can spend years coming in and out of hospital without anyone sitting down and discussing their experiences and their distress in order to make sense of them.’ (Johnstone, 2014, p.53). Reflecting monologic rather than dialogic organisational cultural styles in many mental health services, and a corresponding lack of collaborative care planning, people are often *told* what their problems are. In the absence of their involvement in discussions, or their agreement about how accurate this information feels to them, this can threaten relationships and trust between users and mental health workers, and the recovery process (Grant and Leigh-Phippard, 2014; Grant et al., 2015; Newman et al., 2015).

Stopping people from telling their stories, thus having these stories respected and validated by mental health professionals, also relates to the ‘confirmation bias’ phenomenon, frequently occurring in mental health treatment settings (Thomas, 2014). This refers to the act of mental health workers actively selecting information from and about users of their service that fits their medicalised views of them. Users in turn may well self-select when telling their stories to match these views, and mental health nurses often *see* users' neutral or contextually