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

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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 practises, to both clarify its moral purpose and consider emerging implications for pedagogic practise 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 organisations 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 criticise 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 practise 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

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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 stigmatisation, 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 organisations, 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 practise. 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 practises (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 practise 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'