Nursing the Lore of Madness

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Philosopher William James’ succinct definition of philosophy as “an unusually stubborn effort to think clearly” (Fulford, Stanghellini, & Brome, 2004) neatly sums up its importance in the discussion of mental illness. The complexities of the human mind and behavior necessitates the use of philosophical thinking in considering disease, illness and well-being in relation to mental health (Fulford, Stanghellini, & Brome, 2004). Unlike the biomedical model which attributes physical aberrations to lesions, anomalies in behaviors are seen as misconducts (Szasz, 2000). This raises more questions as to how to deal accurately with workings of the mind which Dawson (1994) reiterates by stating that causality and management of mental disorders requires profound comprehension of the mental state. The author adds that psychiatric nurses in particular would benefit much from revisiting philosophical concepts abundant in psychiatry and mental health in order to fully appreciate the numerous means which mental illness can be considered.

He further adds that historically, psychiatry has been studying mental illness in view of the irregular mind as opposed to modern psychiatry’s fascination with the irregular brain. This paper aims to elucidate the ways that modern psychiatry constrains the philosophy of psychiatric nursing through its empirical, reductionist and paternalistic approach to mental illness.

Psychiatry’s search for credibility and recognition found realization through its alignment with the biological model of mental illness which is largely based on empiricism (Szasz 2000; Wilkin, 2001; Dawson, 1994). Jaspers, the father of psychopathology, stressed the central role of empirical evidence in psychiatry, and posited that only a descriptive view of the behavioral and social dysfunction characteristic of mental disorders will facilitate their determination of causality and treatment (Dawson, 1994). This basis on empiricism is exemplified in the psychiatric diagnostic system, the DSM, which is as descriptive as its source (Szasz, 2000;
Dawson, 1994). It operates in the assumption that mental disturbances are departures from objective reality which causalities that are biological in nature, and which can be pegged and treated with medications (Szasz, 2000; Dawson, 1994). Littlejohn (2003) believes that psychiatry’s diagnostic system creates mental illnesses as evidenced with the progressive revisions which lists several new disorders from normal behaviors such as Disruptive Mood Dysregulation Disorder (DMDD) for excessive tantrums, and Premenstrual Mood Dysphoric Disorder for excessive PMS symptoms (American Psychiatric Association, APA, 2014). Elevating these normal problems of living to diseases reiterates the narrow view of the medical model in considering anomalies in behavior. Moreover, Littlejohn (2003) claims that mental aberrations arising from distress do not necessarily have a medical origin, and their inclusion in the DSM means that this diagnostic system is not purely objective, but may be motivated by socio-economic and political forces. Dawson (1994) also adds that these anomalies are not necessarily indicative of mental disorder as most people have experienced some form at some point, usually as déjà vu or prophetic dreams. This shows that there are several dimensions to the workings of the mind, and abnormalities do not readily point to a disease that can be cured by pharmaceuticals (Littlejohn, 2003). In contrast, psychiatric nursing’s holistic view takes in all aspects of the person presenting with mental distress including the biological and psychosocial causality and treatment (Littlejohn, 2003). According to Peplau (as cited in Buchanan-Barker & Barker, 2009) psychiatric nurses provide guidance to patients in their search for solutions to their problems in living. As such, psychiatric nurses have the capacity to be more of value than their current adjunctive roles to psychiatry (Littlejohn, 2003) with their philosophy of care encompassing the person. But being a by-product of medicine (Szasz, 2000), psychiatric nursing
bears the burden of supporting psychiatry and its commitment to empiricism while exerting efforts to expand its own philosophy of care.

Through its association with biomedical science, psychiatry reduces the complexity of mental illness to a concept of disease. This reductionist view is supported by the promoters of the medical model of mental illness, most notably by Virchow in his cellular theory of disease for which he attributes it to the presence of lesions in organs and tissues (Szasz, 2000). But Szasz (2000) scoffs at the notion of lesions in the mind as implied by the medical model, for brain lesions would constitute medical illness, not mental. Similarly, Dawson (1994) negates this reductionist approach to abnormalities in the mind, insisting on the metaphor of the mind-brain to the computer. He explains that the mind resembles the software, while the brain resembles the hardware. He expounds that a glitch in the program (behavior) would require tuning of the software (mind), not of the hardware (brain). For him, there is a distinct difference between an anomaly in the mind and in the brain. Szasz (2003) reiterates this point that the mind is rational, not empirical, because of its unique experiences and perceptions. Moreover, Hospers (1997) states that perception and experience are subjective, depending on the reality of the observer. The mind then is more than the sum of its components, as Dawson (1994) points out that the brain state does not equal the mental state. Harari (2003) echoes this assertion by citing Siegel’s proposition that the mind is constructed by an interplay of complex circuitry involving neurological systems and interpersonal communication through the brain’s facilitation. Reducing inorganic mental illness to a brain dysfunction alone would not only be un-holistic, but alienating as well for the person who is experiencing a different but unique form of their own reality. Harari (2003) also cites Husserl who stated that the phenomena of mental illness and experience cannot be minimized further because they are significantly influenced by culture and historical contexts.
This further illustrates the many layers and facets that mental illness is enmeshed in, therefore needing a holistic treatment (Barker, 2009) which psychiatric nursing is in a vantage position to provide.

Psychiatry is a coercive force in mental health, as asserted by Szasz (2000). The author claims that its rarely contested power puts competent people involuntarily in institutions, violating their autonomy through the guise of securing the person and the society at large from harm. He further states that historically, psychiatry has been used to control persons deemed incompatible with society, as evidenced by abuses committed by psychiatrist in Germany and Soviet Union, and by current institutions for the criminally insane or not liable. Similarly, Wilkin (2001) states that this is a form of psychiatric colonialism where doctors strive to control the mentally ill through medication and legal edicts. He adds that in the face of this paternalistic hold, psychiatric nursing is in danger of being overwhelmed. Littlejohn (2003) echoes this sentiment stating that in support of the psychiatric diagnostic criteria, psychiatric nursing creates ‘nursing ‘diagnoses’ tailored to the diagnoses chosen from the DSM. In addition, Szasz (2000) asserts that the contracting strategy between psychiatrist and patient puts more emphasis on the controlling nature of the relationship because of the power imbalance inherent in the relationship, which is contradictory to the implied equality in the term contracting. Buchanan-Barker and Barker (2009) raises the dilemma of psychiatric nurses who must choose between gainful employment and aiding in coercive psychiatric practices. The authors highlight the distinct irony between the participation of nurses who participate in these compulsory activities and their philosophy of care which aims to help patients “grow and develop”. To this, Littlejohn (2003) offers his views that psychiatric nursing is perfectly capable of asserting its own philosophy- one that is the median between empiricism as defined in the second paragraph, and idealism as
promoted by Szasz (2000), and Buchanan-Barker and Barker (2009). The author expounds that a creative realism philosophy will facilitate the release of psychiatric nursing from the paternalism, coercion and empiricism of psychiatry. He raises a priori requirements on which the profession can stand independently: that mental disturbances must be a real experience for the patient, that medication is not exclusive to psychiatry and may or may not mitigate mental illness, and that psychotherapies are not the only source of evidence-backed efficacy of interpersonal interactions. Only by removing itself from the knowledge derived from psychiatry and psychology can psychiatric nursing stand on its own, as long as the above a priori conditions are met.

In summary, constricting philosophies of psychiatry deprives the discipline of psychiatric nursing from developing and implementing their own. Empiricism is highly evident in the way psychiatry views mental distress as biological in origin, not as a product of the person’s difficulties with living. Psychiatry’s unshakeable belief in empirical observation is also apparent in the way the DSM prescribes and imposes labels on mental illness as if these encompasses everything. Similarly, the approach of reductionism in psychiatry also serves to enhance its affinity for empiricism, but fails to consider that the brain functioning is very different from mind functioning. Reducing mental illness to its unit forms inevitably touches on brain parts, which is not congruent with abnormalities in mind functioning. A more holistic approach of internal and external factors to the consideration of mental disorders deserves more merit. Furthermore, the paternalistic and coercive aspects of psychiatry is contradictory to psychiatric nursing’s philosophy of patient-centered care. Moving away from these philosophies towards integration of best practices will enable the discipline to eventually stand on its own without the crutches of psychiatry.
References


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