Crazy Making: The Reproduction of Psychiatry by Nursing Education

by

Simon Adam

A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy

Department of Leadership, Higher, and Adult Education
Ontario Institute for Studies in Education
University of Toronto

© Copyright by Simon Adam (2017)
CRAZY MAKING

Crazy Making: The Reproduction of Psychiatry by Nursing Education

Simon Adam

Doctor of Philosophy

Department of Leadership, Higher, and Adult Education
Ontario Institute for Studies in Education
University of Toronto

2017

Abstract

This is a study of how psychiatric discourse linguistically and institutionally figures in nursing education in Ontario. Correspondingly, it is a study of ‘mental health’ nursing education in undergraduate nursing programs, specifically, those offered by college-university partnerships. It is likewise an investigation of how psychiatry has come to colonize nursing by way of the nursing academy. A mixed qualitative methodology study, its analysis draws on the author’s experience as a nursing student and faculty member, with data also coming from student and faculty interviews, observation periods, and a number of curriculum and institutional documents.

Two primary approaches are employed—critical discourse analysis and institutional ethnography. Critical discourse analysis is used to unearth how the structure and function of language play a role in the reproduction of ‘mental illness.’ The language of nursing mental health literature is examined as a producer of psychiatrically-colonized constitutions of ‘mental health.’ What is demonstrated is how nursing linguistically downloads psychiatric discourse, thereby reproducing an ideologically biomedical framing of ‘the patient.’

With institutional ethnography, the thesis makes visible the operational complex of the relations that comprise the nursing program under study. Beginning in the everyday world, the author traces the institutional processes which embed and maintain a problematic construction of
the ‘mentally ill,’ in the process, maintaining a perpetual state of psychiatric ruling. Reinforcing this psychiatric reproduction are ‘disciplinary’ practices—those docility-producing teaching practices which are common to university professional education. These too are examined as an arm of the institution, as inscribers of psychiatric discourse, effectively perpetuating a problematic understanding of ‘mental health’ for nursing.

The thesis ends with a discussion of implications for critical thinking and directions for nursing.
When through the centuries have we enjoyed ourselves so very much?
As we reproduce as much as does happen in a rabbit’s horny hutch
People also reproduce in their own unique way and continue to dispute
Who is better looking or can more friend recruit and for them root,
But modesty should always be our watchword and honesty to the end
Even if it drives you around the bitter circuit and your heart does rend.

But soon the festival of lights is coming up to enlighten this world
Be you of any age into which planet we have been unwillingly hurled.

When the time comes to hang up this mortal coil we bear
We should accept our the passing like soldiers in battle,
And on our hearts bear the pain while not thinking it fair
As we from within hear the dreaded death unfair rattle.

***

MEL STARKMAN, PSYCHIATRIC SURVIVOR
Acknowledgements

I imagine that anyone who has written a doctoral dissertation would agree that it is no small feat. On the part of a whole number of people, the work demands patience, time, energy, understanding, commitment, and an open mind. And a number of people indeed came through for me and for this project. This project is the product of a combination of their knowledge as well as a substantial amount of their resources, without which it could not have been possible.

First, I want to express a deep and sincere appreciation and a profound respect for psychiatric survivors, for without them, there would be no such project. Without their experiences—their journey through the institution—and their very important knowledge, I could not have gained the critical consciousness which launched me into this project. It is they to whom I am first and most sincerely indebted.

I would like to acknowledge the student participants for their valuable input, their time-commitment to the interviews and focus groups despite their busy schedules, and their courage to interrogate with me a subject area that is rife with power relations, often not in their favour. As my reader will shortly appreciate, these students, who by the time this dissertation is completed will have been registered nurses, undoubtedly providing exemplary care, comprise a major part of this project. A big thank-you to them, and I hope to have represented their perspectives as accurately as possible here.

Deep gratitude likewise goes to my faculty participants who shared with me their valuable work knowledge, their theorizations, their own questions, their discomforts, and of course, their time and energy. Theirs is a perspective that also came to be a major element of this project. I am also thankful to my other faculty colleagues who in their efforts to support me throughout my doctoral journey, often engaged me in dialogue about my research and
consistently encouraged me to remain grounded and focused. Thank you Drs. Laura Nicholson and Michele McIntosh. Thank you Susan Morales, Donna Simpson, and Linda Scott.

My supervisor, Dr. Bonnie Burstow has been the single most supportive force for this project and throughout my doctoral work in general. While difficult to do justice to my gratitude to Bonnie here, it suffices to say that her counsel, her guidance, and her unyielding commitment to my learning made this project and my doctoral studies an enjoyable reality and an authentic experience. Bonnie’s presence, her availability, and her quick, specific, and honest feedback on my academic work were vital ingredients in the success of this project. I am deeply appreciative of her unmatched support for me, both academically and personally.

I am immensely grateful to the guidance of Dr. Lynne Young, one of my committee members, whose unique area of expertise in critical discourse studies and language analysis took my own thinking and this project to another level. It is not without consistent and ongoing dialogue with her that I remained focused on what was methodologically the most difficult part of the project for me. Regardless of whether Lynne was in Toronto, Ottawa, the US, Israel, or Morocco, her availability marked a commitment for which I am very deeply thankful. This also goes with another deep expression of thanks to the late Dr. Roxanna Ng who directed me to consider attending a course taught by Lynne, hence, my being introduced to her. Thank you, Roxanna!

Many, many thanks to Dr. Jamie Magnusson, also a committee member, for her important feedback on my proposal, which kept me focused and added rigor to the institutional research dimension of it. I very much appreciate her ongoing commitment and support of my work on this project and the reading of multiple drafts of this manuscript.
It is likewise not without the time and energy of my thesis support group that this project came to fruition in the way it did. Their providing me with the space in which I can mull my thoughts, consider new ideas, refine my thinking, and attain clarity was foundational to my success. Their feedback and their contributions diffusely reverberate through this project in many important ways. A heartfelt thank you to Drs. Jeff Myers, Adam Perry, and Mandeep Kaur. A likewise big thank you to Mary Jean Hande, Lauren Spring, Kelly Kay, Sona Kazemi, Eric Zorn, Sharry Taylor, Efrat Gold, Graham Vardy, and Edward Wong.

Laura Charles: My peer, my go-to person for methodology chats, my co-theorist in multi-method approaches, my conference presentation partner several times over, my friend. I do not know where to begin! Thank you Laura for entertaining my out-there ideas, my conundrums, and my painful moments when things made almost no sense. Thank you for being my methodological sounding board and for sharing your work with me and keeping me inspired to push the boundaries of theory and methodology. Without your valuable patience and your perspective, this project will not have reached the creative heights that I believe it did.

My family and my friends--my personal rock, without which the very foundation of this project could not exist: Cynthia, my dear friend, coparenting partner, and mother of my beautiful son. Thank you for juggling time, energy, space, and ideas to make room for me. Thank you for your presence, particularly during the difficulties, both personal and academic. Thank you for keeping me motivated, for listening to my rants, and for somehow salvaging meaning from them.

Sebastian, my most amazing toddler: While you may not be old enough to appreciate your own patience and the generosity of your time as I went about conducting this research and writing this dissertation, I so very deeply do. I love you.
Mom, dad, and my fantastic four (Edmond, Sue, Salam, and Sawsan [always in my heart]): Thank you for believing in me and in my scholarship. Thank you for understanding in every way, thank you for being the warm and open people that you are, and for what obviously paved the way for this dissertation. The Woodards (Jim and Rene): Thank you for your belief in me and for the many important encouragements you gave me along the way. Thank you for taking me into your remarkable family during the midst of my dissertation journey, an event that no doubt contributed to my success and the accomplishment of this project. Thank you for the moments of patience with which you inspired me and for the calm that your poise and composure brought into my life. If my memory serves me right, I believe most of chapter two was written in your cozy, peaceful, and lovely basement.

A deep gratitude goes to my two good longtime friends Robert Campiti and Cathy Rumeo, whose ongoing care and love for me nurtured me in an infinite number of ways. Thank you Robert for your delicious and necessary dinners that came just at the right time after a long and consuming day of data analysis and writing. Thank you for the personal chats and the ongoing encouragement. A big thank you to my good friend Cathy, whose reasoning with me through the unreasonable made way for the scholarship which culminated in this project. I can only hope that I am able to reciprocate your support.

Lastly, I want to thank my reader, who undoubtedly exercised courage to push the boundaries of his or her thinking in picking up and reading this dissertation. I want to thank you, my reader, for your time, for your interest in both this project and its broader implications, and for keeping an open mind. It is my sincere hope that you find it useful whether in your practice, your personal life, or both.
# Table of Contents

ABSTRACT .......................................................................................................................... ii

ACKNOWLEDGMENTS ........................................................................................................ v

TABLE OF CONTENTS ......................................................................................................... ix

LIST OF FIGURES ................................................................................................................ xiii

LIST OF APPENDICES ............................................................................................................ xiv

CHAPTER ONE: INTRODUCTION TO THE STUDY AND LITERATURE REVIEW .......... 1

  Study Entrée: A disjuncture in the academy ................................................................. 1

  The disjuncture, two years later ..................................................................................... 3

  Clinical difficulties: Foreshadowing the disjuncture .................................................... 6

  Disengaging from the discourse: Making a radical shift ............................................. 9

  The research problematic ............................................................................................... 11

    My standpoint and perspective ................................................................................. 12

    The perspectives of students and educators ............................................................. 12

    Looking up and out: Directing attention to the extralocal ....................................... 15

  A brief overview of the project ..................................................................................... 16

    Chapter-by-chapter overview .................................................................................... 17

  Language in this dissertation ....................................................................................... 18

  Review of literature: A promising counter-narrative ................................................... 18

    Nurses critical of psychiatry ....................................................................................... 19

    Nurses critical of mental health education ................................................................ 25

  The critical literature: Linguistic capture .................................................................... 29

  My position towards psychiatry: Influencers ............................................................... 31

  Diverging voices: My position versus the nursing critiques ....................................... 33

  Conclusion ...................................................................................................................... 34

CHAPTER TWO: METHODOLOGY .................................................................................... 36

Critical discourse analysis ............................................................................................... 38

  Norman Fairclough on critical discourse analysis ...................................................... 39

    Grammatical mood ..................................................................................................... 42

    Grammatical modality ............................................................................................... 42

    Metaphors ................................................................................................................ 43

    Euphemisms .............................................................................................................. 43

  Lilie Chouliaraki and Norman Fairclough on hybridity ............................................. 44

  Mikhail Bakhtin on speech genres ............................................................................. 46

  Michel Foucault on the ‘docile body’ ......................................................................... 47
CHAPTER THREE: DESIGN, METHODS, AND INSTITUTIONAL ACCESS

Methods

Interviews

Classroom Observation

Texts

Journal notes

Data analysis

Ethics

Access to data: Institutional hoops and loops

Access to texts

Access to the clinical setting

Access to administrators

Guarding the curriculum

What is lost

What makes this project an important contribution to knowledge

Returning to the overview of the project and concluding

CHAPTER FOUR: THE MENTAL HEALTH ASSESSMENT: A LEXIAL AND GRAMMATICAL ANALYSIS

The mental health assessment: A systemic functional linguistics analysis

Rationale for selecting this text specifically

Surface problems: (S)objective contradictions

Tenor: Reader-writer relations in the mental health assessment

Grammatical mood

Grammatical modality

Background assumptions: Ideological loading in the mental health assessment

Discursive hybrids and linguistic genres

Hybrids in the literature

Hybrids in speech
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Language: Consequences on nursing knowledge and practice</td>
<td>93</td>
</tr>
<tr>
<td></td>
<td>Zooming out and concluding</td>
<td>94</td>
</tr>
<tr>
<td></td>
<td>CHAPTER FIVE: INSTITUTIONAL RELATIONS, TEXTUAL RELATIONS, AND THE DISCOURSE OF UNDERGRADUATE MENTAL HEALTH NURSING EDUCATION</td>
<td>96</td>
</tr>
<tr>
<td></td>
<td>The ‘small hero’ and the institution</td>
<td>96</td>
</tr>
<tr>
<td></td>
<td>A brief introduction to the institution</td>
<td>98</td>
</tr>
<tr>
<td></td>
<td>Formation</td>
<td>99</td>
</tr>
<tr>
<td></td>
<td>Early problems: Division of teaching work</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Maintaining order: The curriculum administrative process</td>
<td>103</td>
</tr>
<tr>
<td></td>
<td>Curriculum policy: Ironically, what <em>does not</em> govern curriculum</td>
<td>104</td>
</tr>
<tr>
<td></td>
<td>The hierarchy of curriculum-based decision making</td>
<td>105</td>
</tr>
<tr>
<td></td>
<td>Enter external partners</td>
<td>107</td>
</tr>
<tr>
<td></td>
<td>The acute psychosis unit: “Students unaware of risks”</td>
<td>108</td>
</tr>
<tr>
<td></td>
<td>Looking beyond the ‘partnership’: Extralocal influences</td>
<td>110</td>
</tr>
<tr>
<td></td>
<td>“Deficiency in mental health content”</td>
<td>110</td>
</tr>
<tr>
<td></td>
<td>Student registration exam failures: A program ‘vulnerability’</td>
<td>112</td>
</tr>
<tr>
<td></td>
<td>Psychosocial integrity? Not exactly!</td>
<td>113</td>
</tr>
<tr>
<td></td>
<td>Everyday work and other extralocal influences</td>
<td>115</td>
</tr>
<tr>
<td></td>
<td>Undergraduate nursing education: An inter-institutional circuit</td>
<td>119</td>
</tr>
<tr>
<td></td>
<td>The nursing academy and psychiatric discourse: The textual relations</td>
<td>121</td>
</tr>
<tr>
<td></td>
<td>Undergraduate nursing and mental health education: Rule by text</td>
<td>122</td>
</tr>
<tr>
<td></td>
<td>Undergraduate nursing and mental health education: The intertextual hierarchy</td>
<td>124</td>
</tr>
<tr>
<td></td>
<td>Nursing education as ‘discipline’: Imprinting psychiatry onto nursing</td>
<td>129</td>
</tr>
<tr>
<td></td>
<td>Revisiting the disjunction and concluding</td>
<td>134</td>
</tr>
<tr>
<td>6</td>
<td>CHAPTER SIX: ‘CRITICAL THINKING,’ PSYCHIATRY, AND THE INSTITUTION: TOWARD A RADICAL DIRECTION IN NURSING EDUCATION</td>
<td>136</td>
</tr>
<tr>
<td></td>
<td>Dominant theories of critical thinking in nursing</td>
<td>136</td>
</tr>
<tr>
<td></td>
<td>Faculty and students on critical thought: The local perspectives</td>
<td>140</td>
</tr>
<tr>
<td></td>
<td>The clinic and the ‘science’ of critical thinking</td>
<td>140</td>
</tr>
<tr>
<td></td>
<td>“Those with means and wealth are eccentric and those without are delirious”</td>
<td>144</td>
</tr>
<tr>
<td></td>
<td>Tracing critical thinking in nursing education: A case example</td>
<td>147</td>
</tr>
<tr>
<td></td>
<td>Critical thinking and the discourse of mental health</td>
<td>149</td>
</tr>
<tr>
<td></td>
<td>Critical thinking: Where we are now</td>
<td>151</td>
</tr>
<tr>
<td></td>
<td>Radical thinking: Where we need to go</td>
<td>154</td>
</tr>
<tr>
<td></td>
<td>Conclusion</td>
<td>155</td>
</tr>
</tbody>
</table>
CHAPTER SEVEN: TOWARD A SHIFT IN NURSING THOUGHT AND PRAXIS:
RECOMMENDATIONS FOR CHANGE................................................................................. 156
Psychiatry must be abolished. Here is Why................................................................. 157
Riding the waves of psychiatric reform: What is at stake.......................................... 160
Institutional resistance: Dissolving the ‘collaboration’.............................................. 160
Institutional resistance: Working from within the ‘collaboration’......................... 162
Linguistic resistance: Discarding the discourse......................................................... 163
Other recommendations for the faculty member and the nursing scholar............ 165
Recommendations for leaders and other relevant organizations......................... 166
What does the abolition of psychiatry mean for nursing and nursing education? ............ 168
Conclusions ................................................................................................................. 171
REFERENCES ........................................................................................................... 173
APPENDICES ............................................................................................................ 185
NOTES ....................................................................................................................... 217
List of Figures

1. Figure One. Levels of analysis……………………………………………………37
2. Figure Two. The College of Nurses of Ontario Competencies: Writing psychiatry into nursing……………………………………………………………………………….37
3. Figure Three. Smith’s act-text-act sequence……………………………………..54
4. Figure Four. Ethnographic texts: An intertextual hierarchy………………………….55
5. Figure Five. ‘Assessment of appearance and behaviour’ …………………………………80
6. Figure Six. The ‘focused’ assessment……………………………………………………..82
7. Figure Seven. Imperatives…………………………………………………………………84
8. Figure Eight. Modality: The absence of modalization……………………………………85
9. Figure Nine. Interdiscursivity: The emergence of hybrids……………………………..88
10. Figure Ten. Brain imaging………………………………………………………………..90
11. Figure Eleven. The ‘small hero’ versus the institution………………………………………97
12. Figure Twelve. Curriculum administration map………………………………………..106
13. Figure Thirteen. The inter-institutional circuit and undergraduate nursing education…120
14. Figure Fourteen. The intertextual hierarchy of the undergraduate mental health nursing discourse……………………………………………………………………..126
15. Figure Fifteen. The intertextual hierarchy of critical thinking…………………………148
16. Figure Sixteen. The continuum of ‘critical thinking’…………………………………152
List of Appendices

1. Appendix A. Institutional text on depression…………………………………………..185
2. Appendix B. The mental health assessment chapter……………………………………187
3. Appendix C. Undergraduate nursing curriculum overview…………………………….211
4. Appendix D. Systemics flow chart and path of textual analysis (in red)……………….212
5. Appendix E. Critical thinking diagram…………………………………………………….213
6. Appendix F. Scholarly paper instructions and evaluative rubric……………………….214
Chapter One

Introduction to the Study and Literature Review

This is a study of ‘mental health’ nursing education. It is a critical investigation of ‘mental health’ language, theory, and practice as they are taught by nursing educators to nursing students in undergraduate nursing programs. As an example, I examine the nursing program in which I formerly taught. In so doing, I explicate the various contradictions in the language of ‘mental health’ and bring to the fore the institutional relations that govern nursing education and maintain a colonization of nursing consciousness by psychiatry.

The purpose of this chapter is threefold: First, I introduce the study and provide an everyday experience which served as the entrée into the project. Second, I briefly present the perspectives of the nursing students and educators I interviewed which, taken together with my own experience, give experiential shape to the problematic of the research. Third, following a brief clarification of some of the language I use in this dissertation, I engage in the review of literature of the nursing critiques of psychiatry and mental health nursing education. Following this, I outline the point which marks my departure from the existing critique advanced by nursing scholars.

Study Entrée: A Disjuncture in the Academy

It is 8:30 am on Wednesday in the fall of 2012. My second-year nursing students are to receive a lecture on the concept of quality of life in the context of chronic illness. They have read three articles in preparation for today’s thought-provoking lesson. We begin with a short reflective exercise that frames the concept as a highly subjective one, possibly the most subjective of all concepts covered in the course. My students and I engage in various learning
exercises based on the readings, carefully deconstructing the concept and effectively explicating its subjective nature.

A problem, however, presents itself with one of the articles, raising for us an irreconcilable contradiction. The article advanced a number of nursing interventions said to ‘enhance’ the quality of life of patients on psychiatric wards. One such intervention was the setting of restrictions on patients as a way of ensuring the ward’s safety (Pitkänen, Hätönen, Kollanen, Kuosmanen, & Välimäki, 2010). Other interventions outlined were: Secluding patients, restricting the time they can socialize with other patients, and rescinding other ‘privileges.’ These interventions appeared to be couched in a covert analysis that psychiatric patients are inherently violent and that this violence needs to be controlled, better yet, prevented.

The contradiction for me was having to teach this material knowing that it is scientifically, socially, and ethically problematic. The very language in the article posed a problem. It was particularly difficult for me to avoid a substantial amount of the language used in this article yet somehow preserve the integrity of its equally-problematic ideas.

To the best of my ability, I engaged my students in a critique of the article, knowing however, that they were only responsible for its actual content. This meant that I was only to test their knowledge on what is found in the article, and not on a critique of it, per se. I left the class feeling a sense of defeat. While I probably encouraged some critical thinking, I knew that what my students will most likely retain is that their psychiatric patients are inherently violent, that nurses are institutional agents of behavioural control, and that such control leads to a better quality of life for patients.
The Disjuncture, Two Years Later

The construction of the violent mental patient, not dissimilar to the one above, can likewise be seen in the following excerpt, taken from a reflective paper written by one of my fourth year nursing students (two years more advanced in the program than the above student group) (identifiers removed):

Jane was diagnosed with dissociative identity disorder (DID). DID involves separate and multiple personalities present in a primary individual. DID is commonly a result of individuals who have suffered an abusive or traumatized life event. In Jane’s case, she was constantly abused as a child and had developed two different personalities: Sarah, age six and Amber, whose age she could not remember. Even though Jane is an adult, tall, and has a heavy build, she manages to fluctuate between these two child alters to cope with certain situations. Jane also suffers from suicidal ideation and was hoarding plastic cutlery, purposely breaking them to form sharp edges, and superficially cutting her arms and wrists.

The security guard who was constantly observing Jane brought this emergent situation to Andrea’s (my preceptor) and my attention. Andrea and I, along with another nurse, Kay, went into the patient’s room. Both Andrea and Kay had to physically pin down Jane by holding down her arms. My hands were small enough to open Jane’s fingers to remove the sharp object.

All staff are given a panic alarm button and a set of keys for the unit. This set is usually worn with staff hospital ID badges around our necks. In this instance, Andrea pressed the panic alarm triggering a code white (violent patient emergency). Within five minutes, four security guards arrived to the unit and joined two unit staff nurses who came into the patient’s room to restrain her.

At this point, it was a six-person restraint on the patient. It was therefore safe enough for Andrea and me to run quickly to the medication room and get a verbal STAT order from the psychiatrist to administer a common anxiolytic (Lorazepam), intramuscularly to Jane. The process was all very quick and I remember withdrawing the medication under Andrea’s observation with little prompting from her, while I confirmed the drug’s dosage with her. I also remember entering the patient’s room with an alcohol swab, gloves and the needle in hand. The security guards and two additional nurses managed to direct the patient to turn over and lay down on to her stomach so that I was able to administer the needle into her gluteus. Andrea landmarked the outer right quadrant of Jane’s buttock. I wiped the area with the alcohol swab and injected, aspirated the needle, and slowly administered the medication.
I was anxious at this point, as it was my first intramuscular dorsogluteal injection. It was very quiet in the room and everyone was focused on my administering the injection. Jane was put in a four-point bed restraint immediately after the injection. I received praise on doing a good job from both the nurses and my preceptor.

What is most troubling about this excerpt is neither the violence of the health care team nor the fact that benign patient behaviour was pathologized and considered to be an illness, troubling though that is. What is most unsettling about this case is the student’s gratification in having done a ‘good job’ and her preceptor’s validation of this. The fact that Jane is ‘ill’ was a given, that she was violent was inferred from her supposed illness, and that the need for the team to intervene was consequently deemed necessary. In fact, the student wrote about these courses of action as common sense occurrences. They were not the object of the student’s reflection or critical thinking (the goal of the paper). What was at the heart of the student’s consciousness is the overpowering of the patient, the perfection of the injection technique, and the restoration of safety to an environment apparently made dangerous by the patient.

This is the sort of nursing work that is being produced by nurse academics, perpetuated in the clinic, and is said to enhance patients’ quality of life on psychiatric wards (Pitkänen, Hätönen, Kollanen, Kuosmanen, & Välimäki, 2010). Note that the student identified as being anxious during the learning activity. However, her anxiety, also in a common-sense way, is accepted as normal—even expected—whereas that of the patient is not.

I have underlined several words and phrases in the above excerpt so as to give my reader a flavour of how psychiatric discourse (which includes general medical framing) sneaks into nursing language and practice by way of merging with ‘common-sense’ discourses. In this case, the discourses of safety, security, risk, and surveillance (language underlined) are intertwined with the overarching discourse of psychiatry. Concepts from these other discourses are in turn
recontextualized as psychiatrically-relevant clinical concepts. Later, we will see how this sort of ‘hybridization’ of discourses (with or without the speaker’s or writer’s knowledge) legitimates psychiatry and disseminates psychiatric ideology.

While I was to evaluate this student’s critical thought process, my evaluation was not to be of the student’s criticality of the diagnosis, the ascription of dangerousness to the patient, or of the circumstances underlying the events she describes. I was to evaluate her thinking from within a certain framework, one that ignores any real critical analysis and one that overwhelmingly focuses on the clinical. What this sort of education sanctions is the labeling of patients as ‘mentally ill’ and dangerous and the promotion of forced treatment as morally and professionally necessary. The student then, in a common-sense manner, accepts the label(s) of her patients, forcibly ‘treats’ them, and emerges with a heroic sense of fulfillment.

Again, as with the experiences I had with my second-year students, I felt the same sense of restraint. I had little to no control over either the content or the evaluative frameworks that informed my pedagogical work.

What eventually became clear to me was that while my students enter the nursing program with a preconceived understanding of ‘mental illness,’ eventually, this construction becomes concretized and made a scientific reality. What begins as an early phenomenological discussion about patients and their quality of life appears to fall by the wayside as critical thought is gradually (in some cases, rapidly) replaced by ‘skills.’ My probing my students’ thinking during lectures and during the many debriefing sessions we had following their clinical experiences confirms this suspicion.
Clinical Difficulties: Foreshadowing the Disjuncture

I began my career as a nursing student in 2001, and later, as a staff nurse in a community hospital emergency department in 2003. In the winter of 2004, I transferred to a large urban academic hospital to work in its emergency and trauma units until my resignation from bedside nursing altogether in November of 2014. While this is a project about nursing education into which my entrée was a disjuncture felt in my teaching work, it is necessary for my reader to also understand the clinical context of my disjuncture as integral to my point of entry. It is my experiences as a nursing student and as a novice clinician which provided me with the basis by which to understand the difficulties I experienced later, which when taken together, contextualize my standpoint for this research.

In the fall of 2001, I was enrolled in a mental health clinical practicum as part of my nursing education. Of the five clinical practicums I was to complete, this is the one I would describe as the most ‘casual’ and the least ‘hands-on.’ What was peculiar about this clinical placement was that it hardly resembled a ‘typical’ clinical environment. This is not to say that the setting was not a robustly-equipped clinical ward. Indeed it was, complete with nurses, doctors, orderlies, medical supplies, stretchers, medications, patient charts, a nursing station, and such clinical work processes as shift reports, medical rounds, medication dispensing, documentation, and so on. What was peculiar about this setting—something I had not noticed at the time I was a student—was its tidiness, the ‘sterility,’ and the apparent ‘cleanliness’ of the ward. The optics were such that no medical equipment was visible. No sign of ‘hospital’ was really to be seen on this ward. The hallways, three of them adjoined to form a large C-shaped figure, were simply empty of equipment, furniture, or anything resembling a hospital wing. Unlike other hospital wards, everything was hidden: The charts, the communication equipment,
the cleaning equipment, even the staff, partitioned behind a large thick fiberglass wall. What’s more is that the staff were also hidden in another sense. None dressed in the usual hospital ‘scrubs’ attire. The staff–students included–were dressed in ‘business casual’ wear. The dress, I was told, was to make the patients feel as if they are not in a hospital, which helps flatten the clinician–patient power dynamic. The ‘emptiness’ of the ward was explained to me as a necessary intervention to prevent patients from hurling objects at the staff and at each other. A quick visual sweep of this environment and one can almost palpate the hybridity between psychiatry and discourses of safety, security, and risk, much like that in the above student excerpt.

I quickly became acquainted with the processes of the psychiatric ward that comprised the work of the mental health nurse. Some of these included observing and documenting ‘violent patient behaviour,’ routinely medicating patients, and assisting with various procedures such as electroconvulsive therapy (ECT).

I recall an experience as a student while caring for a young woman–a school teacher–diagnosed with ‘obsessive compulsive disorder.’ While having cared for her on two consecutive days (our clinical rotations comprised of two consecutive days in a week for 12 weeks), I recall her repeatedly uttering: “I can’t breathe. How do you breathe? How does one breathe?” This was her ‘documented’ behaviour over several days while she was on the ward. Our routine response to her was to redirect her to the reality that she was breathing effectively, occasionally demonstrating the pursed-lip breathing technique. As a number of interventions proved ‘ineffective,’ it was decided that she could benefit from ECT.

The following week, she would receive ECT and I would accompany her to another institution for the ‘treatment.’ I recall her being quite literally packaged for shipment. She was
undressed completely and put in a hospital gown, placed on a stretcher, neatly wrapped in blankets, her chart was assembled into a large binder, and away she and I went to a near-by hospital in an ambulance-like vehicle. At no time do I recall being briefed on the procedure or the consent process, about which I knew very little. I do not recall discussions of that nature taking place with the patient either.

We arrived in the ‘recovery’ room, where a team of nurses and physicians was waiting to promptly carry out the procedure. The patient was given an intravenous line, into which an anesthetic agent was injected to temporarily paralyze her. A mouth guard was also inserted into her mouth to protect her teeth from the grinding, something which often occurs during the procedure. Electrodes were bilaterally placed on her temples. I cannot recall the number of times she was shocked. Recounting only one episode, I hope, is sufficient in conveying the injurious quality of this ‘treatment.’ I recall her body becoming instantly rigid, her jaw so severely clenched that I could see accentuated lines of musculature running down her neck. Her head was held down by a large strap and further supported by the nurse immediately after the shock was given. Similarly, while attempting to maintain control of her convulsing limbs, the rest of the team members physically held her down. Her body looked like it was being pulled in various directions while the health care team was trying to hold it together.

I recall thinking how interesting this observation was. My priorities as a student laid in the observation of the procedure and the studying of the nurse’s role during it. I was to help ensure her prompt revival from the anesthetic, check her for urinary and/or fecal incontinence, and engage in small talk with her upon waking. Small talk, however, was out of the question given her thorough confusion and severe headache immediately after ECT. I recall discussing ‘the case’ with my preceptor, framing the ‘treatment’ as interesting, necessary, and ostensibly
successful. This is despite my never seeing this patient again, a common reality for nursing students. Often, ‘continuity of care’ is interrupted by the fragmented patient assignments and timeframes given to students in their clinical practicums. This is also true for a large number of bedside nurses, particularly those working in acute and critical care areas such as the emergency department. Often, treatments are given and patients are discharged without the nurse’s (or the team’s) knowing the long term consequences to the patient.

Understandably so, at the time, I had no critique of ECT, certainly no critique of psychiatry to any degree. I had no critical knowledge base from which to theorize, for example, that her utterance around her breathing difficulties came from an experience rooted in trauma, perhaps a near-drowning episode, perhaps a near strangulation experience by her husband, and so on and so on. As a student, my interests lay in the carrying out of my preceptor’s suggestions, which were to observe the procedure, document the nurse’s role, and partake in basic care of ‘the post-ECT patient’. As expected, I acted in line with the institutional order— that of the hospital and that of the nursing academy. To me, observing and partaking in ECT was yet another nursing academic task I needed to complete, in principle, not dissimilar to removing staples from an abdominal incision. It would be eight years later that I would come to realize the grave consequences that this patient likely suffered from ECT. Having begun as a classically uncritical practitioner, routinely partaking in the administration of damaging psychiatric interventions, a dramatic change in my understanding of psychiatric discourse, almost a decade later, would bring me to a radical shift.

**Disengaging from the Discourse: Making a Radical Shift**

For 11 years, I would go on to practice bedside nursing. Toward the latter end of my bedside career, however, my work progressively became morally and personally problematic.
During this time, I enrolled in graduate studies and participated in various coursework, research, and activism, all of which raised my political and moral awareness in the critique of psychiatry. I completed courses delivered from an antipsychiatry framework and participated in a number of activist initiatives as part of an antipsychiatry organization in which I became an active member.

I became aware of the inherent problems of psychiatric discourse and practice. I came to recognize that the discipline of psychiatry is largely rooted in a sociopolitical discourse and less a medical or scientific one. Psychiatric interventions, many in which I participated in administering, became an irreconcilable problem in my nursing practice. Having partaken in the administration of ECT, the secluding of patients, the administration of chemical restraints, and involuntarily ‘treating’ people became the most regretful experience in my nursing career, at times verging on shameful.

I owe my moral awakening to those psychiatric survivors who so patiently educated me with their lived experiences, to other activists who shared the survivors’ standpoint, some of them survivors themselves working toward the common goal of dismantling the institution, and to my politically informed and critically oriented graduate program.

After an eight-year period of overlap between bedside nursing and teaching, I eventually resigned from the bedside to pursue teaching on a full-time basis. Given the clinical context in which some of the difficulties arose, which in turn helped me understand my disjuncture on a teaching-learning level, it is to the education of nurses that I decided to turn my attention. While passing many days and many evenings in reflection on my experiences as a student and clinician, I knew that what I needed to do is investigate one of the root causes of the lack of criticality in nursing. As I became more comfortable as a permanent full-time faculty member, I began to politicize the work that I do. I began asking questions about teaching and learning in the nursing
academy, questions that extended beyond the experience of the student and individual faculty member. I became armed with a certain political knowledge and skill, and a deeper sense of moral awareness which set the stage for the launching of this research project.

**The Research Problematic**

The more I politicized my work, the more it grew in complexity. I wanted to know how curriculum was determined, how an academic program comes into inception, and who is involved in the making of such a complex operation. The more I advanced into my teaching career, the more I pursued the answers by talking to staff and faculty members. I then came to appreciate the sheer complexity of the nursing program in which I formerly taught and the institution into which it is hooked. I learned that despite other educators having identified as being critical of psychiatry, their critiques nonetheless appeared to be colonized by psychiatric theory and language. Fueled by the initial sense of defeat, and now, a sense of isolation, I began mounting informal data that came to serve as the initial lines of inquiry for this research project. Correspondingly, I identified what Smith calls the project’s research problematic (1987 & 2005).

The problematic sets the research stage for a political examination of the organization of an institution. It helps the researcher maintain grounding in the perspectives of those being governed, given it is from those perspectives that the problematic begins. It begins with local, everyday experience—a disjuncture—and moves outwards, directing the researcher’s attention to various institutional strands of work processes that explain the social and political origins of that disjuncture. My problematic begins in my daily teaching experience—the experience briefly outlined in the opening of this dissertation. I begin there and then. I begin with the difficulties I have thus far identified and as an educator for whom such difficulties have been mounting for several years.
My Standpoint and Perspective

My standpoint is that of a former clinician and a current nursing educator caught in the discourse of psychiatry, an oppressive discourse that is held together by an apparently impenetrable institution. Psychiatry became a problem for me early in my career, beginning in my clinical work as an emergency nurse, the main problem being the pathologization and medicalization of the human condition. As I outlined above in the disjuncture, the entry point into my research problematic was language. Psychiatric ‘interventions,’ however, are also a major problem. Moreover, my standpoint is informed by my deep concern about the material being imparted on future nurses. It is fueled by the frustrations resulting from my repeated unsuccessful attempts to facilitate change in the nursing program. It is fueled by yet another worry about the criticality and teaching work of nursing educators and nursing scholars.

The Perspectives of Students and Educators

By speaking to students and other educators, I came to discover that albeit to a lesser degree, they too shared my discomfort with psychiatry and with nursing’s adoption of the medical model approach to ‘mental health.’ The students discussed with me their grappling with the idea of ‘mental illness.’ The students’ difficulties laid in the contradiction between ‘real’ or ‘concrete’ disease and ‘mental illness.’ They theorized about the inherent oppressiveness of psychiatric diagnoses. The students too shared some of their everyday difficulties, not dissimilar to those that presented me with my own disjuncture. Consider the following quote:

If you look at the diagnosis of schizophrenia, you can see whole sections of oppression in it. If you look at individuals diagnosed with schizophrenia, a huge proportion of them are vulnerable populations. Most of them are Black men, they are most likely to face physical
treatments, and are most likely to be involuntarily committed instead of receiving counseling. (Nursing Student)

The students made a distinction between organic illness and ‘mental illness.’ They described pathological illness as ‘tangible,’ thus, a scientific phenomenon. ‘Mental illness,’ however, was framed by the students as existing outside scientific discourse, thus, questionable as far as ‘real illness’ goes:

I guess concrete is tangible, right? There is no grey area. With something like pathophysiology, it’s the disease process: It occurs this way and this is what the outcome is, and in this sense, it is concrete. For example, diabetes. (Nursing Student)

The educators whom I interviewed also wrestled with the idea of ‘mental illness’ while advancing a non-biomedical critique of it. One educator shared that she incorporates “social supports, family interactions, coping, and friends” as she teaches ‘mental health.’ Another lamented that “nurses don’t get that kind of education [critical social approach]. They really know nothing about mental health and they’re only focused on body care, pain management, and technical procedures.” One particularly concerned educator offered a long history of struggle with teaching psychiatric content in her course. Similar to what the students said, she too rejected ‘mental illness’ as a scientific reality and with pathophysiological origins. She expressed her displeasure with its being incorporated into the course she teaches (a foundational nursing course on pathologies of the human body). Sharing her 12-year struggle in an effort to the have ‘mental health’ content removed from the pathophysiology course, she said:

We only used to have it over two weeks. Now, apparently we’re down to one [week] because, well, is it an illness? Should it be in patho? This has been the fight and the
debate over where it fits. It’s in. It’s out. The argument is that it isn’t an illness, that there
really isn’t enough medical model content in order to have it in class. (Faculty Member)
Note her last sentence, in which she appears to suggest the possibility that if ‘mental disorders’
were more ‘medical model,’ their incorporation into the course may be more acceptable. Even
more importantly, note her resistance to the reification of mental illness as a disease—a promising
possibility to which we will return in the final chapter.

The perspectives of students and educators were powerful, compelling, and somewhat
encouraging. I felt reassured that I was not alone. My everyday teaching experiences, coupled
with those of the students and educators validated for me that the issue extends beyond my
experience and that my difficulties are indeed rooted in an institutionally multifaceted problem.
Yet despite the felt sense of identification with some students and colleagues and despite the
newfound source of solidarity, in the end, our voices remained silent. Neither I nor seasoned
faculty members have been able to make substantial positive change to the program. It is not,
therefore, in the everyday experience that this can be understood. And while the everyday
experience is central to the beginning of an ethnography such as this, it is the reorientation from
the particular and towards the extralocal and the political that will unveil the structures
implicated in maintaining our silence.

My standpoint, my perspective, and my problematic are largely informed by my own
extensive clinical and teaching experiences and to a significant degree, by the insights I have
gained from speaking with colleagues and students. It is for this reason that my reflections and
my own experiences as an educator are central in this project. That is not to say that those of my
students and colleagues are unimportant. While my critique of psychiatry is much more radical
than theirs, taken together, it is sufficient that a ‘discomfort’ with the discourse is enough to
combine them as a collective voice of resistance and a springboard for discursive and institutional change, as we will later see.

**Looking Up and Out: Directing Attention to the Extralocal**

As I came to see that my voice and my actions were largely inconsequential, I began to wonder about the education of nurses in general. I puzzled over the contradiction between nursing theory and nursing practice. I wondered about language in nursing education. I questioned the semantics of various concepts, ‘mental illness’ included. I saw my work as an educator as being embedded in a complex circuit of social relations called the ‘undergraduate nursing program.’ Why is it, I wondered, that I could not introduce and teach my own concepts? Why is it, that despite my discomfort with the language and the practices, I could not substantially alter the curriculum? I began asking questions related to the history of nursing as a profession. I began asking more general questions, ones that forced me to think about politics and power. I speculated about the class relations, an area in which nursing has a long history of struggle. I reflected on the discourse that underpins nursing’s struggle for autonomy as an independent science. I became sensitized to the fact that nursing, being such a young discipline, is to a large degree a linguistic offshoot of medicine. Given this and given the highly gendered nature of nursing, I wondered about textual ruling and the ways in which such ruling manifests.

Consider the idea of the medical directive, for example. Medical directives are instructions to nurses written by physicians to carry out orders in the absence of a physician. In addition to making nursing work a textual process, this hinges on a gendered divide—a patriarchal medical system downloading doctor work onto the nurse. A clear example of how men rule women by way of texts.
I came to see myself as existing in two worlds: One that positioned me as an educator capable of inspiring change to problematic practices, and another that implicated me as the producer of those very same practices. I came to question my work as an educator and its very organization. I wondered about the curriculum that I teach and the literature which constitutes it. If those who teach the curriculum cannot directly alter it, then who can? Are there curriculum policies that guide this sort of work? Who writes these policies and who enacts them? Does this sort of work happen in meetings? Who is invited to these meetings? How are they structured? What about the transparency of this process? What role does class play in setting curriculum? How do other schools of nursing carry out this work? As I discovered that to various degrees, my disjuncture is also felt by nursing students and other educators, this led me to wonder about resistance. I also became interested in whether or not any resistance manifested, and if so, to what degree it so did.

**A Brief Overview of the Project**

This multi-year and multi-site research project is an ethnographic and linguistic investigation of the ‘mental health’ content and modus operandi of one of the largest undergraduate nursing programs in Canada. The program produces approximately 450 nurses each year. The overarching research question is: How does nursing education produce ‘mental illness?’ While a number of sub-questions steered the investigation more specifically, these I outline and address in the subsequent chapter and as they become relevant to my analysis. The research involves a number of focus group interviews, participant observation, and analysis of texts, to be discussed in greater depth in chapter three.
Chapter-by-Chapter Overview

Thus far, in this chapter, I began with my entrée to the project, I identified the research problematic, and presented the perspectives of the students and faculty members I interviewed. While recognizing the importance of situating this project in relevant literature, next, I provide a concise literature review of nursing critiques of psychiatry and critiques of mental health nursing education. In chapter two, I provide a discussion of the methodologies which guided this project. I flesh out the multi-methodology approach which combines institutional ethnography (Smith, 1987, 2001, 2005, 2006a, & 2014), critical discourse analysis (Fairclough, 2001 & 2003; Chouliaraki & Fairclough, 1999) Bakhtinian analysis (1981 & 1986), and Foucauldian discourse analysis (1977/1995). In chapter three, I outline the project design and the methods by which the research was carried out. I also provide a discussion of the ethical review process followed by a critical discussion on institutional permission and access to data. In chapter four, the first of the three analysis chapters, I undertake a critical discourse analysis of relevant texts. I offer a linguistic micro analysis of the discourse, as I examine the use of language and the ideological diffusion of this language into nursing consciousness. Situating this linguistic analysis into the work processes of educators and students, in chapter five, I examine a number of institutional structures that perpetuate this discursive diffusion. The governing of curriculum and its material impact on the work of students and faculty members are explicated. Correspondingly, I focus on institutional texts as ‘ruling’ units (Smith, 1987 & 2005; McCoy, 2006) in perpetual dialogue with educators and students (the ruled). In chapter six, I draw on data from student and faculty interviews as I engage in a critical discussion on the concept of ‘critical thinking’ in nursing education. In the final chapter, I offer some conclusions, insights, and recommendations for nursing educators and implications for nursing more broadly.
Language in this Dissertation

It is important that at this juncture I say a few things about my use of language. I have thus far emphasized a number of psychiatric concepts and ideas. In so doing, I have enclosed psychiatric language within single quotation marks as an indication of its being a problematic discourse. Examples of such concepts and ideas include: Mental illness, mental health, bipolar disorder, posttraumatic stress disorder, recovery, and treatment. While I continue using this language, for ease of read, I will no longer after this point enclose it within quotation marks, except in the case of direct citation, in which case it will be enclosed within double quotation marks. In the next section, where I review the literature, psychiatric concepts and ideas are very heavily relied on. It is important for my reader to be reminded that I will insert my own alternative language when describing people’s emotions, thoughts, and states of being. Some examples of alternative concepts I will use may include: Trauma, emotional difficulties, confusion, distress, fear, sadness, alternate reality, happiness, and a sense of wellbeing.

Review of Literature: A Promising Counter-Narrative

While I engage in what is traditionally known as a literature review in order to situate my project and probe the landscape of work previously done in the area, it is also necessary (and I would argue, more relevant) to discuss ‘literature’ in the context of its discursive entry (and non-entry) into nursing education and practice.

In this dissertation, I engage with the literature in two ways. First, in this chapter, I focus on the small and valuable emergent body of work from which my project draws inspiration and to which it adds a new dimension. To that effect, I examine the current research endeavors of critical nursing scholars in the area of mental health and mental health nursing education.
Second, in the analysis chapters, I engage with the literature (a different body of work) as a ‘mainstream’ or biomedical body of scientific work from which nursing mental health education largely draws its understanding. Taken as the ‘text’ which contributes to the psychiatric status quo, I weave a representative sample of this literature (the nursing mental health assessment) into the forthcoming discourse and institutional analyses in order to examine its contribution to the production of mental illness.

The literature I review here is divided into two general categories, the first is a body of work by nurses critical of psychiatry. The second comprises nursing critiques of mental health nursing education.

**Nurses Critical of Psychiatry**

This literature comes together as an eclectic collection of a number of critiques advanced by nurses and leveled at the mental health industry\(^2\). While I present a review of these critiques, I also explore some of their limitations insofar as such limitations render them caught in and colonized by the discourse of psychiatry.

While deconstructing psychosis, Nixon, Hagen, and Peters (2009) reject the concept of psychosis altogether and advance a redefinition of it as a potentially transformative and enriching experience for those who experience it. The authors give us a phenomenological window through which to glimpse the experiences of six people with psychosis. Here, the concept of psychosis as defined by psychiatric texts is contested on grounds of the lived experience. As such, a number of those who reported having experienced an alternate reality welcomed it as a transformative and educative experience. Brad Hagen (2007), in another study, critiques the Beck Depression Inventory and the DSM’s depression diagnosis criteria in general. He reports on the theoretical and practical problems inherent in this tool and cautions nurses on its limitations, which include
CRAZY MAKING

numerous cultural, gender, and theoretical biases. While cautioning nurses, he also highlights the tool’s strengths, an indication of the author’s finding usefulness in its application on some level. In another piece, Hagen, Pijl-Zieber, Souveny, and Lacroix (2008) probe the ethics of accepting gifts from the pharmaceutical industry. They problematize the pharmaceutical sponsorship of nursing and medical education, particularly, the education provided in such health care institutions as hospitals. The authors call into question the motivations and interests of the pharmaceutical industry in providing industry-sponsored medical education, drawing on the nursing code of ethics. Specifically, they highlight the ethical principle of Justice. They remind nurses of their duty to “put forward, and advocate for, the interests of all persons in their care . . . [Nurses] should promote appropriate and ethical care at the organizational/agency and community levels . . . [and] should advocate for fairness and inclusiveness in health resource allocation” (p. 33). In another study, while looking at ECT as a damaging psychiatric treatment, Ejaredar and Hagen (2013 & 2014) spotlight the experiences of women who had undergone the treatment and who reported on their experiences as being predominantly negative, resulting in persistent memory loss and cognitive deficits. In a similar study, Hagen and Nixon (2011) examined the experiences of women who had experienced transformative alternate realities (psychiatrically known as psychosis) and who have had interactions with the mental health industry. The authors argue that “psychiatric diagnosis and labels [are] oppressive and destructive” (p. 60). They provide accounts of the lived experiences of 18 women who, among other things, described their interactions with the mental health industry as invalidating and violent. In a more general critique of psychiatry, Hagen and Mitchell (2001) suggest a number of nursing intervention alternatives for nurses caring for what they term thought-disordered clients. They propose solution-focused therapy, maintaining that patient supervision and the
administration of antipsychotic medications alone are inadequate. In some of their more recent work, Wojtowicz, Hagen, and van Daalen-Smith (2014) critique mental health practices as they are observed by undergraduate nursing students. The authors argue that mental health practices to which undergraduate nursing students are exposed during their clinical rotations trigger significant moral distress related to the perceived lack of nurses talking meaningfully to their patients . . . a hierarchical power structure for physicians, a lack of information given to patients about their psychiatric medications, and an inability for their nursing instructors to advocate for ethical change. (p. 257)

Wojtowicz, Hagen, and van Daalen-Smith (2014) offer a window into possibilities for nursing clinical education. They point to the problems found in psychiatric interventions and ‘interprofessional’ relations on the psychiatric ward, yet concurrently invoking that same discourse which substructs the very same relations. The authors’ concern is neither necessarily the interventions nor nursing relations, rather, their concern appears to revolve around the loss of interest by nursing students to work in mental health settings. It is thus logical to surmise that whatever their other concerns may be, when it comes to the construction of this piece at least, the authors are not necessarily interested in patient emancipation, but rather in the expansion of the mental health enterprise, ostensibly with more nursing bodies. That is not to say, of course, that the authors’ intentions are not rooted in the best interest of the patient.

Van Daalen-Smith (2011) brings compelling phenomenological attention to women’s experiences with ECT. In her study, seven women speak about their encounters as recipients of this psychiatric treatment. She provides a rather visceral account of the experiences of women who described shock as having resulted in “damage and devastating loss” (p. 457). The author explicates a contradiction in the perceived benefits of ECT. According to the nurses she
interviewed, the treatment provided a positive outcome for the recipients, a finding that diametrically conflicts with the experiences of the patients, whom van Daalen-Smith had likewise interviewed. Concurrently, van Daalen-Smith and Gallagher (2011) examined the nursing literature that covers electroshock. They report that “very often, only the pro-ECT arguments are given, only the pro-ECT research is cited, only the pro-ECT perspectives, themes, and ethics are given a voice. Negative accounts of ECT are rarely to be found” (p. 212). They interrogate the literature, while suggesting a dishonesty in the balance of the positive/negative accounts in it. The authors, in the critique of certain aspects of psychiatry, pull away a veil of ignorance that has long obfuscated nursing consciousness. Van Daalen-Smith (2011) and van Daalen-Smith and Gallagher (2011) demand that nurses question the ethics of partaking in ECT and mechanically taking up the biases in the ECT nursing literature. While van Daalen-Smith offers us a compelling and a daring phenomenology, her reader is left to wonder about her position on the continued and growing use of ECT. While she generally warns against its harmful effects and cautions nurses in reading its literature, she engages in political silence about ECT and as a nurse, neglects to give a position on its continued use. In 2014, van Daalen-Smith, Adam, Breggin, and LeFrançois critique the very same treatment while taking up the standpoint of children. They critique the available literature as well as the absence of statistical data on the administration of the treatment to children. The authors, two of whom are nurses, call for an outright ban for the treatment in children, arguing that while it has been demonstrated to devastate the pediatric brain, what is of equal concern is the unknown developmental risk to which children who are given the treatment are exposed.
A peculiar piece of work which claims an antipsychiatry framework, advances the notion of ‘therapeutic community.’ O’Brien, Woods, and Palmer (2001) introduce the idea of therapeutic community as a group of people with similar problems [who] come together to share a household where they share some common purpose. In general, the common purpose should focus on the nature of being an individual in society, recovery from illness, and on personal growth…” (p. 6)

O’Brien, Woods, and Palmer (2001) hope that these people will ultimately make “healthy lifestyle choices to eventually return to society” (p. 7). This ‘therapeutic community’ appears to be suspiciously and dangerously reminiscent of community treatment orders³ (CTOs), where compliance with psychiatric medications and ‘social integration’ replace the “background knowledge” of diagnoses and institutionalization. While CTOs stand in stark opposition to the position of antipsychiatry, so does the use of such psychiatric terms as mental illness and recovery, very frequently seen in this article. Thus, “de-emphasizing the diagnosis” is at best a liberal critique of the discourse. While de-emphasis is suggestive of a relatively mild critique of diagnosis, it is simply where the critique ends. Again, what we see here is, while an attempt is being made to replace psychiatric discourse with a compassionate and humanistic one, the authors nonetheless appear to be hopelessly caught in it.

Using poetry, time changes, and other literary devices, Grant (2010), in what she calls an experimental ethnography, sketches out her experience while grappling with alcoholism for two decades. She examines how stigma and othering arise as a result of “us-them divisions” (p. 577) and invites her reader to critically examine and end such divisions. In an innovative practice-development project initiative, Grant, Biley, Leigh-Phippard, and Walker (2012) redirect the
reader to a powerful alternative to the current psychiatric status quo. They too, however, rely on such psychiatric concepts as recovery and mental health. As noted above in the work of other critical nurses, what seems to appear again here is a clear psychiatric discursive intrusion into nursing consciousness.

Fanker (1996) pits the fetishization of biological psychiatry against nursing’s commitment to holism and holistic care. The author urges mental health nurses to “resist a reductionistic biological world view . . .” (p. 180). Specifically, what is critiqued here is the extreme form of ‘biologization’ of mental illness but not by doing away with biological psychiatry, per se. To that effect, Fanker (1996) asserts that it would be “absurd to suggest that biological research and treatment have no place in the understanding and management of mental disorder . . .” (p. 180).

In a recent, more general critique of psychiatry, Grant (2014) advances a post-structuralist re-imagining of qualitative research in the area of mental health. She rejects psychiatric labeling and diagnoses, advancing a reconceptualization of subjectivities “in terms of varieties of difference rather than the continued replication of homogenizing diagnostic or thematic categories…” (p. 548).

Likewise contributing to this literature, in a discourse and institutional analysis piece, I examine the discourses of psychiatry and pharmacology in the context of emergency nursing work (Adam, 2014). I identify various intricacies that institutionally constitute these two discourses, their various discursive representations, and their interactions with the consciousness of the nurse. I conclude that their constant discursive and institutional bombardment makes for an inescapable colonization of nursing by psychiatry. This book chapter marks my initial
theorization and analysis of psychiatry and its related discourses as intrusive to and colonizing of nursing work and nursing education.

**Nurses Critical of Mental Health Education**

Critiques of nursing education from the vantage point of psychiatry appear to be very limited. Interestingly, the majority emerge out of Australia and New Zealand. This is likely a response to a nation-wide review of the mental health education of undergraduate nursing that swept across the two countries in the late 1990s.

In an effort to understand the origin of the poor recruitment and retention of mental health nurses, Clinton and Hazelton (2000) conducted what they call a critical review of the relevant shortcomings of Australian universities in the context of undergraduate and postgraduate mental health nursing education. They theorized three contributing factors to inadequate mental health education: The limited or overcrowded clinical placements, inexperienced or incompetent faculty, and an insufficient amount of psychiatric theory. They suggest that with emphasis on these three factors, progress in the way of greater interest by nurses to enter psychiatric nursing is a real possibility.

Critiquing mental health nursing education from a historical perspective, Prebble (2001) attributes the “reduction of skills” and the “weakening of the profession” to a “marginalization and invisibilization of psychiatric/mental health nursing within comprehensive programmes” (p. 136). Fearing the extinction of mental health nursing, she recommends “an augmentation” to undergraduate nursing education by embedding a separate mental health curriculum within it. On this idea of ‘mental health nursing extinction,’ Holmes (2006) writes about “the slow death of psychiatric nursing” (p. 401) as attributable to the lack of government funding, loss of interest by nurses in the field, and various damning governmental and media reports on the specialty. From
an educational perspective, seemingly in agreement with Prebble (2001), Holmes suggests that the removal of direct-entry psychiatric nursing programs was a mistake that contributed to the theorized ‘slow death’ of psychiatric nursing.

As noted, a high concentration of nursing critiques of mental health education appeared to come out of Australia and New Zealand. An overwhelming number of these focused on the attitudes of nursing students towards the mentally ill and mental health nursing more generally. These too emerged after the sweeping nation-wide review of mental health nursing education in the two countries.

Henderson, Happell, and Martin (2007), Surgenor, Dunn, and Horn (2005), Happell and Gogh (2007), Happell, Robins, and Gogh, (2008), Gogh and Happell (2009), and Happell (2009) report that a negative attitude portrayed by the nursing student towards mental health nursing is a major factor in the slow demise of mental health nursing in Australia and New Zealand. While the discourse of ‘attitudes’ is not at all new, what makes it interesting here is its aggressive resurgence immediately following these national reviews. Concurrently, these authors also arrived at the same somewhat expectable finding, namely that increasing psychiatric theory and clinical placements promise to correct negative attitudes and remedy the dying mental health nursing field. Of note, these studies neither give an operational definition of ‘attitude’ nor for what constitutes a ‘negative’ one, much less how or why is more theory said to result in attitudinal shifts.

In 2012, Happell and Gaskin (2012) completed a ‘systematic’ review of the literature that covers student attitude. Predictably, they ‘find’ that “psychiatry ranks lowly in comparison with other areas of nursing in terms of undergraduate students preferred area of work” (p. 156).
Attitudes, they unsurprisingly suggest, can be improved by longer clinical training and an increased amount of psychiatric theory.

Nursing scholars have long theorized the importance of immersing students in psychiatric theory and clinical practice (Peplau, 1989; Moller, Pierce, Shanahan, & Loch, 1991) and advocated for advanced studies in psychiatric nursing (Rosenthal, 1984). Accordingly, that the critiques of mental health nursing education located the problems within the realm of insufficient amount of theory, incompetent educator, and student ‘attitudes’ is not at all surprising.

One study, which examined nursing students’ attitudes on mental illness, suggested “that mental illness arises from interpersonal experiences during childhood” (Keane, 1991, p. 16). What makes this finding interesting is that despite the overwhelming majority of work in the area having been done from within the framework of biological psychiatry, this confirms that nursing students can hold a critical social position toward the ‘biologization’ of mental illness. Another curious finding in this study which appears to contradict much of the above critiques, is the idea that mental health clinical education creates a “significant increase in stereotyping” (p. 16) by the nursing student. The author finds this to be a likely consequence of “caring for chronic mentally ill patients who have had several hospitalizations, who may be homeless or unemployed with few support systems, and who have limited cognitive skills” (p. 17). “Because criteria for hospitalization have become more stringent” the author outlines, “the group may have observed aggressive episodes that influenced attitudes” (p. 17). It remains unclear, however, what constitutes an aggressive episode in this study, much less how or why the students’ observing one would impact their attitude. Moreover, ‘criteria for hospitalization’ has continued to become more and more ‘stringent’ since the early 1990s. That is, the criteria for what constituted ‘acute illness’ has become more and more defined in favour of decreasing the number of inpatients and
hospital lengths of stay. This has resulted in more hospitals housing ‘acutely ill’ patients than ever before. It is logical then to assume that whatever it is that the students observed in the study by Keane (1991), which contributed to their stereotyping (presumably a very ‘sick’ patient) is much more prevalent and acutely present in hospitals today. What then, becomes of this potential increased stereotyping resulting from having observed ‘aggressive episodes?’ How is it that a series of studies specifically carried out on student attitudes make no mention of it? This incongruity surfaced as another problem with the nursing mental health literature. Namely that the various studies conducted here narrowly define the discourse by way of preemptively arriving at the ‘discoveries,’ whether they be student attitudes, lack of enrolment, disinterest, and so on.

While ‘reviewing’ their data collection instrument, Surgenor, Dunn, and Horn (2005) made what were deemed ‘minor’ changes to a previously developed attitudinal questionnaire. “Specifically, the word ‘psychiatry’, was changed to ‘psychiatric nursing’, and the term ‘psychiatric patient’ was changed to ‘person with a mental disorder’” (p. 104). What the researchers essentially did was take a pre-existing questionnaire, originally developed for medical students (Calvert, Sharpe, Power, & Lawrie, 1999), and simply replaced a number of major concepts within it as if they were interchangeable. Here is a clear example of nursing’s discursive conflation and confusion between its own discourse and that of psychiatry. This is the sort of thing which creates discursive overlaps between the two and further drives the spokes of psychiatric discourse into nursing consciousness. What is more peculiar is that this major discursive conflation is expressed as a ‘minor change’ in language.

A study that promised to develop ‘patient-centered’ teaching introduced a trial teaching program in a psychiatric clinical setting, which focused on communication skills and relationship
building between nursing students and patients (Reynolds, 1982). In it, the author critiques the overemphasis on psychomotor nursing skills, proposing a reorientation towards ‘interpersonal skills’ instead. While using the patient as a pedagogical tool is a clear objectification and hardly ‘patient-centered,’ the intent to develop a teaching methodology to equip nurses with more sensitive skills is nonetheless humanistically promising.

Barbara Keddy (1996) advances a post-structuralist feminist critique of psychiatric nursing discourse. Drawing on Dorothy Smith’s notion of the ruling relations (1987 & 1990b), she denounces the biomedical and patriarchal discursive domination of mental health nursing knowledge. She rejects the interventionist approach to mental illness and advocates for feminist counseling for people suffering from mental illness. While asserting that “information is humanly created” (p. 381) and labeling assumes “that patients are mechanistic beings that are objective and impersonal” (p. 387), Keddy puzzlingly remains trapped by psychiatric language herself. She very astutely deconstructs labeling theory, and while problematizing such ideas as ‘patient,’ ‘illness,’ and ‘care,’ she regretfully reminds us, that despite her critique, “this is not to suggest that there are not any conditions, such as schizophrenia, that benefit from psychotropic medications” (p. 387).

Like most the other nursing works reviewed here, once again, contradictions and circularity. Whether mounting a critique against psychiatry as a clinical practice or as a discourse, Keddy and the other critics fail to step outside of psychiatry, in which they appear to be inescapably tangled.

**The Critical Literature: Linguistic Capture**

Dorothy Smith developed the concept of institutional capture (2005). Institutional capture, she says:
has the capacity to subsume or displace description based in experience. Institutional capture can occur when both informant and researcher are familiar with institutional discourse, know how to speak it, and hence can easily lose touch with the informant’s experientially based knowledge. (p. 225)

She outlines this concept in the context of an institutional ethnographic interview to caution the ethnographer on the slippery slope of institutional language. Smith’s intent is for the ethnographer, while gathering interview data, to ensure that it is done in ‘ordinary language’ and that any use of institutional categories, concepts, or abstractions by both interviewer and interviewee should either be avoided or deconstructed using plain language. In defining the concept, Smith interchangeably uses the terms institution and discourse. In this context, what she means by institutional capture is really linguistic capture. I expand on Smith’s concept of institutional capture to include not only linguistic capture, but also bodily capture. That is, being captured not only by spoken language, but also by way of institutional activity, acting on the body in a disciplinary and mechanical way as described by Foucault (1977/1995). The curriculum administrator who routinely reviews course outlines and ‘signs off’ on them with little insight into their content, for example, can be said to be materially and linguistically captured. He or she is ‘captured’ within a certain routinized set of doings, which not only include engaging with language, but also with her or his body. Accordingly, by linguistic capture, I refer to being ‘caught’ within a certain language, while the broader concept of institutional capture denotes a routinized engagement with certain practices, which may or may not include language. I am creating a distinction between these two ideas for two reasons. The first is because it will later be more relevant and accurate to speak of linguistic colonization in terms of linguistic capture, particularly in the following critical discourse analysis. The second is while the bodily
captured social actor in institutional ethnography is almost always also linguistically captured, it is not always the case. It is possible that while local (or extralocal) actors perform institutionalized and routinized processes using their bodies, they do so irrespective of language and texts. A common example of this in the nursing academy is when the chair or director of the program regularly ‘shuffles’ faculty members to create new teaching teams for better personality ‘fits’ and team dynamics (B. Hall, personal communication, October 17, 2013).

The critical literature from the vantage point of nursing education, with the exception of one (Adam, 2014) can be said to one degree or another, to be linguistically captured. Each piece, to some extent, implicitly or explicitly relies on psychiatric language and theory. This language spears even the most critical of the scholars. Despite some very convincing critiques, the circularity of some of the nursing logic is such that the very discourse that is being critiqued is also linguistically activated and taken as common-sense. Once again, it is important to note that while the intention of this sort of nursing scholarship is deeply oriented toward the best interest of the patient, it is its narrow linguistic repertoire which positions it as caught in the discourse of psychiatry. This linguistic capture (or colonization), as we will later see, is more closely examined in chapter four, and to a smaller degree, in chapter five.

My Position Towards Psychiatry: Influencers

Leveled at various aspects of the institution, critiques of psychiatry have been progressively mounting since the early 1960s. Scholars from the fields sociology, education, journalism, and psychiatry itself have advanced a number of foundational and discourse-altering critical analyses. Following is a number of their contributions.

While rejecting the medical model of illness, Ronald David Laing (1960) re-theorized psychosis, advancing a theory of a ‘divided self.’ He attributed the triggers of psychosis to
phenomenological and existential struggles in patients’ lives. He re-envisioned psychosis as brought about by the social rather than the biological history of the individual.

Goffman (1961) inquired into the lives of mental institution inmates, examining the practice of ‘institutionalization’ and the socialization of the mental patient. As a major critic of the psychiatric system, Erving Goffman theorized the idea of ‘disculturation,’ a process by which the institutionalized mental patient is stripped of pre-existing identity and re-groomed as an inmate.

Thomas Szasz (1974), in one of his most controversial work, advanced a compelling theory on the social construction of mental illness. Using ‘hysteria’ to demonstrate how mental illness is a type of rule-following and game-playing phenomenon, he explicated how mental illness is a myth—a metaphor—asserting that “minds can be ‘sick’ only in the sense that jokes are ‘sick’ or economies are ‘sick’” (p. 267). His critique of psychiatry is underpinned by the assumption that the institution is run by discourses of power, social control, pseudo-science, and medical politics. Szasz here provides a powerful and compelling re-envisioning through the deconstruction of language in order to demonstrate that what psychiatrists call mental illness is simply a method of communicating feelings.

Other more recent critiques of psychiatry raise questions about modern psychiatry as a medical ‘science’ and a helping profession and anchor their analyses from various dimensions. Peter Breggin, for example, built a massive critique by scientifically demonstrating the brain-disabling consequences of psychiatric medications (1991, 2002, 2008a, & 2008b) and electroshock (1979 & 1984).

Robert Whitaker (2002) sketched the history of American psychiatry, beginning in the mid-18th century. Using a historical critique of the science that underpins psychiatry, he traced
its inception and its evolution into present day. Whitaker critiqued the scientific research that supports the development of neuroleptic medications, while raising very important questions about the scientific validity of psychiatry and exposing its interests vested in profit-making, self-affirmation, and legitimacy.

Bonnie Burstow took up a feminist standpoint to critique psychiatry as an institution that perpetuates the oppression of women (2005) and commits violence against them disguised as ‘treatment’ (2006). More recently, with her highly critical and visionary piece, Burstow (2015) reintroduced institutional ethnography to the study of psychiatry, and while examining its multi-institutional and discursive dimensions, she makes a compelling case for its abolition. Burstow (2016) likewise produced an institutional ethnography critique of psychiatry, taken up from a variety of perspectives, including nursing, social work, law, and survivor perspectives, to name a few. Other critical standpoints that add to the larger critiques of psychiatry include David Oaks’ human rights perspective (2011) and Stastny and Lehmann’s (2007) humane treatment and self-help approach.

The works cited here are by no means exhaustive, given the critique is multifaceted and comprises multiple movements that are simultaneously organizing and theorizing resistance. Some of these assume a critical position while others explicitly oppose psychiatry and publicly call for its dismantlement. In that respect, I stand on the side of the abolitionist scholars, those whose ultimate goal is to see the institution with all of it supporting institutions, discourses, and structures dissolved altogether.

**Diverging Voices: My Position Versus the Nursing Critiques**

What marks my point of departure from my nursing colleagues is my abolitionist position toward the psychiatric industry. In my many discussions with colleagues, I have found that while
in dialogue, a number of them are capable of speaking as abolitionists in many instances. Their publications, however, routinely fall short of abolitionism. Almost always, their published work, as seen above, consists of reformist, and at best, liberal critiques. This perspective is not only in stark opposition to mine, I view it as potentially dangerous and regressive work. It not only creates a façade of an ‘improved’ mental health system, it arms the industry with ways to conceal its damage and corrupt interests by acting on these very critiques in strategic and apparently ‘corrective’ ways, hence the problem with reform.

My position is that I have no interest in reforming either the current mental health system or the mental health education of nurses, as I see them both foundationally flawed, and as such, the only appropriate response is a complete uprooting. Any attempt at reforming or liberalizing the mental health system further strengthens it and further entrenches deeper its damaging roots into people’s lives, into nursing education, and throughout society in general. Thus, while I respect and value the counter-narrative imagined by my nursing colleagues, is it here where I leave it.

My long term hope for the institution of psychiatry is not its ‘refinement’ or ‘improvement’ as the current mental health nursing discourse goes, but rather, its complete dissolution.

**Conclusion**

My intentions with this chapter were first to open up the study with an everyday work experience, and second, to contextualize it by presenting the relevant literature. Additionally, my aim was to begin with a locally-constructed research problematic and to situate the project in the existing nursing discourse, from which I make an acute departure. I hope to have at the very least conveyed that this project begins with an everyday disjuncture, and as my reader will later see,
will return to that same experience. The disjunction presented in the opening of this chapter serves as my starting point into the ethnography, later to be recontextualized in light of the institutional analysis to follow. What appeared as some everyday difficulties gave rise to a series of politically-informed questions, which came to serve as the research problematic. Proceeding with the research problematic, the study can be anticipated to unfold as a complex institutional investigation with far-reaching implications. While I claim a stark departure from the analysis that informs the nursing literature, the literature served as a sketch of the landscape of the critical thinking of nursing, also a concept to be examined in depth later.

In the chapter which follows, I outline the project’s methodologies and offer some possible solutions to limitations to institutional ethnography, specifically in the analysis of language and texts.
Chapter Two

Methodology

In this chapter, I outline the research methodologies and discuss how and why I came to use them in the combination that I do.

The methodology that guided this research is a combination of a number of qualitative approaches. The project can be broadly conceived of as an ethnography and a sociolinguistic language analysis. The overarching methodological framework for this project is institutional ethnography, into which language analysis is both woven and contextualized.

The general field of critical discourse studies covers a wide variety of methods. Examples of these include the discourse-historical approach (DHA) (Reisigl & Wodak, 2009), corpus linguistics (Mautner, 2009), and the sociocognitive approach (van Dijk, 2009), to name a few. Namely, what sets the DHA apart from other methods of critical discourse analysis is its historical analysis, which focuses on the “diachronic and reconstruction and explanation of discursive change” (Reisigl & Wodak, 2009, p. 120). Corpus linguistics makes use of technology-enhanced methods of data analysis for large sums of data. This method has predictably been critiqued for its decontextualizing the data (Mautner, 2009), as with many methods which rely on computer software for data analysis. The sociocognitive approach to critical discourse analysis makes use of language users’ mental representations (cognition) as relevant to the study of discourse. This method posits that discourse, cognition, and society are in a constant triangular interaction, iteratively producing the social. A variety of other methods of critical discourse analysis have been developed, including a strictly Foucauldian critical discourse analysis method\(^5\).
In this project, I make use of Norman Fairclough’s method for critical discourse analysis, in part also known as systemic functional linguistics (2001 & 2003). I also use methods for hybrid analysis developed by Chouliaraki & Fairclough (1999), and draw connections between hybridity and what Mikhail Bakhtin terms *speech genres* (1986). As I carry out the institutional ethnography, I also draw on Michel Foucault, especially for his theories on discipline and power (1977/1995).

The following diagram depicts the methodologies and theories in relation to one another. While they all overlap and inform one another in an iterative manner, there also is an important linear relationship to them. To that respect, my reader will note that I begin with the ‘micro’ language analysis and spiral out into the ‘macro’ ethnography.

![Figure 1. Levels of analysis](image-url)
The methodologies can be viewed as offering four levels of analysis. The lowest level is that of Fairclough’s, which examines the structure and function of written language. This ties into the higher level of hybrid analysis (Chouliaraki & Fairclough, 1999). Bakhtinian theory on speech genres is particularly relevant here, given that some hybrids eventually become stable ways of speaking and writing, hence, a *genre*. While Bakhtin is not viewed as a critical discourse analysis methodologist here, it is his early theory on genres which in part served as a precursor to the way linguistic hybrids are understood today. Foucauldian discourse analysis moves beyond language as an analytical unit and looks at the practices of discipline and the practice-based inscription of language. Foucauldian discourse analysis is closer to the ethnography than it is to the language analysis methods in that it considers practices (teaching and learning practices) as inextricable components of discourse. But given ‘practices’ are also institutional work processes, they are thus understood and analyzed as both institutional and discursive phenomena. Finally, as these ‘levels’ of discourse analysis are situated within the context of the ‘ruling’ institution, institutional ethnography explicates the local and extralocal relations of power which distribute and reinforce the ideology that is inscribed by the discourse.

In the following section, I discuss each of each of these ‘levels’ of analysis, beginning with the lowest. Embedded in each of these discussions is a list of relevant research questions. Taken together, these questions constitute the project’s sub-questions, which generally guided the data collection and analysis.

**Critical Discourse Analysis**

Critical discourse analysis is a field of study encompassing a set of methods for examining discourse. Critical discourse analysis helps explicate how people discursively obtain,
maintain, and perpetuate power. While I do not strictly adhere to one methodologist in my use of critical discourse analysis, I largely make use of Norman Fairclough’s systemic functional linguistics (SFL) approach (2001 & 2003) and Lilie Chouliaraki and Norman Fairclough’s hybrid analysis methods (1999). I also draw on Mikhail Bakhtin’s theory of speech genres (1981 & 1986) in some areas.

The analytical focus for a critical discourse analysis is on explicating how dominant ideology circulates in a social institute. What makes the discourse analysis critical is its treatment of ideology as necessarily implicated in the perpetuation of social problems. This project is underpinned by three main assumptions about discourse and discourse analysis: That discourse does ideological work; that discourse analysis is interpretive and explanatory; and that discourse is a form of social action.

**Norman Fairclough on Critical Discourse Analysis**

One can often infer the context of a text’s narrative by simply reading through the text. With little to no analytical effort, readers and listeners can fairly accurately draw a number of conclusions about the contextual features of any given written or spoken text. Take for instance, the following two examples:

**Example One**

*If you have a sad, despairing mood that lasts for more than two weeks, it may be depression.*

*Depression is not the same as sadness, though it can be triggered by the sadness caused by loss (e.g., loss of a loved one, loss of hearing), stress or major life change (e.g., retirement, moving). Depression can also be caused by some medical conditions, such as chronic pain, thyroid problems, stroke or Alzheimer’s disease. Certain medications and alcohol use can cause depression as well. Depression may also develop for no apparent reason.*

*People who are depressed cannot just “get over it.” Depression is a biological illness caused by a chemical imbalance in the brain. It affects thoughts, feelings, behaviour and*
physical health.

Example Two

Age-related changes in sensory perception can affect mental functioning. For example, vision loss (as detailed in Chapter 15), may result in apathy, social isolation, and depression. Hearing changes are common (see discussion of presbycusis in Chapter 16). Age-related hearing loss involves sounds of high frequencies. Consonants are high-frequency sounds, and so older adults who have difficulty hearing them have problems with normal conversation. This problem produces frustration, suspicion, and social withdrawal, and it makes the person look confused. Data analyzed from a large Canadian study suggested that older adults with overall functional impairment (e.g., inability to perform housework) exhibited more cognitive impairment 5 years later than did those without functional impairment (Tuokko, Morris, & Ebert, 2005).

Meanwhile, the era of older adulthood contains much potential for loss of loved ones, job status and prestige income, energy, and resilience of the body. The grief and despair surrounding the losses can affect mental health and result in disorientation, disability, or depression.

At first glance, we can minimally say that the two texts are about depression and possibly even specify that they have to do with depression in older adulthood. We can say that the first text appears somewhat informal while the second uses technical and academic language. Correspondingly, we can hypothesize that the first is constructed for the lay reader, while the second, for a reader who is versed in medical and scientific vernacular and/or practice. At the very least, on reading the two together, one can readily appreciate a marked contextual divergence between them. The source of the first text is a patient/family information document on depression for older adults, taken from a psychiatric institution’s website (Appendix A). The second is an excerpt from a section of a chapter in a nursing textbook describing the mental health of older adults (Weaver, 2014, p. 86) (Appendix B).

Knowing little to nothing about the sources of these texts, we were able to deduce a number of contextual details about them. This is possible because they are marked by semantic, lexical, and grammatical features which direct us to infer certain characteristics about their
context. While it is often the case that reading any given text leaves the reader with an
impression of the context, an SFL analysis explicates the linguistic process which leads us to
arrive at this impression. It also provides us with a coherent method and process by which to
understand how we arrive at the conclusions which we can draw about the context of written and
spoken texts.

Deeply held assumptions, known as ideologies, Fairclough (2001) maintains, are
intrinsically embedded in language. Ideology “is most effective when its workings are least
visible . . . and visibility is achieved when ideologies are brought to discourse not as explicit
elements of the text, but as background assumptions” (p. 71). These background assumptions
make a discourse ‘natural’ or in many ways, unquestionable. Naturalization is a strategy for
making a certain discourse ‘common sense’ or taken-for-granted. For example, teaching nursing
students the text as it is, without the insertion of a critique, gives monolithic value to the text.
The repetitive practice of doing this, for example, in other courses during the students’ nursing
studies further reinforces the contents of the text. Repetition creates an inscription of the text’s
concepts into the student’s everyday thinking, which become ‘common sense,’ integrated into
the student’s emerging professional identity. Naturalization that is achieved by the ingraining
practice of repetition can be named a discursive strategy, one which can be examined using
critical discourse analysis. Naturalization reinforces and maintains the dominance of a particular
discourse and is one method by which discourse is legitimated and made a concrete reality for
students.

Also inscribed are assumptions, or ideologies, hidden in the language of a text deployed
as the medium for the transmission of knowledge. In critical discourse analysis, this ‘invisible’
ideology—or the ideological loading in texts—is also explicated. This is done using focused
probing of the language, examining, for example, the lexical choices made by the author and the grammatical construction of sentences and clauses within a given text, their relation to one another, and the relationship this creates with the reader or listener.

As certain characteristics of language are interrogated using critical discourse analysis, invisible ideology is brought into view. As the analysis of the discourse of mental health nursing education is carried out, the nursing literature with which students and faculty interact is dissected and analyzed. This linguistic dissection involves the identification and examination of specific linguistic elements of a given text, listed below.

**Grammatical mood.** Mood refers to the grammatical distinction between types of sentences (declarative, imperative, and interrogative sentences) (Fairclough, 2003). Analysis of grammatical mood helps explicate power relations between writer/speaker and reader/listener. By way of how the former addresses the latter in deploying a certain grammatical mood in writing or speaking, inferences can be drawn about the nature of the writer/reader or speaker/listener relationship and the power dynamics between them.

**Grammatical modality.** Modality is a feature of language by which speakers and writers use modal auxiliary verbs such as *may, might, must, should, cannot*, in order to express mood, voice, and emphasis. Examining modality helps explicate “what people commit themselves to when they make statements, ask questions, make demands or offers” (Fairclough, 2003, p. 165). Of analytical importance here are both the presence and the absence of these auxiliary verbs. Consider the following sentence, for example: *Inappropriate dress, poor hygiene, and lack of concern with appearance occur with depression.* The writer here expresses certain authority and claims to knowledge that dictate what constitutes depression in the context of hygiene and dress. With a relatively high degree of certainty (given the absence of modalized verbs), the writer
creates a certain power relation with the reader that is rooted in authority over knowledge in a matter-of-fact way. In other words, the writer holds absolute power over the claims made in this statement. Other possibilities in which the sentence could have been constructed, which would diminish certainty, and hence, authority over the claim is: *Inappropriate dress, poor hygiene, and lack of concern with appearance may occur with depression.* Note the use of such subjective concepts as ‘inappropriate dress’ which insert professional subjectivity and disguise that a judgment is actually being rendered. Subjectivity will also be examined, later in chapter four.

**Metaphors.** A metaphor is a method of representing one aspect of reality with another. Different metaphors have different ideological attachments (Fairclough, 2001). Metaphors are sometimes used in nursing mental health education, for example, in the representation of depression as a ‘dark cold cell.’ Metaphors are often used as pedagogical strategies in addition to their being used in mental health nursing literature as ‘content’ in both written and spoken discourse. Metaphors as learning and teaching tools act as discursive reinforcements of certain perspectives.

**Euphemisms.** A euphemism is a substitution of one word for another in order to avoid the former’s negative values. Examples of euphemisms include the substitutions of the term *seclusion* for *incarceration* and *sedation* for *restraint*. For example, the statement: *Sedation was administered to alleviate anxiety and the patient was placed in seclusion under 24-hour observation* is a euphemism for: *The inmate was chemically restrained and incarcerated.*

Questions for critical discourse analysis considered here are: How are these linguistic devices used in the nursing literature? What dominant ideology does their use perpetuate? What consequences does the use of these linguistic devices make possible?
While analyzing these linguistic devices explicates the ideological orientation of a particular text, this cannot be done in isolation of language use. That is, language (written and spoken) is used in nursing education in specific analyzable ways. One such strategic use of language is in the combining or hybridizing of multiple discourses. This discursive hybridity (Chouliaraki & Fairclough, 1999) is the discourse resulting from combining two or more ‘recognizable’ ways of speaking and writing. For example, the fusion of words from the discourses of weather reporting and culinary science render the phrase: *It’s so hot outside that you could fry an egg on the sidewalk.* In more complex and highly developed instances, certain hybrids become routinized and stable ways of speaking, effectively becoming ‘independent’ languages. These ‘independent languages’ are what Bakhtin (1986) names *speech genres.* Speech genres will also be identified in so far as they arise out of the hybridization of discourses and their subsequent repeated use. Next, I discuss Chouliaraki and Fairclough’s method for hybrid analysis, followed by Bakhtin’s theory on *speech genres.*

**Lilie Chouliaraki and Norman Fairclough on Hybridity**

In late modernity, Chouliaraki and Fairclough (1999) affirm, “boundaries between social fields and therefore between language practices have been pervasively weakened and redrawn, so that the potential seems to be immense, and indeed hybridity has been widely seen as a characteristic of the ‘postmodern’” (p. 13). Discursive hybridity comes to be as a result of speakers’ and writer’s selective (and sometimes unconscious) use of components of various discourses in a stable and cohesive way. That is, the ‘bringing together’ of language from discourses somewhat socially and linguistically proximal to one another makes a hybrid. For example, and as we will shortly see, the combining of language and picture media of
‘neurology,’ ‘brain sciences,’ and psychiatry result in the discursive hybrid of neuropsychiatry (Chapter Four, Figure 10).

Along with this discursive hybridity, Chouliaraki and Fairclough (1999) state, is a sort of recontextualization of one discourse into another. Using the example of the neuropsychiatry hybrid, as we will see in Chapter Four, that the discourse of neurology is taken and inserted into that of psychiatry, thus reinterpreted (recontextualized) as a supporting discourse, and in some instances, a legitimating one.

In many instances, discursive hybridity is done unconsciously (as in the egg-on-the-sidewalk example above) and with little material social consequence on everyday life. Hybridity, however, can also be seen as a strategic way of deploying ideology by way of harnessing legitimation. This is particularly important when we examine hybridity which combines ‘legitimate’ and scientific discourses (neurology, chemistry, etc.) with those which have little scientific basis (psychiatry, psychology, etc.).

Hybrid discourses pervade social life. It would thus be impossible (and not necessarily useful in investigating social life) to identify a ‘pure’ discourse, free from the infiltration of another. What is of specific interest to this project, is the consequence achieved by the hybridization of specific discourses. That is, in the context of understanding how psychiatry comes to colonize nursing, discursive hybrids make the former a concrete ‘common-sense’ reality by virtue of specific hybrid formulae. These hybrids, in their repeated use (clinical, pedagogical, research, etc.), become stable, acceptable, and recognizable ways of speaking and writing. In essence, they become independent genres of speech and writing, which give rise to whole institutions and discourses such as neuropsychiatry (neurology + psychiatry), neuropsychopharmacology (neurology + psychiatry + pharmacology), and so on and so on.
Mikhail Bakhtin on Speech Genres

While it is beyond the scope of this project to examine media discourses, their impact on the consciousness of the nursing student is worth noting here. Media discourses are powerful precursors to the reproduction of a certain image of the psychiatric patient. Nursing students, simply by way of being in the world, enter the nursing academy with some degree of understanding of what constitutes ‘the psychiatric patient.’ That is, their immersion in media discourses (social media included) and popular discourse, to a large degree, constructs for them a certain reality of how such a person ought to look and behave. The more that students take in these discourses, the more proficient they become in internalizing their images and speaking their language. Namely, such discourses construct the psychiatric patient as a behaviourally unpredictable, often dangerous, psychosocially inept, and a must-be-feared-and-controlled individual. Often, media narratives attribute the ‘integrated’ and ‘well-adjusted’ patient to recent advances in science, to the success of medical interventions, and to the apparently thankless work of the heroic psychiatric team. Students learn to speak and write in the sort of language which describes the psychiatric patient in this context. This ‘context’ is a sort of genre of speaking and writing—the genre of the mental illness in the media. A speech genre, Bakhtin (1986) explains, is a ‘subcategory of speech’ or a form of utterance. On that, he states:

Language is realized in the form of individual concrete utterances (oral and written) by participants in the various areas of human activity. These utterances reflect the specific conditions and goals of each such area not only through their content (thematic) and linguistic style, that is, the selection of the lexical, phraseological, and grammatical resources of the language, but above all through their compositional structure . . . Each separate utterance is individual, of course, but each sphere in which language is used
develops its own relatively stable types of these utterances. These we may call speech genres.” (p. 60)

Bakhtin goes on to differentiate between primary and secondary speech genres. Primary speech genres are those which comprise ‘everyday dialogue’ of which letters and ‘small talk’ are examples. As a methodological concept, I draw on secondary speech genres, defined as a complex and highly specialized language, which arises “in more complex and comparatively highly developed and organized cultural communication (primarily written) that is artistic, scientific, sociopolitical, and so on” (p. 62).

Genres are examined as the subcategories of speech (and of writing) which inform and co-construct the discourse of psychiatry. That is, the overlapping and dialogically related stable forms of speaking and writing of which pharmacology, psychiatry, and the State are examples converge as a ‘unique’ language for nursing. While not always the case, genres often emerge as a result of various combinations of discourses, or discursive hybrids.

Questions considered here are: Which hybrids result in ‘stable’ genres? How are these genres used by social actors? What social implications does their use have on nursing and society in general? How can the social actor ‘escape’ these genres? Are other genres possible? If so, what are they and how can they be used?

Michel Foucault on the ‘Docile Body’

So far, I have been discussing the critical discourse analysis methodology as an analysis of language—the very structure and function of language. I have thus far presented two ‘levels’ of language analysis: The first is Fairclough’s structure and function of language. The second is the higher level of discursive hybrid analysis (Chouliaraki & Fairclough, 1999) and genre analysis (Bakhtin, 1986). These levels of analysis allow for the examination of language at the level of its
content. That is, an analysis of words and sentences. As I move beyond analysis of discourse ‘content,’ I draw on Foucault’s theory of the docile body (1977/1995) to outline a method for investigating how training and discipline reinforce and drive deeper into nursing consciousness the ideological spears of psychiatric discourse. While the methodologies of Fairclough, Chouliaraki, and Bakhtin focus on language, Foucault’s focuses on the practices by which this language is articulated and materially worked into the student’s consciousness.

Michel Foucault uses the figure of the 17th century soldier as an example to demonstrate how the body became an obsessive target for the exercise of power. While sketching out a theory on how disciplinary corporal power proliferated in Classical France, he outlines an ‘anatomy of discipline,’ substructed by strict methods of control and obsessive supervision of activity. These methods, according to Foucault, are the means by which the ‘docile body’ is produced. A docile body is one that may be “subjected, used, transformed, and improved” (p. 136). While circumscribing this anatomy of discipline, Foucault writes: “These methods, which made possible the meticulous control of the operations of the body, which assured the constant subjection of its forces and imposed upon them a relation of docility-utility, might be called ‘disciplines’” (p. 137). Foucault’s concept of docility-utility is helpful, particularly in understanding nursing education. If Fairclough’s and Bakhtin’s approaches help examine the what of discourse, Foucault’s explicates the how, at the level of the practice of teaching and learning. That is, methodologically, the concept of the docile body makes obvious pedagogical practices as generative of teacher-learner power relations foundational to analyzing discourses embedded in them.

As the Foucauldian discourse analysis is carried out, the following general questions are pursued: How does the institution inscribe the discourse of mental health into the consciousness
of the nursing student? How do the concepts of repetition, observation, and examination produce a docile nurse? What is the relationship between ‘docility’ and critical thought? What are the broader implications of the production of this docility in the nursing academy?

**Institutional Ethnography**

Institutional ethnography emerged out of Smith’s critical work in the field of sociology. Informed by feminist, Marxist, and Foucauldian thought, it marks a radical epistemological departure from traditional methods of qualitative inquiry. It is a method that begins in the everyday and everynight ‘local’ experience of people (recall my disjuncture from Chapter One). It examines how such experience is coordinated by extralocal systems of ‘ruling.’ A major tenet of institutional ethnography is that with or without their knowledge, local actors are involved in the maintenance of their own governance, however problematic.

Throughout this dissertation, I make use a number of institutional ethnography concepts that are not self-explanatory. In that respect, I make reference to the ethnographic interview, ethnographic mapping, and ethnographic texts. In the following section, I give a brief definition for each and its relevance to this project.

**The Ethnographic Interview**

Institutional ethnographic interviews depart from those of traditional qualitative methodologies in the type of the data they assemble. Unlike strictly interviewing for a phenomenology study, for example, interview data in intuitional ethnography are neither coded nor thematized. The ethnographer is not necessarily in pursuit of a deep understanding of lived experience, per se. Interviews in institutional ethnography are investigative tools that direct the ethnographer through relevant institutional paths. Interviews examine local actors’ work knowledges, and for this project, this constitutes student work, teaching work, and curriculum
development work. By way of understanding the particularities of the local work, in the pursuit of how these particularities are extralocally organized, the ethnographer is led to the next step in the research, which may be another interview, a text, or another space to observe. Ethnographic interviews function as building blocks for the investigation of the circuit of the relations of ruling. Each interview gives the ethnographer a window into the local experience—the work actualities—as well as linkages to other experiences and work sites.

Interviews give the ethnographer ‘talk.’ People are trained in using institutional concepts. How people speak reflects the social relations in which they are embedded. The focus on language in institutional ethnography, on listening to people’s talk, and on how this talk is used as data is important. People’s talk reveals organizations and the social operations in which they operate. This is the sort of talk pursued in an institutional ethnography interview. It is also possible to identify a substantial majority of institutional texts and the act-text-act sequences (Figure Three) in the ethnographic interview.

Mapping

Dorothy Smith (2005) defines institutional maps as:

always indexically related to actual territories. Analogously, institutional ethnography’s project of mapping institutions always refers back to an actuality that those who are active in it know (the way that the phrase YOU ARE HERE works on a map). A map assembles different work knowledges, positioned differently, and should include, where relevant, an account of the texts coordinating work processes in institutional settings. (p. 226)

Susan Turner (2006) further developed mapping methodology for institutional ethnography, an analytical dimension substantially drawn upon in this project. I make use of
maps to depict various ‘pockets’ of the institution in which textual interception and textually-based governance occur.

Consider the map below. Institutional texts are represented by the square with a folded corner, whereas the circles depict work processes. This institutional ethnography map depicts how a legislative text enters the work of the nursing educator, inserting with it the concept of mental health. Resulting from this textual insertion is the integration of psychiatric literature into the curriculum. This map shows how the mandate of the College of Nurses, deployed in the textual form of ‘competencies’ comes to organize the teaching work of the nursing educator and the learning work of the nursing student. The insertion of the text causes a local reverberation, triggering a course of action on the part of the educator to modify specific nursing course content, augmenting curriculum with psychiatric content, and ultimately ‘enhancing’ (read colonizing) the psychiatric knowledge of nursing students.
Ethnographic Texts

As noted above, the analysis of ‘texts in action’ takes the institutional ethnographer through institutional paths that lead to the ‘extralocal’ and to the structures of governance. Texts help explicate the linkages between the local and the extralocal in order to understand how local, everyday action is governed (Smith, 2001). This governance succeeds by way of the strategic deployment of texts, which do its ruling work. As another central concept in institutional ethnography, texts come into analytical play as mediators of sequences of action. In the
intertextual map above—and this project more generally—texts are seen as mediators of sequences of teaching and learning work.

Texts, Smith asserts, are to be treated as temporal phenomena. They are theorized as such because they are analyzed in interaction with people as they go about their everyday work. They are inserted into and are in constant articulation with the work of the local actor. Texts are treated as vectors that direct the local actor’s consciousness and actions. In a material way (and immaterial, to be discussed later), they intercept sequences of work and are theorized to navigate local work. Perhaps it can be more accurately said that institutional texts are themselves embedded in temporal processes of local work, which makes their articulation to the work a temporal phenomenon. Thus, their insertion into and articulation with local work is the temporal process, not so much the texts themselves. For purposes of clarity, it is important to have made this distinction, though methodologically, it is inconsequential.

The following diagram, taken from Smith’s work (2006a) illustrates this ‘work-text-work’ relationship. Note the time’s arrow, which depicts the institutional process and not the text itself as a temporal, ongoing process.
Given that texts can be infinitely replicated (in hard or soft versions, or in people’s consciousness), they have the capacity to do this sort of mediation of work en masse. To that effect, they coordinate, organize, and influence multiple work sites both synchronously and asynchronously. The replicability of texts ad infinitum factors into the ethnographer’s analysis of the ruling work that texts do.

Ethnographic text analysis directs the ethnographer to also consider their relationship to one another (known as intertextuality) and the hierarchy that often forms by institutional texts (known as an intertextual hierarchy). While texts are examined as mechanisms that rule people in their work sites, they are also analyzed for their ability to ‘rule one another.’ That is, in every institutional setting where more than one text is at play, often, there emerges a text (or a combination of texts) that resides at the apex of any textual hierarchy. This high-ranking text is what Smith calls the ‘boss text’ (Smith, 2005). Consider the following intertextual hierarchy, for example:
The Diagnostic and Statistical Manual of Mental Disorders (DSM) appears as the boss text, under which a number of intermediary texts are located. The boss text’s function in this hierarchy is to dictate the contents of the intermediary texts. Recall the textual embedding of provincial legislation into teaching and learning work from Figure Two. If we isolate the relevant texts here, we can see how that sort of work can be traced beginning locally and moving upwards. The local text course outline, for example, is modified to incorporate the concept of mental health as an evaluative construct within it in response to the upper level text legislation (the CNO Competencies for Entry-Level Registered Nurse Practice). This sort of incorporation is necessary, given the legislative text mandates it. The legislative text, in turn, draws on the DSM—the boss text—whose concepts and theories ripple down the hierarchical chain of texts and into the capillary level of teaching and learning work.

Intertextual hierarchies in institutional ethnography are larger level maps than those that demonstrate act-text-act sequences. They function as a sort of illustrative summary of the relevant institutional texts and their relationship to one another.
Texts in institutional ethnography are those written and printed material (hard or soft versions) such as institutional policies, books, pamphlets, identification cards, websites, and so on. Smith (2006a) theorized the act-text-act processes (Figure Three) as occurrences of material interaction with real or virtual texts, which may take the form of opening a book and reading through it, downloading and reading a policy document, or browsing a website. While this sort of textual ‘activation,’ is in many instances very much the case in contemporary institutions, it is also seen where local actors, without materially interacting with a text, often ‘distantly’ activate it, or evoke its concepts and theories in order to guide their work. In fact, the latter is more often the case in contemporary efficiency-driven health care and educational institutions. To that effect, I expand on Smith’s notion of ‘textual activation’ to include both the material and the immaterial, distant (or mental) activation of institutional texts. Thus, hereafter, my use of the term *activation* includes both the material handling as well as the ‘distant’ mental evocation of institutional texts.

The questions which guided the institutional ethnographic analysis are: How is the undergraduate nursing curriculum set? What are the work knowledges of the nursing student, educator and the curriculum administrator? What power relations can be seen between the academy and psychiatry? What is the institutional work that goes into perpetuating these power relations? What are the texts that mediate these relations? How do psychiatric and legislative texts shape nursing texts out of which nurses are educated? What is the relationship between these texts?

**Why These Methodologies? Looking for Meaning**

As I discussed above, institutional ethnography has the potential to bring into view the practices that underlie the difficulties for the everyday person. As an approach to investigating
social life, it is a powerful tool which opens up how an institution governs itself and the people within it, how institutional texts deploy coordinating power that is far beyond their apparent everyday use, and how obscure or invisible power relations can be made visible and subject to interrogation.

While the importance of text analysis in institutional ethnography cannot be understated, it is not without limitation. As I grappled with institutional ethnography’s treatment of texts, I found what came to be an epistemological void. I discovered that institutional ethnography fails to account for the role of the construction and interpretation of texts. It overlooks the analytical value in the how of the text’s development and the interpretive work that is often done by local actors. Much like institutional ethnography’s ‘macro’ activation, the ‘micro’ interpretation (or semiotic) has the potential to create a variety of different sequences of work based on the interpretive practices of the activator. After all, it is real people reading and interpreting real texts. This interpretation work can be analyzed to bring into view how the linguistic construction of mental illness comes to be in the nursing academy. This distinction is important because it allows for the analysis of various ‘readings,’ of texts, as in for example, a ‘critical’ reading of a mainstream mental health article.

Smith’s theory on language modestly ebbs and flows throughout her work. As she generally speaks of the importance of ‘interpretive practices,’ she dismisses the vast majority of the field of linguistics on grounds that it divorces itself from the social setting and abstracts lived experience. She laments that “while language and mind, language and cognition, language and thought are the preoccupations; the social is no more than an after-thought” (Smith, 2005, p. 75). As she theorizes language as a coordinator of subjectivities, Smith glosses over the fact that semiotic work is a necessary precondition for this coordination. Indeed it is the subjectivity of
actual people, doing actual interpretive work whose actions are being coordinated. At one point, however brief, Smith did appear to have wrestled with semiosis as potentially informative to institutional ethnography’s analysis of texts. On that, she writes: “Activated by the reader means that the activity or the operation is dependent on the reader’s interpretive practices” (Smith, 1990a, p. 121), and it is these very ‘interpretive practices’ that the linguistic analysis of texts interrogates.

I drew in the language theories and methodologies in an effort to address institutional ethnography’s semiotic gap. It is my hope that the combination of these methodologies will help me adequately explain how the social actor is institutionally ‘hooked’ and to a certain degree, linguistically colonized. Taken together, these methodologies support an analysis at both the micro and macro-level explorations of institutional texts, talk, and action.

**Conclusion**

This project is complex. Its data are multidimensional and multidirectional. They are multidimensional because they emerged from diverse social spaces: The abstract textual, the classroom, the interview, and the researcher’s own experience (more on this in the following chapter). The data are multidirectional in that they allow for a complex and rigorous analysis of the construction of mental illness from various directions: The micro linguistic, the macro speech practices, the disciplinary, ‘professional,’ and the large-scale institutional governing dimension.

In the following chapter, I discuss the study design, the methods and procedures used to carry out the research, and the various institutional obstacles I encountered while collecting the data.
Chapter Three
Design, Methods, and Institutional Access

In this chapter, I provide a detailed account of the research methods. I discuss how the data were analyzed and outline the ethical review processes that the research underwent. I engage in a critical discussion of the difficulties in gaining institutional access and the corresponding consequences which forced a redesign of the project. While theorizing the institutional barriers I encountered during data collection, I provide a brief analysis of what led to my being shut out of a certain aspect of the institution. While it may seem unconventional to discuss logistical and seemingly mundane research process in such detail, this is important—if not necessary—(as my reader will later see) in order to contextualize the institution. In other words, the barriers and difficulties I encountered as a researcher are yet another institutional reinforcement of dominant discourses and clues to the protection of certain interests. I close the chapter with discussions on what was lost as the project was forced into a redesign as well as, in spite of this loss, why the project remains to be an important contribution to knowledge.

Methods

This study was originally designed as a multidimensional and complex ethnography with diverse approaches to data collection. While it remains a complex and carefully designed study, for reasons of institutional access (or lack thereof), I modified it as I encountered difficulties making contact with certain participants and gaining admission to certain institutional settings.

The data collection methods involved focus group interviews with nursing students, nursing educators (university and college level), classroom observations, and textual analysis. Occasionally, reflective journal notes which I have accumulated throughout the course of my teaching over the last two years also came to serve as data.
Interviews

In small focus groups of two to four members each, I interviewed seven nursing students close to finishing their nursing studies. Open-ended questions initiated and guided the discussions. The student interviews ran approximately between 60 and 90 minutes and were conducted either at the university which the students attended, on the phone, or using a combination of both venues.

I also interviewed eight faculty members from both the university and the college. The faculty interviews also took place at the university and over the phone and ran between 60 and 90 minutes.

Classroom Observation

I undertook nine hours of observation of mental health nursing lectures. Six of these took place at the university and three took place at the college. The university lectures were part of a course titled *Nursing Professional Issues and Trends*, in which mental illness was theorized as a ‘trend.’ The three-hour college lecture I observed was part of a course titled *Pathotherapeutics: Nursing Implications*. In this course, mental illness was theorized as a biological disease of the brain, thus, its inclusion in this science-based course on human pathology.

During and shortly after the observation periods, I took notes specifically on the pedagogical strategies of the educator and the language used by both students and educators. I documented the ways in which educators and students theorized mental illness and how both groups understood and made use of various psychiatric concepts and theories. I also made notes on the various texts drawn upon by both students and educators throughout the lectures, a number of which fell outside the reading lists of the respective courses.
The undergraduate nursing curriculum is comprised of a number of theoretical nursing courses (core courses), clinical practicums, ‘professionally-related’ elective courses, and liberal studies courses (see Appendix C for the curriculum overview). The faculty responsible for teaching the respective courses were approached and asked for the course outlines along with their corresponding reading lists. Despite multiple requests, three faculty members did not respond. The five clinical practicum courses do not have reading lists and subsequently were not included. Given the general topic is mental health nursing education, the literature from the liberal studies courses was excluded from the corpus of data, as it is not specific to nursing. Of the 38 courses that constitute the curriculum, 16 were selected based on their being nursing ‘core’ courses. Of the 16 core courses, reading lists were obtained for 13 of them and were carefully read. All literature in the form of articles, book chapters, standards of practice, and government reports in the area of mental health was isolated. A total of 33 such pieces of literature emerged, which came to serve as the final sample of literature data.

A number of other texts, particularly relevant to the ethnography, include institutional curriculum policy, the College of Nurses of Ontario’s standards of practice, position statements and recommendations from various professional groups and federal accreditation-grating agencies, institutional ‘strategic documents’ such as the strategic plan, and various legislation documents. These texts were identified in the interviews, during the observation periods, and otherwise from my own intimate knowledge of the program and its history.

Journal Notes

My reflective journal notes, taken over the course of two years, constitute my observations around the nursing academy, critical reflections on my work and the work of my
colleagues, as well as reflections on institutional access during the course of my data collection period for this project. Albeit to a rather small degree, these too also came to serve as data for this project.

**Data Analysis**

Given the methodological complexity of this project, I find it important to say a few words here on how the data were analyzed. The data consist of a number of interview transcripts, observation field notes, and various texts (literature and institutional policies). The interview data and the institutional texts were largely analyzed using the institutional ethnography framework, while the literature and the observation data underwent language and discourse analysis.

While examining a representative textual sample of the nursing mental health literature (the mental health assessment [Appendix B]), I engaged in the analysis of a number of linguistic devices in order to explicate the hidden ideology in the text. For example, an analysis of euphemisms in one of the pieces of mental health nursing literature made evident an otherwise concealed narrative of professional control and violence. It brought into view how violent psychiatric interventions, concealed behind ‘softened’ language are communicated to readers as scientific and necessary. The statement: *Sedation was administered to alleviate anxiety and the patient was placed in seclusion under 24-hour observation* conceals and makes common-sense the violence in chemically restraining a patient and incarcerating him in solitary confinement, as a consequence of his observed behaviour. This is achieved by language that appears benign, professional, and often referenced by legitimating sources. Legitimation is another linguistic device which often comes into interplay with euphemisms. As I examined the literature for these devices, I did not do so in a linear fashion. Rather, I looked at how a number of them worked together to create a synergistic effect of ideological loading. This analysis unveiled their
combined linguistic power as a strategy that conceals and mystifies the violence of psychiatric interventions while at the same time advancing such interventions as an unquestionable, scientific, and legitimate reality.

Eventually, as social actors become immersed in such language vis-à-vis text and talk, they become well trained in speaking the language of ‘mental health,’ also combined with other such legitimating discourses as epidemiology, neurology, oncology, safety, and so on. They assemble various lexical and grammatical combinations of these discourses and begin conversing in them in clinical and classroom settings as a stable, professionally-sanctioned common-sense language. In many cases, this ‘stable language’ is preconstructed and handed to them in the academy. This is what Chouliaraki and Fairclough (1999) term an interdiscursive hybrid. Both the classroom observation data and the interview transcripts underwent hybrid analysis. Following is an example of a faculty member recalling a work experience, linguistically demonstrating how the two discourses of cancer care and psychiatry intersect:

I remember in my clinical practice in oncology there were times where patients were diagnosed with depression based on their cancer diagnoses. I often think not that the patient isn’t clinically depressed, but going back to the previous statement, that the judgment is up to the clinician to assess the patient: I mean it makes an adherence in the way we would manage the patient so it will have clinical significance. But I also think that there are cases where a patient hasn’t been assessed and they are told they are not depressed but when you look at the severity of their symptoms you wonder why this patient hasn’t been diagnosed. So, under-diagnosis and over-diagnosis have been present in my clinical experience in oncology. (Faculty Member)
Underlined (unbolded) are words from the discourse of oncology (cancer), whereas the boldfaced words are those from the discourse of psychiatry. Words that are bolded and underlined are those which cross both discursive boundaries, hence creating a hybrid between the two. Taken together, this hybridity becomes a certain ‘stable way’ of speaking. It becomes a particular language with which to fully communicate behaviours, life histories, treatment plans, expectations, and so on. In other words, a Bakhtinian *speech genre*. Note the word *patient* creates the most overlap, given the person is constructed as a ‘patient’ by both discourses, thus making it unclear (or a successful hybridity tactic) whether it is ‘the cancer patient’ or ‘the psychiatric patient’ to which the speaker is referring.

As I went about analyzing the excerpts, by way of having isolated the language in various exchanges with faculty and students, various discursive hybrids, along with their implications, began to emerge.

Carrying out a Foucauldian discourse analysis involved examining those everyday teaching practices in the nursing academy. As such, I looked at how the strategic use of repetition, observation, and the examination as disciplinary strategies inscribe psychiatric discourse onto the consciousness of the learner. I drew on my observation notes, and to a small degree, my own experience as a nursing clinical supervisor and lecturer.

I interrogated the field notes for ‘disciplinary’ tactics. That is, I looked for actions and events created by the educator which subject the learner to the discourse in an authoritative, cumulative, and mechanical way. These are events that demonstrate, for example, repetition of a particular idea using various media.

While observing a lecture on mood disorders, for example, I noted the educator’s repeated verbal reinforcement of mental illness as having biological origins. The message was
enhanced with a variety PowerPoint photographs depicting brains of those with depression as compared to those without depression (a photographic discursive hybrid of the discourses of neurology, biology, and psychiatry). These methods in turn were followed up with such statements as: “How can someone say that this is not a medical problem? How can you just ‘snap out’ of mental illness?”

The analytical emphasis here rested on the strategic and multidimensional repetition of the biological argument. This sort of reiteration further drives deeply the inscription of the argument into the consciousness of the learner, to be later tested and examined at various intervals during the course.

While carrying out the ethnography, I interrogated the interview transcripts in pursuit of the work knowledge of the participants. In an effort to understand their everyday experience, the interview transcripts helped me construct their day-to-day interactions with the discourse of psychiatry. I also identified those texts that appeared to mediate the work of the speaker, and this initiated my tracing of those texts, which extended beyond the local setting and intersected with other texts and with the work of other such social actors as educators, administrators, and legislators. It is this sort of tracing of work sequences and textual interception which was at the heart of the ethnographic analysis. I also identified all the relevant texts, most of which interacted with one another in a hierarchical manner. Correspondingly, the institution’s intertextual hierarchies were made visible.

**Ethics**

The proposed research was reviewed by four different institutional review boards. The University of Toronto facilitated a delegated review, as did the three other educational institutions: One university (the university in which the research took place, hereafter referred to
as the host university) and two other educational institutions (one of which also hosted the research, hereafter referred to as the host college). Given the nursing program under investigation is offered collaboratively between a college and a university, it was a requirement that all research conducted on the program be separately approved by each institution which offered it. The first to approve the research was the University of Toronto, followed by the host college, then the host university. Approval was granted for one year, during which all the human subject data were collected from the host institutions.

The host university asked for extensive changes to and clarifications of the research design and conduct. Most of these were erroneous requests, likely resulting from a misreading of my research protocol. Following are three brief examples of these requests, with my responses to the research ethics board (REB) beneath each one:

**Host university REB:** The wording of some of the interview questions raised concern that the research is not being conducted in an unbiased way. For example: “How is the nursing academy entrapped within a power relation with psychiatry?” versus something more neutral as a precursor to this question such as, “in your view, what is the relation between the nursing academy and psychiatry”. Another question that reveals bias is: “What is the institutional work that goes into perpetuating these power relations?” The questions do not give participants the freedom they need to participate in a truly voluntary way; participants may not feel comfortable disagreeing with the researcher’s view, which appears to be very explicit in the recruitment messages and the interview questions.

**My response:** “How is the nursing academy entrapped within a power relation with psychiatry?” is a research question and not an interview question. Please refer to section 11 of the approved protocol. You will note that the title of the section reads “Research Questions:” Likewise, “What is the institutional work that goes into perpetuating these power relations?” is also a research question. The questions in this section of the protocol are not interview questions; therefore, will not be asked of participants.

**Host university REB:** The student consent form mentions the possibility of setting up a second interview; however, this second interview is not in the approved REB protocol.
My response: Indeed it is. Please review section 12(a) in the approved protocol. The statement reads: “Additionally, after the focus group interviews, if relevant to the research and depending on the responses of certain students, some students may be asked to also partake in a second focus group interview or an individual interview, at a later date.”

Host university REB: The faculty consent form contains a consent statement to take part in the clinical observation at the hospital, but this part of the study is not yet developed and has not even been submitted to any hospital for ethics review; therefore, faculty cannot provide consent for the clinical observation part of the study.

My response: The consent forms do not contain such statement. I have reattached them here for your review. The consent to observation is for classroom lecturing time only, and not clinical. Please note that it never was part of the design of this project that faculty be observed in clinical.

The ethical review process of the host university resulted in the longest delays and most extensive redesign of the project, including the elimination of a major source of data (the observation of students in clinical settings). The third response above appears to point to a certain discomfort felt by the university, which later rears its head as a precursor to an insurmountable barrier to data. Below, I elaborate more on the host university’s ethical review process as I discuss permission and access to the institution.

**Access to Data: Institutional Hoops and Loops**

Data collection spanned two-and-a-half years, in small part due to the complexity of the project, but overwhelmingly, due to the ‘institutional red tape’ which I frequently encountered. Here, I discuss three processes: The first is the process of the collection of course outlines and reading lists. The second is the request for permission to observe students in clinical settings. The third process is my failed efforts in attempting to interview curriculum administrators.
Access to Texts

As discussed briefly above, I began the data collection process by gathering course outlines and reading lists of the courses of the nursing program under study. This involved approaching nursing faculty members either in person or by email and soliciting their course outlines and readings lists. At the point where I had gathered about half of the course outlines, I was asked by a program coordinator to stop the process given I had not received ‘permission’ to carry out this research. Perplexed, I inquired what permission it was which I needed to obtain, given there were no human subjects involved in my research at this point. The response was that I had needed to ‘go through proper channels’ first before I carry out any data collection.

Though there exists no identifiable ‘proper channels’ process, I quickly learned as a contract faculty (at the time), that despite the absence of such a process, an invisible social order was very much at play. This is the social order that became markedly visible during those times when power structures, namely those which govern curriculum, became undermined.

This experience delayed my data collection efforts by 10 months, during which my project was placed on the agenda of program leadership teams, discussed during several consecutive monthly meetings, and subjected to a number of restrictions. Among such restrictions were the preservation of the highest degree of institutional anonymity as well as the submission of all potential future publications and conference presentations which emerge out of the project to the program director of the host university for review prior to dissemination.

Access to the Clinical Setting

Soon after the collection of course outlines came to a close, the project underwent ethical review. The initial study design included the observation of nursing students in mental health clinical settings as they interact with their preceptors (staff nurses assigned to oversee students).
While the ethical review boards of the University of Toronto and the host college approved this, the host university did not. It was subsequently removed on grounds that it was ‘underdeveloped’ and due to my ‘failure to obtain permission’ from the clinical institutions I planned to observe. Despite my placing clear language in the protocol that no such observation would occur without the ethical permission of the institutions in question, the host university, indeed quite strongly ordered that this part of the research be eliminated. Below is a demonstrative excerpt:

More information is needed regarding the plan to observe students in their clinical placements. All that is stated is that this segment of the research has not yet been submitted for review by any hospital REB. Please note that the approval from [the host university] cannot cover this component of the study, since this part of the study is not yet developed. Please confirm that this segment of the research is not being included in this application for ethics review and delete reference to this component from the application. (Host university REB response letter)

Constructed as a technical ‘permission’ problem, the host university inserted an apparently irreversible ruling against my research. While it appeared to take no issue with my examining various texts and sitting in on lectures delivered by my colleagues, my unsupervised presence in its associated clinical practicum settings appears to have threatened a certain status quo. Otherwise, why would the university use such finite and commanding language as “confirm that this segment of the research is not being included” and “delete reference to this component”? My suspicion is that while the university perceived little threat from my other research methods (which speaks to a certain political naiveté on its part), it drew the line at my clinical observations, in that these appeared too risky to the sociopolitical order of the institution.
The grossly inaccurate claim that “all that is stated is that this segment of the research has not yet been submitted for review by any hospital REB” likely resulted from a sort of institutional discomfort. Indeed, there is extensive language on clinical observations in the protocol, including the stipulation that such observation will only take place upon institutional permission from the respective clinical agencies. Though I cannot be certain whether it was a misreading of the protocol or a discomfort with it that led to the university’s decision, my suspicion, at the very least, is that it is both. Consider the following two excerpts from the protocol:

**Excerpt One**

<table>
<thead>
<tr>
<th>5. OTHER RESEARCH ETHICS BOARD APPROVAL(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Does the research involve another institution or site?</td>
</tr>
<tr>
<td>(b) Has any other REB approved this project?</td>
</tr>
<tr>
<td>If Yes, please provide a copy of the approval letter upon submission of this application.</td>
</tr>
<tr>
<td>If No, will any other REB be asked for approval?</td>
</tr>
<tr>
<td>Yes ☒ Host College REB, one or two other hospital REBs (hospitals to be identified in August, 2014).</td>
</tr>
</tbody>
</table>

**Excerpt Two**

A total of five students will be observed in their clinical practice placements at one or two hospitals (to be identified in August 2014). This project will also be reviewed by the REB of any hospital at which observation will take place. It is not possible to identify the hospitals at this point because the students who will be observed in their clinical practice settings will not have been assigned their respective hospitals until August, 2014. While a formal observation checklist does not exist, given the methodology does not lend itself to that, what I will be observing are the following: The student’s interaction with his or her preceptor. Specifically, the teaching interaction that takes place between the two, the
language that is exchanged between the two and the use of various mental health concepts, the various texts that the student interacts with, and other work processes as relevant to an institutional ethnography that provide clues into the use of mental health concepts and their understanding by the student on a clinical level. (Original Research Protocol)

Interestingly, the host university’s authorization appeared to be contingent on, even deferred to that of the hospital. But why was this the case? Why would the degree-granting university— the program overseer— defer such a decision? Is this deferral another barrier specifically deployed to eliminate my presence from the program’s clinical practicums? After all, how can a hospital have the final approval authority on the observation of students whose governance lays in the jurisdiction of the university? Given the barriers which I experienced at the host college led to concerning delays, I decided to comply with the host university’s order to remove this segment of the project, in an effort to prevent further lengthy delays. This was necessary, because any further delays would have jeopardized my ability to obtain student participants, given the academic year was soon to begin, after which the students will have completed the program.

Access to Administrators

In addition to interviewing students and faculty members, my plan was to also interview program administrators. Theirs is an important perspective on how the governing of curriculum (its inception, ongoing updating, as well as accreditation) comes to be. These would be the same administrators who in light of my gathering course outlines, subjected my project to microscopic inspection and firm control. Indeed, upon receiving institutional permission, I was informed by the chair of the host college that the “leadership team would be happy to give interviews.” After
sending a number of reminders and several weeks of doing so, I finally received formal interest in participation from two of the three administrators. However, what appeared as an interest to participate in my research never actually materialized. The administrators continuously made promises to participate yet simultaneously avoided participating. I continued to be promised interviews for the duration of the entire project’s interview and observation data collection period, though no such interviews materialized. I was thus not able to interview curriculum administrators. Despite the lip service, they were simply inaccessible.

**Guarding the Curriculum**

Why were the administrators at the host college so resistant to my gathering course outlines? Why was my project subjected to such microscopic observation and control by the host university? What were the host university and college attempting to conceal, if anything, by deploying their ‘red tape?’ Why was it that on the one hand, faculty are encouraged to carry out collaborative research and take part in cross-institutional dialogue, and on the other, restricted, delayed, and in some instances, denied access altogether? The short answer lays in the fact that the political bent of my research likely threatened a long-established institutional order. But more specifically, what I found myself running up against, time and again, was a nearly impenetrable curriculum dearly protected by a powerful institution.

At virtually every juncture of the research process, there was a barrier. While gathering institutional texts, during the ethical review process, during participant recruitment, and even at the stage of analysis and dissemination. This is partly attributable to the fact the faculty and administrators who developed the very courses I was critically analyzing reserved a certain right to protect them. Their perceiving a potential threat to the integrity of their courses (and to their intelligence) triggered a resistance by which my research became the subject of strict
institutional control. In my many side conversations with colleagues, I came to understand that there is a vested interest, especially by faculty who claim original authorship of nursing courses, to maintain the intactness and protect the integrity of ‘their’ courses. The implications of my research, it appeared, flew in the face of this established institutional ‘ownership’ of nursing knowledge. I recall a cautionary comment made by an administrator from the host college in a discussion, which further contextualizes this sort of ownership. The concern with my gathering course outlines for research purposes, she stated, is that “some faculty might get their backs up and become upset if they feel that they’re being evaluated” (B. Hall, personal communication, October 17, 2013).

It is not only the claim to ownership which erected barriers, but also a sort of protection of the status quo and of the program’s ‘reputation.’ In the same conversation with the above administrator, I also came to learn that the host university “has been burned in the past by the media” and must be very cautious with the reputation of the program, to which it interpreted my research as a clear threat. What the host university set out to prevent, it seems, was the possibility of my exposing damning ‘weaknesses’ in the program, which could render negative consequences, on student enrolment numbers, for example. It is this sort of reputational worry and the unyielding protection of curriculum which subjected my research to many months of debate, control, and obstruction, including the elimination of my presence altogether from its clinical practicums, despite my being a clinical supervisor in the very same program for over eight years.

While jumping through the institutional hoops of permission and access, I quickly came to appreciate a new social location which I often found myself occupying. I was constructed, it appears, as a political researcher with a threatening critique of the nursing program. This is how I
came to be viewed by the administrators—the very same view which denied me access to the clinical setting and to the curriculum administrators’ perspectives and subjected my project to an ever-present institutional gaze.

**What is Lost**

Denying me access to the clinical setting comes with a consequence to understanding how psychiatric discourse dominates. How psychiatric discourse circulates between the student and the preceptor and how it is taught to the student by the preceptor and other clinicians are two dimensions of data which have been lost. Not only the observation of the use of language is lost here, but also that of the disciplinary clinical practices exercised on the nursing student in the inscription of the same discourse.

Another substantial dimension of data that is lost is the perspective of administrators. Theirs is a unique experience which could have directly informed this project on issues around curriculum inception, program governance, and various extralocal operations and politics that impact the program and its curriculum. Although clinical observations and administrator interviews were not possible, the project remains a complex and a rigorously-designed piece of research. While I cannot claim that my experience can fully replace these missing components of data, I have drawn on my clinical supervision experience as a faculty member and as a student as well as my own knowledge of the program in an attempt to address this gap in the data.

**What Makes this Project an Important Contribution to Knowledge**

Though the ‘institutional red tape’ and the safeguarding of the program resulted in real limitations, this study is nonetheless a unique and an important contribution to nursing knowledge and to the critical mental health discourse. The multi-methodological design of the study speaks to its rigor and creativity. It is rigorous as it tackles research questions using a
variety of data sources and multiple levels of analysis. The study leaves little to be assumed, given it is an empirical analysis of the material working conditions of social actors, the texts with which they interact, and the everyday language they use. An original contribution to nursing knowledge, this study challenges nurses, nursing scholars, and those critical of psychiatry to redefine mental illness and to reimagine and begin to reinvent a new language with which to describe the human condition—a language that is uncontaminated by psychiatry.

Returning to the Overview of the Project and Concluding

I began this dissertation with a personal experience. My entrée was a disjuncture deeply felt both in my bedside practice and my teaching experience, and to some degree, also shared by students and colleagues. Resulting from approximately a decade of repeated experiences of similar disjunctures, extensive graduate work, and my commitment to social justice, I went about designing this complex and intricate investigation. I have thus far sketched a brief review of the literature, provided a discussion of the methodologies guiding the project, outlined its design, and theorized around the ‘institutional red tape’ deployed to obstruct my data collection efforts at various stages.

In the following chapters, as I carry out the analysis, I begin with the micro language analysis—the analysis at the level of the word and the phrase. As I proceed through the methodology spiral (Figure One), I move towards an analysis of the hybrids of discourse, then to the ‘practices’ of discourse as a discipline. Finally, as I examine the structures of ruling, the institutional ethnography fits together how nursing education perpetuates a colonization of itself by psychiatry as well as the impact of this colonization on critical thinking in nursing.
Chapter Four

The Mental Health Assessment: A Lexical and Grammatical Analysis

As the first of the three analysis chapters, this chapter explores the micro linguistic dimension of an aspect of the nursing mental health literature as a way to explicate how psychiatric discourse is legitimated by nursing education. First, I examine a sample of the mental health literature using a systemic functional linguistics approach (Fairclough, 2001 & 2003). Then, I present a discussion on how hybridity (Chouliaraki & Fairclough, 1999) of discourses comes about in the nursing mental health literature, how students and educators converse in these hybrids as an everyday phenomenon, and how these discursive hybrids achieve psychiatric legitimation. Lastly, I close with some questions to consider for the chapter which follows—the institutional ethnography.

The Mental Health Assessment: A Systemic Functional Linguistics Analysis

The context of any written or spoken text, according to systemic functional linguistics (SFL), is understood by examining the text’s genre and register. Here, I begin by examining the register of the nursing mental health assessment (Weaver, 2014) (a sample of the mental health nursing literature), after which I undertake a hybrid and genre analysis.

The three elements of register are field, mode, and tenor. Field examines what the language is being used to talk about. Mode refers to the role that the language is playing in the interaction. While I examine register, I look at the reader-writer relations (tenor) by identifying the mood and modal features (Fairclough, 2003) of a sample of the mental health assessment (Weaver, 2014). This is also known as an analysis of the relationships between the interactants.
The Sample Text: Context and Background Information

What I refer to as the ‘mental health assessment’ is a chapter by the same title located in a textbook titled *Physical Examination and Health Assessment*. The textbook is a first-year nursing resource used in what is called the *Health Assessment* course (see Appendix C for the curriculum overview). The text represents a foundational source of the assessment knowledge for the nursing student. That is, gaining mastery in the content of this textbook also provides the nursing student the assessment skills for such sub-specialties of nursing as cardiology, respirology, neurology, and so on. Psychiatry is one such sub-specialty, to which one chapter in the book is devoted—the one analyzed here. The textbook has been used in the nursing program since the program’s inception in early 2000, though the specific edition analyzed here was introduced in 2014.

Each chapter is structured into six distinct ‘physical assessment’ categories. These are: *Structure and function* (anatomy and physiology of the body system), *Subjective data*, which consists of the health history gained from questions asked by the examiner (reader), *objective data* which constitutes the “core examination part of each body system chapter, with skills, expected findings, and common variations for healthy people, as well as selected abnormal findings” (Jarvis, 2014, inside cover), *documentation and critical thinking*, consisting of case studies and sample documentation entries, *abnormal findings* (tables, charts and photographs describing pathological disorders and conditions), and *Special considerations for advanced practice*, consisting of illustrations and tables designed for ‘special circumstances’ where appropriate. Not all chapters contain all six categories. The mental health chapter, for example, consists of only three: *documentation and critical thinking, abnormal findings, and special*
considerations for advanced practice. It is important to note, however, that the previous edition of this chapter also included structure and function and objective data (Jarvis & Stanyon, 2009).

**Rationale for Selecting this Text Specifically**

I selected this chapter for two main reasons: The first is because the chapter is the longest-lasting mental health text in the program. With minor variations between editions, the chapter has been used since the program’s very inception, hence its enduring impact on nursing knowledge. Secondly, I consider it to be the foundational text for the nursing student’s mental health assessment knowledge. Unlike other curriculum literature, this chapter is directly focused on the clinical examination of mental status and considers mental illness as its basis for this examination. It is by way of this chapter that the student is introduced to the discourse of mental health/illness as an emerging clinician. It is also based on this chapter that the student is tested for his or her mental health assessment knowledge, which in turn he or she is expected to apply in practice during clinical practicums. Suffice it to say that the chapter is powerful and central to the organization of the mental health nurse’s knowledge in this program. While I examine this text in some detail here, I remind my reader that the relations, the contradictions, and the problematic constructions found in this text are hardly unique to this text and indeed are common characteristics of the general corpus of the mental health literature of the nursing program. Refer to Appendix B for further reference and for the entire mental health assessment chapter.

**Surface Problems: (S)objective Contradictions**

Consider the following statement made by a faculty member: “There is excellent stuff in those textbooks, but how it is brought to life is dependent on the values, beliefs, and the lens of the person who is doing the teaching.” If this quote suggests that educator subjectivity factors
into nursing pedagogy, the following points to a more diffuse sort of subjectivity in mental health settings—that is, clinician subjectivity:

It’s so heavily contextualized, Simon. I think it depends on the clinical team and their tolerance. For example, there are some outpatient clinics that I’ve had working relationships with, that I can see depending on who the counselor or clinician is and the team and their experience level, they won’t be able to tolerate certain types of behaviours . . . How come there is such a range of tolerance for even behaviours on a forensic unit? I find it very interesting as a mental health consultant, that you can pretty much predict when they would make a referral based on who’s working on the weekend. For example, if they were people who expected rules to be obeyed, weren’t flexible, and believed heavily in notions like limit-setting . . . You come in on a Monday and you look at who was working over the weekend and you would know this person would have had more PRN medications [euphemism for tranquilizers] administered, and that kind of thing.

How is it that an ostensibly scientific profession such as nursing can be so subjective? How is this subjectivity endorsed and how does it come to be woven into nursing education and clinical consciousness? In part, the answers lie in the texts themselves—those texts which the educators use to prepare nursing students for the ‘work force.’ To begin to understand how this subjectivity becomes a ratified ‘skill’ inserted into nursing work, we must begin at the level of the text—its language and its very construction.

Let us turn our attention to the mental health assessment text. Refer to an excerpt below. The figure is an excerpt from the mental health assessment chapter, specifically that which outlines the assessment of patient’s appearance and behaviour.
Figure 5. ‘Assessment of appearance and behaviour’

<table>
<thead>
<tr>
<th>Normal Range of Findings</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appearance</strong></td>
<td>Sitting on edge of chair or curled in bed; tense muscles, frowning, staring eyes, and restless pacing occur with anxiety and hyperthyroidism. Sitting slumped in chair, walking slowly, and dragging feet occur with depression and some organic brain diseases. Restless, fidgety movements may occur with anxiety. Apathy and psychomotor slowing may occur with depression and organic brain disease. Abnormal posturing and bizarre gestures may occur with schizophrenia. Facial grimaces may be associated with such conditions as cerebral palsy, chorea, hypocalcemia, tetanus, pain, tardive dyskinesia, tic disorder, and Tourette’s syndrome. Dress can be inappropriate with organic brain syndrome. Eccentric dress combination and bizarre makeup may occur with schizophrenia or manic syndrome. Unilateral neglect (total inattention to one side of body) may occur after stroke. Inappropriate dress, poor hygiene, and lack of concern with appearance occur with depression and severe Alzheimer’s disease. Meticulously dressed and groomed appearance and fastidious manner may occur with obsessive-compulsive disorders. Note: A dishevelled appearance in a previously well-groomed patient is significant.</td>
</tr>
<tr>
<td><strong>Posture.</strong> Posture is erect, and position is relaxed.</td>
<td></td>
</tr>
<tr>
<td><strong>Body Movements.</strong> Body movements are voluntary, deliberate, coordinated, smooth, and even.</td>
<td></td>
</tr>
<tr>
<td><strong>Dress.</strong> Dress is appropriate for setting, season, age, gender, and social group. Clothing fits and is put on appropriately.</td>
<td></td>
</tr>
<tr>
<td><strong>Grooming and Hygiene.</strong> The patient is clean and well-groomed; hair is neat and clean; women have moderate or no makeup; men are shaved, or beard or moustache is well-groomed. Nails are clean (though some jobs leave nails chronically dirty). Use care in interpreting clothing that is dishevelled, bizarre, or in poor repair; piercings; and tattoos, because these sometimes reflect the person’s economic status or a deliberate fashion trend (especially among adolescents).</td>
<td></td>
</tr>
<tr>
<td><strong>Behaviour</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Level of Consciousness.</strong> The patient is awake, alert, and aware of stimuli from the environment and within the self and responds appropriately to stimuli.</td>
<td></td>
</tr>
<tr>
<td><strong>Facial Expression.</strong> The expression is appropriate to the situation and changes appropriately with the topic. There is comfortable eye contact unless precluded by cultural norm, e.g., for members of some Aboriginal cultures. <strong>Speech.</strong> Judge the quality of speech by noting that the patient makes laryngeal sounds effortlessly and makes conversation appropriately. Note whether the voice is raised or muffled, whether the replies to questions are one-word or elaborative, and how fast or slow the patient speaks. Normally, the pace of the conversation is moderate, and stream of talking is fluent.</td>
<td></td>
</tr>
</tbody>
</table>

The first and most readily visible feature in this text is a sort of problem of subjectivity. The mental health assessment appears to be largely hinged on the subjective interpretation of the assessing nurse in all of its domains, including appearance, behaviour, cognitive and intellectual function, insight, judgment, and thought process. Correspondingly, it would be difficult to read this text and ignore its highly subjective language, for obviously, what constitutes relaxed, clean, well-groomed, moderate, and appropriate greatly varies among observers. Compare this, for example, to the nursing assessment of the cardiovascular system, where the nurse auscultates over the patient’s chest and observes the rate, rhythm, and any audible arrhythmias of the heart.

The language of subjectivity in the mental health assessment permits the insertion of the assessor’s biases and the superimposition of his or her values as a normative baseline for the ‘assessment’ of appearance and behaviour. Herein lays the permission for the practitioner to categorize ‘colourful make-up,’ for example, as aberrant behaviour, if not a direct sign of mental illness. The slippery slope of this sort of subjective permissibility goes on to take jurisdiction over not only appearance, but behaviour, thought process, and various other social dimensions of the individual.

Practitioner subjectivity is further concretized using various application exercises throughout the chapter. To that effect, the following excerpt constitutes an assessment exercise designed for the nursing student’s compiling ‘subjective’ and ‘objective’ data in order to diagnose and plan interventions:
Again, the subjectivity problem is clearly visible in the above application exercise, but appears even more entrenched on further examination. Peculiarly, subsumed under the subjective section are such data bits as socially inappropriate behaviour, daughter reports, hygiene and grooming have decreased, according to her husband, and force her into conversations. It would seem that what is meant by ‘subjective’ here is not at all the subjective experience of the patient, as one would assume. Rather, what is considered subjective are simply any data gathered by means of asking questions. This includes asking questions of anyone, which may or may not include the patient. Consequently, the patient account is rendered altogether absent and replaced by that of the daughter, the husband, and whomever else may find the patient’s behaviour ‘socially inappropriate.’
The author then goes on to suggest ‘areas of focus,’ based on these two ‘levels’ of data. Four such ‘areas’ are suggested, and these are: Confusion, impaired social interaction, impaired memory, and wandering (Weaver, 2014, p. 97). Moreover, outlined are ‘nursing diagnoses,’ and they include: Risk for self-directed violence and other-directed violence and impaired social interaction, among several others.

What the reader is instructed to do here is make a number of uncritical leaps: The first is to take as subjective what is not remotely subjective. The second leap has to do with interpretation and the insertion of professional subjectivity. This is where the assessor takes the reported and the observed and ‘judges’ them against a set of pathological categories (see Figure 5, right-hand column). The third and final leap is a diagnostic leap by which the assessor is directed to formulate, in problem-based language (read psychiatric discourse), nursing diagnoses in order to generate interventions for each.

The human condition is not only fractured into quasi-scientific bits of information and psychiatric categories, it is completely superimposed by that of professional ‘judgment.’ The sufferer’s perspective, the most important ‘source of information’ in the assessment, is rendered irrelevant and only incorporated as falsely identified ‘subjective’ data, thoroughly diluted by the perspectives of the family, the professional, and so on.

**Tenor: Reader-Writer Relations in the Mental Health Assessment**

Minimally, we know thus far that professional subjectivity is sanctioned as a legitimate part of the ‘mental health assessment.’ It is, as it would appear, woven within the scientific language of ‘mental health,’ ‘nursing diagnoses,’ and so on. But there is more to this text. There is more, whereupon examining its tenor, we can decipher how something such as professional subjectivity becomes an unquestionable assumption in nursing assessments. The question to
address here is: How is the insertion of the professional’s subjective interpretation made, on the one hand permissible, and on the other, a monologic, inarguable reality for the student? To begin answering this question, we must examine the linguistic interpersonal dimension—the relations (tenor)—created between the writer and the reader by way of how the language is constructed. One way this is done is by examining the text’s grammatical mood and modality (Fairclough, 2003). I do not carry out a full SFL analysis of the mental health assessment here, as it is beyond the scope of this project. I have, therefore, diagrammed and marked in red the ‘path of analysis’ taken in order to begin to answer the above question (see appendix D). This ‘path’ of analysis on this sample text is sufficient in order to give us a flavour of the relations deployed in language, later to situate them more solidly in and understand them in the context of the institution.

**Grammatical mood.** Three types of sentences identify grammatical mood in language: Interrogatives, declaratives, and imperatives. Imperative phrases give orders and demand action from the reader or listener. The mental health assessment is for the most part linguistically designed to give matter-of-fact orders by way of imperative statements, deployed as orders, not dissimilar to what is traditionally known as the ‘doctor’s orders.’ Here is an example (command verbs underlined):

<table>
<thead>
<tr>
<th>Figure 7. Imperatives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Record</strong> the patient’s explanation verbatim to describe the reason for the visit. <strong>Be</strong> knowledgeable of the psychiatric diagnoses (DSM-V) provided by the attending physician/psychiatrist. <strong>Ask</strong> about what the patient understands about the need to visit your agency. <strong>Note</strong> childhood diseases, surgeries, and trauma (especially if any resulted in concussion or loss of consciousness). <strong>Ask</strong> about parental use of alcohol and drugs, birth trauma, any pattern of injury suggestive of any childhood abuse or neglect, and any obstetrical history. <strong>Ask</strong> specifically, “Have you ever experienced or witnessed anything that threatened your life or safety or the life and safety of a loved one?” if the answer is “yes,” <strong>ask</strong> for details, keeping in mind that psychological trauma is associated with many mental disorders (e.g., anxiety and depression).</td>
</tr>
</tbody>
</table>

Other frequently used command verbs include: *Inquire, point, use, assess, say, sort, cluster,* and *conduct*. The various command verbs, underlined in figure seven above, give a flavour of the text’s grammatical mood. Designed remarkably similar to an instruction manual, the mental health assessment in this way, is made to be the ‘how-to’ for the ‘investigation’ of and the ‘discovery’ of mental illness.

Imperative statements present an authoritative, monologic account for what constitutes mental health and mental illness, and what to do about the latter. We can begin to see this sort of linguistic ‘ordering’ as a symptom of the rigidity of the disciplinary nature of nursing education (examined later).

**Grammatical modality.** Another example follows below. Underlined are the expressions relevant to the marking of modality.

---

of the scientific legitimacy of mental illness, its impact on Canadian population health, and the consequent need for urgent intervention. This ‘certainty’ is even seen in the predictive statement: *One in three are expected to experience a mental health problem.* Where one might expect making predictions on the level of population health should be marked by some degree of reservation, given, after all, it is only a prediction, the author here instead makes an absolute assertion while drawing on Health Canada to legitimate her claims.

Interestingly, however, the last underlined expression, marked with the modal verb *can* appears as the only one isolated speculative phrase with respect to the cause of mental illness. Embedded among absolute assertions, this has at least one major implication: While the author almost never speculates about the biological origin of mental illness (See page 83 of appendix B), she appears to do so here. That is, throughout the mental health assessment chapter, it is made clear that the definition of mental illness is derived from psychiatric texts, with the ‘social dimension’ as an add-on. The medical discourse is front and centre—the dominant discourse by which to understand mental illness—speculatively and parasitically followed by the social.

As with the grammatical mood analysis, the sort of modality analyzed here is repeated throughout mental health assessment chapter. Grammatically, its sentences are abundantly marked by an absence of modal verbs, often constructed as absolute matter-of-fact statements. Taken together as the beginnings of a critical discourse analysis of the mental health nursing literature, the analysis of grammatical mood and modality reveals important tenor characteristics to the nursing mental health assessment. These linguistic characteristics help facilitate the text’s deployment of its ideological orientation in a surreptitious yet a matter-of-fact way.
Background Assumptions: Ideological Loading in the Mental Health Assessment

Briefly examining the mental health assessment using a functional grammatical lens allows for some explanation of how professional subjectivity enters mental health nursing discourse. Moreover, and beyond the overt problem of professional subjectivity, we can begin to appreciate how the construction of the language in the assessment can create reader-writer power relations in specific ways. These relations maintain a certain status quo as they deploy a certain ideological bent.

But what does all of this tell us in terms of the common sense or background assumptions of this text? What exactly is this ideological stance that is being transmitted by way of specific lexical and grammatical structuring? An imperative-laden instructional text such as the mental health assessment appears to assume that the reader is an ‘empty’ shell into which knowledge is mechanically deposited. The reader must be assumed to be of the highest level of passivity, given the mood and modality of the text. This is an important distinction as we begin to appreciate how a certain docility is being created in the nursing academy. The reader, then, is assumed to be a receptacle into which ‘legitimate’ content is routinely deposited, to be tested later in a transactional, ‘banking system’ style of education (Freire, 1971/2000).

To recap, at this point, we have begun to pick up major problems in the mental health assessment, first by way of examining its subjective nature, and second, by examining its linguistic construction and the reader-writer power relations that this construction creates. By way of examining grammatical mood and modality, we have begun to see how these relations also serve to legitimate the discourse of psychiatry, and his legitimation is one of many ways the discourse is reproduced. Legitimacy is also achieved, as we will see in the next section, by discursive hybridity (Chouliaraki & Fairclough, 1999), or what Bakhtin (1986) might term...
speech genres. Following is an analysis of discursive hybrids as they appear in and are operationalized by nursing education.

**Discursive Hybrids and Linguistic Genres**

Discursive hybrids appear in many forms in nursing mental health education. The blending of psychiatric discourse with other discourses is found in many situations, such as in spoken language, written language, and in various visual depictions. These hybrids, in whatever form they materialize, come about as a result of the combining of one or more discourses with psychiatry, either lexically, grammatically, visually as in with the use of photographs and video media, or various combinations of the three modes. What results is a hybrid, or a sub-discourse of psychiatry. Analysis of hybrids—their development and their use—is important in understanding how psychiatric discourse is further legitimated. Below is a simplified diagram of how hybrids might come into existence:

![Figure 9. Interdiscursivity: The emergence of hybrids](image-url)
Hybrids manifest in speech and in the literature in at least two ways: In written and spoken language as well as in depicted media. Discourses most frequently hybridized with psychiatry include: Neurology, pharmacology, epidemiology, diagnostic imaging, and discourses of risk, safety, security, and surveillance. What follows is a discussion of some examples of the hybrids which materialize in mental health nursing education, beginning with those that appear in the nursing literature.

**Hybrids in the Literature**

Let us return to Figure eight. As we reexamine this text now, we can see legitimation work in at least two ways. Drawing on such institutions as Health Canada, the Public Health Agency of Canada, and the World Health Organization grounds the author’s claims in the authority of State and global discourses. Given their discursive and institutional power, their insertion is in its own right, a legitimation strategy. What is more, however, is that the solicitation of such institutions also brings along with it an ‘epidemiological’ way of seeing and thinking. What is inserted into the discourse of psychiatry are the discourses of epidemiology and public health. That way, psychiatric discourse becomes, like any other medical branch of medicine, one that is understood in terms of the material impact on people and societies. As it goes for understanding obstetrically, for example, that a pregnancy in late maternal age in a woman who is diabetic constitutes a ‘high risk pregnancy,’ mental illness is similarly understood on these demographical/epidemiological terms. Thus, such concepts as bipolar disorder and schizophrenia are lent epidemiological, thus, scientific legitimacy when written about as among the leading causes of disability globally. This sort of hybridity legitimates psychiatry by masquerading it as scientific and a legitimate branch of medicine.
Discursive hybrids appear not only in written text, they are also constructed using other media. Refer to the figure below as an example of a photographically-represented hybridity:

Figure 10. Brain imaging


The figure above depicts a hybrid of the discourses of psychiatry, neurology, pharmacology, and diagnostic imaging. While linguistic hybridity achieves one sort of legitimation of psychiatric discourse, photographic media legitimates on another level. It presents, with the highest level of objectivity, a visual and a scientifically irrefutable piece of evidence in support of the biological legitimacy of mental illness. Harnessing the objective optic power of the PET scanner, psychiatric discourse makes a visual imprint on the consciousness of the nursing student. Looking at the adjacent written text, note the synonymous use of the patient’s being well with her being treated with medication, a discursive conflation of two very different ideas. Moreover, the equating of the brain’s prefrontal cortex as being ‘active’ (a metaphor) with wellness is another uncritical ‘leap’ that the reader/viewer is instructed to make here.
Hybrids in Speech

Chouliaraki and Fairclough (1999) define hybrids as “linguistic differences [that] ‘realize’ different ‘genres’ (a genre is a type of language used in the performance of a particular social practice)” (p. 56). Hybrids are ubiquitous throughout the nursing academy. I observed them during lectures, the students fluently conversed in them, and the faculty members articulated psychiatric discourse largely by making reference to other discourses. Consider the following field note as an example, taken during a student presentation:

Presenter states: “Sometimes patients do not disclose their thoughts that they are suicidal. Sometimes they are at risk and you don’t even know it.” Later, the presenting student suggests that it is only through the building of what she terms therapeutic relationships that nurses are able to “find out the thoughts” of their patients and implement interventions, such as revoking pass privileges and secluding and/or restraining patients.”

Marked in bold are words and phrases which belong to discourses of safety, suspicion, and surveillance. Also note the insertion of therapeutic relationships, another legitimating institutional discourse known as the Therapeutic Nurse-Client Relationship discourse, deployed by the College of Nurses of Ontario (This is discussed in greater detail in the next chapter). The larger context of this excerpt is a student presentation on mental illness and addictions during which the students outlines assessments, plans, and interventions for the mentally ill/addicted patient.

Students become trained in speaking in this hybrid way, in this case, by invoking a sense of urgency and alarmism by way of inserting language of safety and surveillance in order to
heighten the importance and hence, lend legitimacy to psychiatric discourse and an ostensible necessity for its interventions.

Educators conversed rather liberally using a variety of psychiatric hybrids. This was whether to describe their own experiences in mental health clinics, the teaching work that they do in the area, or simply to articulate their viewpoints on what constitutes mental health/illness. Following are two quotes demonstrating this.

In response to my asking what mental illness was, the following faculty member, while drawing on the discourse of neurology and human anatomy, observes that

Thoughts come from the brain. And just as the heart can be sick or the stomach can be sick, we believe the brain, which produces thoughts, feelings, and emotions, can also be sick.

Note the reification leap made between the brain (material reality) and thoughts, feelings, and emotions. Note also this reification’s consequence in the form of metaphoric confusion between the ‘brain’s being sick’ and ‘thoughts, feelings, and emotions’ also being sick.

While discussing a teaching experience, another faculty member fuses discourses of safety, self-harm, and surveillance in her mental health lectures, noting that

It’s hard for students to identify mental health patients and promote patient safety. I was able to include it in a discussion on perspectives in year four using the label of ‘patient safety.’ Until then, if a nurse is not able to identify a patient who is at risk for suicide or overdose, it’s a problem for nursing as a profession because I can do a makeover using the structure of the NCLEX to talk about patient safety. That’s why I bring it up, because the issue of mental health safety was not there.
Discursive hybrids were second-nature to students and faculty members. They fluently conversed in them both as interviewees and in dialogue with one another, and the case of faculty members, also as educators as they taught their lessons. These hybrids, not unlike those which emerge in combination with other such branches of medicine as cardiology or nephrology, for example, are indeed expected. Given the interdiscursive nature of scientific and medical discourses, these hybrids are indeed the overwhelming way in which students, faculty, and clinicians communicate. The only trouble here is that for such a problematic discourse as psychiatry, it successfully blends in with the scientific and the objective as a legitimate branch of medicine, with it, reifying the metaphor of mental illness.

Language: Consequences on Nursing Knowledge and Practice

So far, we have begun to see how psychiatric hybrids manifest in the mental health nursing literature and in spoken language. We can, therefore, at the very least conclude that institutional talk is to some degree made up of hybrids of various discourses, some converging as a ‘stable language,’ or an independent genre. That is, the language of the mental health nurse comes together a construction of an eclectic hybridity of discourses, among which psychiatric discourse sneaks in and manifests as any other branch of medicine.

But psychiatric discourse is no exception, given that in any other specialty area of nursing practice, hybrid talk is an everyday phenomenon. This is true of even ‘non-specialty’ clinical places such as the emergency department. It is very common, as I came to observe over my 10 years of emergency nursing practice, that clinicians converse in an overwhelmingly interdiscursive fashion. As an example, in the case of a team discussion around a teenaged boy with a head injury, often what factor in are discourses of legislation, risk-taking, and illegal drugs and alcohol. But this sort of cross-discourse referencing or contextualizing, as in the example of
a head-injured boy, is necessary. In order to mobilize prevention strategies, it is important for emergency practitioners to understand, on some level, the mechanism of such injuries to young men and their socioeconomic demographics, hence the invoking of multiple discourses. It is a different story altogether, however, that for such a problematic discourse as psychiatry, hybridity with other discourses results in much less ‘prevention’ and ‘health promotion’ and more discursive legitimation, the insertion of professional subjectivity, and of course, patient subjugation and oppression.

The structuring of the mental health literature in nursing education grooms nurses to carry out psychiatric practices imbued with a specific ideology. Nursing students are taught (commanded) that the professional’s subjectivity reigns during the mental health assessment, that that of the patient is insignificant, and that despite the stark lack of objectivity, psychiatric discourse is in fact, in a common-sense way, scientific and legitimate.

**Zooming Out and Concluding**

This language analysis is not meant to be exhaustive. Rather, it is the beginnings of an understanding of how this text and other mental health nursing texts alike deploy relations of power and legitimacy as they construct the discourse of mental health and mental illness for the nursing student. It is a glimpse into the complex socio-linguistic and institutional circuit of nursing education. This language analysis is one method that helps unveil how ideology is deployed by way of texts. The textual excerpts I provide above are not to be taken in isolation of the larger institution in which they are embedded. That is, while these linguistic strategies are neither unique to this text nor other mental health nursing texts, what makes them relevant here is their being situated among other discursive and institutional relations with which they are in dialogic interplay. The mental health assessment, therefore, must also be seen in a general sense,
as a ‘ruling’ text (Smith, 2001 & 2005), located in an institutional web of relations and work processes, working as a system that further legitimates and perpetuates psychiatric discourse. The language and the institution work in synergy as they reinforce one another in the delivery of the ‘message’ and along with it, the ideological orientation of the text. The success of the transmission of psychiatric discourse and its penetration deep into nursing consciousness is dependent in one part on its strategic linguistic construction and in another on the institutional practices which authorize and disseminate it.

What exactly are these institutional practices? What are the relations between the social actors in the nursing academy and how do they figure in the construction of nursing mental health discourse and education? How does the mental health assessment factor in this institutional circuit of relations and other mental health and policy texts? How is this institutional circuit governed? How does it gel? I pursue these questions in the following chapter, as I turn my attention to the institution of undergraduate nursing education.
Chapter Five

Institutional Relations, Textual Relations, and the Discourse of Undergraduate Mental Health Nursing Education

We have begun to see how the disjunction outlined in the opening of this dissertation in part came to be. Starting with the very language, we have begun to unearth how the student comes to deem violent psychiatric interventions as necessary, ‘common-sense’ phenomena. By way of examining the structure and function of language, some clarity began to emerge on how the reification of mental illness and the legitimation of psychiatry play out in the nursing academy.

Picking up on the linguistic analysis from the previous chapter, in this chapter, I examine the institutional relations, the textual activities, and the various governing processes which embed and perpetuate psychiatric discourse in the nursing academy. In so doing, I draw upon curriculum development activities and local, provincial, and federal mandates and governance activities in order to map out how curriculum is governed and how the problematic mental health literature factors in. I also examine teaching practices as institutionally relevant and consequential to the reproduction of psychiatric discourse. I close with a short discussion as I return to the disjunction, the clinical difficulties, and the perspectives of students and faculty members outlined in chapter one.

The ‘Small Hero’ and the Institution

I am reminded of Dorothy Smith’s ‘small hero’ depiction (2006b), by which she diagrams the locality of the everyday social actor, positioned on the lowest rung of the institutional order. My reformulation of it below aims to demonstrate the verticality of the
institution along with the actual institutional and discursive location of the ‘small hero’ faculty member.

Figure 11. The ‘small hero’ versus the institution

This is a helpful diagram with which to begin the institutional ethnography. It is helpful to begin with the local actor—the college faculty member trying to bring about change. Its purpose is to contextualize the institutional location of the faculty member and to provide a depiction of an overview of the various institutional and discursive dimensions of this project. We have already examined, linguistically, psychiatric discourse and its colonization of nursing education. We will revisit psychiatric discourse once again, but now in terms of its institutional embedding and reproduction by the institution of nursing education.
A Brief Introduction to the Institution

Smith (2005) uses the terms *institutional* and *institution* to refer to complexes embedded in the ruling relations that are organized around a distinctive function, such as education, health care, and so on. The terms identify the intersection and coordination of more than one relational mode of ruling. State agencies are tied with professional forms of organization, and both are interpenetrated by relations of discourse, including the institutional discourses that are systematically developed to provide categories and concepts expressing the relationship of local courses of action to the institutional function. (p. 255)

A further terminology clarification might be helpful here. In this chapter, I make frequent use of the two terms *program* and *curriculum*. *Curriculum* strictly makes reference to the courses and the content found in course outlines such as the required student readings and the evaluation methods used in the various courses. *Program* refers to a broader concept which includes curriculum, but also various texts, people at various levels (students, faculty members, researchers, support staff, and administrators), their relationship to one another, their work knowledges, and the relevant local and extralocal work processes comprising all these elements.

The undergraduate nursing program is a highly complex and highly developed program with political limbs that link it up to various extralocal institutional structures and practices. It is constructed of people, processes, curriculum policy, and ‘strategic’ business texts, all in dialogic interplay with one another, all functioning as a system to maintain its ongoing integrity. These various institutional factions work in a status-quo-maintaining collective. And while minor changes have come about over the years, its curriculum has largely remained the same since its inception in early 2000. The program can be conceived of as having various local processes that
are articulated to or they themselves extend into extralocal governance and management spaces. To start, let us examine the program, beginning with its very inception.

**Formation**

The program came into existence in early 2000 under an ‘agreement’ between a college and a university partnership, hereafter referred to as the Contract. The Contract, as a central document, came to stipulate specific roles, responsibilities, appointment procedures of committees, funding distribution, program and curriculum management, and other governance activities.

With respect to curriculum, the Contract commenced a cascade of processes which would come to govern curriculum both locally and extralocally. Two committees, which would to some degree authorize the program’s curricular revisions, were struck and have since been pivotal in the maintenance of the ‘quality,’ the ‘integrity,’ and ‘currency’ of the program. These two overarching committees would go on to become the highest level of authorization for the sort of ‘local’ curriculum modification activities in the collaborative structure. They consist of leadership personnel from various levels and some student representatives.

It is based on this Contract that the program was erected and in accordance with the authorization of the two overarching committees (hereafter referred to as the curriculum-specific and the overall program committees), that the tone for the nursing curriculum was set. As a local structure of governance (see Figure 11), the Contract and the activities it set in motion laid the foundation for relations imbued with unequal power distribution and competing interests in the nursing academy.
Early Problems: Division of Teaching Work

To begin to etch away at the problematic with which I began, we will need to understand the program’s structure and the division of coursework among the partnered institutions. This is an important first step because it helps unveil a certain institutional logic and the difficulties it creates for some faculty members as others enjoy a certain privilege, also known as academic freedom.

Students apply and gain admission to the program via the college or directly into the university. Upon completion of the first two years of the degree, the college-site students transfer to the university for their third and fourth years of the program. While students are attending their respective schools in the first two years, they are taught by the faculty hired by that school. When the college students transfer to the university in their third year, however, something peculiar happens. The college faculty remain responsible for the clinical supervision of third and fourth year student practicums, but lose the ability to teach the theoretical courses to those students. This includes all elective courses for those years. While I had long attributed this problem for the college partner to ‘organizational culture’ and ‘tradition,’ it was not until I examined the Contract, in which I came to discover specific language that outlined this work division. This foundational text, it seems, gave birth to a historical practice which came to dictate this sort of division of teaching work and privilege for many years to come.

This was very consequential for college faculty teaching in the program. From a curriculum modification and development perspective, this meant that college faculty had no control over and little to no input into any of the theoretical courses in the second half of the program. For a faculty member looking to affect change in mental health content, for example, this meant doing so in a fragmented, incomplete, and arguably ineffective manner. While small
and incremental changes can indeed be made in the theoretical courses in the first two years of the program, given these are scientific and foundational courses, very little critique can happen here. Given all first and second year courses are considered nursing core courses (not counting the nutrition, psychology, and sociology, as they are not taught by nursing faculty [see Appendix C]), any proposed change to their content would require the authorization of all faculty members teaching these courses. It is not uncommon that such teams consist of an upward of 10 or more faculty members per course, each weighing in with his or her own agenda and interests.

It is in the latter half of the program, however, where a number of elective courses are offered and substantial critique and control over curriculum might be possible. Professionally-related elective courses (in the latter half of the program) are taught by university faculty members who possess the autonomy to shape these courses in whatever way they so choose. University faculty also have the freedom to introduce new courses, whereas college faculty do not. The point is that due to the Contract’s mandate, college faculty are prevented from teaching theoretical courses in years three and four, and their ability to influence curriculum is severely limited.

A second problem: The creation of a course leader and the authority which he or she is given. A course leader is defined in the Contract as a faculty member with the responsibility to teach a nursing core course and to coordinate the development, the review, and the revision of the curriculum of such a course in consultation with other faculty members teaching the same course. The most obvious problem here is that a hierarchy is being created whereby the course leader is essentially in charge of the course, with other faculty members drawn upon as peripheral ‘consultants.’ This locates curriculum control in the jurisdiction of one faculty member, with others acting as adjuncts.
A third problem: The criteria by which the course leader is selected. The Contract outlines that the decision around such appointments shall take into consideration the appointee’s academic background and teaching experience in the respective subject matter. While it is a fair criterion that a course leader ought to possess experience in the course which he or she is leading, what presents a problem, however, is the criterion of ‘academic background.’

It is a well-known fact that university faculty are much more academically prepared than community college faculty. In the collaborative program specifically, the college at which I formerly taught has no doctoral-prepared faculty members, whereas all those at the university are. Moreover, it is generally the case that university faculty engage in more professional development and scholarly activity to bolster their academic background and their programs of research than do college faculty. This automatically places college faculty members at a disadvantage for obtaining course lead appointments. While it is possible that both university and college faculty can have a similar substantive area of expertise, effectively qualifying both for course lead appointments, given the high level of scholarship of university faculty, it is they who hold the competitive advantage for these appointments. It is not a wonder that over the many years I taught in the program that almost all course lead faculty appointments were of university professors. This sort of classist division of labour adds up to an even more entrenched difficulty for the college faculty member. This very early establishment of social order among the institutional partners came to be the status quo over much of the program’s operations for over a decade-and-a-half to follow. It seems that with my acceptance of my college faculty position, I also entered into pre-established textually-sanctioned relations which would negatively impact my career development and severely restrict my academic freedom.
Given this sort of prescribed organization of work, how are critical college faculty who are passionately invested in transforming nursing knowledge to influence curriculum? How are they to rupture out of this seemingly seamless and tight institutional order? The obvious answer is for them to obtain advanced degrees and training in a particular field, attain university appointments, and by virtue of their status, become involved in curriculum change. But what will remain of the college if that were to happen? Will the college partner in such a case be relegated to the academic ghetto as an appendage to the university? That aside, however, and even if college faculty became decolonized from psychiatry and went on to attain university appointments in the hopes of radicalizing nursing education, they will come face-to-face with yet another, more diffuse local structure of governance. It is this structure which generally outlines the who, the how, and the when of curriculum development at any point in the program across the institutional partners. In the following section, I discuss this curriculum administrative process and its impact on nursing knowledge and the teaching work for both the college and the university faculty member.

Maintaining Order: The Curriculum Administrative Process

As we begin to understand how the college faculty member becomes restricted to specific textually-mediated work, we can begin to appreciate how difficult it would be for him or her to influence curriculum, much less radically tackle such a problematic discourse as psychiatry out of it. Some questions that might be asked at this point are: If college faculty have little to no influence on curriculum and little to no impact on discursive shifts in the program, then what of university faculty? Given their privilege within the collaboration, why is it that they do not affect change? Why have they not critiqued psychiatric discourse and begun a discursive shift?
Contract-created problems are, it would appear, the tip of the iceberg. The institutional order deployed by the Contract which sets forth the division of teaching work is but one influential local process. While the above-discussed historical events came to shape work organization in an unfavorable way for the college faculty, there is another, larger system at play that needs to be explicated here. A number of other institutional factions which intersect with the work of both college and university faculty must be brought to the fore. These are various other institutions, processes, and events which at face value would appear irrelevant to curriculum. An examination of their interests, however, not only proves otherwise, it reveals their necessity—the necessity for their governance, their relevance, and their authorization of the various discourses that shape nursing curriculum, psychiatry included. First, I begin with a quick and necessary clarification of what does not have jurisdiction over curriculum. This is a finding which stands contrary to what I and other faculty members believed.

**Curriculum Policy: Ironically, what does not Govern Curriculum**

As outlined in the Contract, all curriculum modifications are governed by university policies. Naturally, in order to understand how curriculum development work is authorized, I poured over the university policy that governs curriculum modifications to existing undergraduate and graduate program curricula. I was surprised to discover that short of unrecognizably reconfiguring the curriculum altogether, most curricular modifications did not require the permission of the university’s senate (the academic policy-making body of the university and the highest level of approval for curriculum modifications) and thus are not subject to governance by this policy. Such curricular modifications as changes in course descriptions, the addition or deletion of courses, and repositioning of courses in a program are considered minor, whose jurisdiction for governance lies at the level of the school of nursing.
Course content, as it were, does not seem to factor into the policy’s authorization, and rightly so. Course content modification is left to individual faculty and faculty teams, under the auspices of ‘academic freedom,’ or so it seems.

If the university senate has little to no influence on curriculum, who then does? I pursued this question for the better part of a year while I spoke to colleagues and managers and poured over other institutional policy, various curriculum guideline documents, and a number of provincial and federal legislation documents. I discovered that curriculum development authorization is less straightforward, rather crude, and most of which is achieved extralocally.

Before we delve into the extralocal and the most consequential dimension of the institution, however, let us first examine one ‘relatively’ local work process: The school’s curriculum decision-making algorithm. It is ‘relatively’ local because it functions as a sort of institutional bridge linking the internal workings of the program to extralocal structures of governance and institutional work.

**The Hierarchy of Curriculum-Based Decision Making**

In the Contract, outlined are the two overarching committees I have briefly discussed. These two committees came into existence shortly after the inception of the program. Two other subcommittees were also created along with a process which joined the four decision-making teams to form a curriculum administration hierarchy. Located at the very bottom of this hierarchy are the student and the individual faculty member. The four committee structures generally form the basis for all executive decisions around course content and structure. Below is a simplified diagram depicting their relationship to one another and to the student and faculty member.
If we ignore the overall program committee for a moment, there would be little that is unique about the above map, for it follows a typical institutional hierarchical structure. The curriculum-specific committee—the highest level committee—has authorizing power over what the lower level subcommittees and local actors ‘recommend.’ Membership in the curriculum-specific committee comprises mainly of leadership faculty and some student representatives. Subcommittees A and B also comprise of leadership members from the school and are afforded with the power to review and recommend curriculum modifications to the overarching committees. The curriculum-specific committee has the final say over curricular changes, whereas the overall program committee possesses a more unique role, allowing it more diffuse control over curriculum.

It is important to note that course-specific curricular changes are not subject to this approval process, given they are done at the level of the course-specific teams (headed by a course lead). The approval process depicted in this map relates to recommendations made by the overall program committee. These recommendations are based on its ‘evaluation’ of the
program, a process which involves the committee’s seeking feedback from faculty, students (via faculty and course evaluation forms), and external partners such as health care and community agencies where students complete clinical practicums. Despite the student and faculty’s appearance as independent feedback providers, their feedback is transformed into the genre of program evaluation ‘data’ gathered by the overall program committee, analyzed, interpreted, and fed up to the curriculum-specific committee in the form of ‘recommendations.’ What is noticeably lost here are the actualities of the student and faculty, as it were, and their nuanced everyday experience. Experience is abstracted, generalized, and transformed into institutional discourse. This sort of local curriculum-specific institutional order categorizes the perspectives of students and faculty as mere ‘data.’ The overall program committee’s work reverberates across the program’s four years, and outward into various community and healthcare agencies and professional bodies, hence its local/extralocal connection.

By way of this ‘evaluation,’ ‘analysis,’ and ‘interpretation,’ the committee helps ensure that graduates are ‘prepared for nursing practice.’ But what exactly does ‘prepared for nursing practice’ mean? Of course, the obvious, and I would add, more popular answer is that graduates are to be equipped with the skills and the knowledge needed to provide safe and effective bedside nursing care. But there is more. There is more to this ‘preparation’ than meets the eye. There is more to it than such fleeting buzz words and institutional concepts as ‘prepared,’ ‘safe,’ ‘competent,’ and so on.

**Enter External Partners**

In its evaluation efforts, the overall program committee gathers data provided by the partner agencies affiliated with the school of nursing. These agencies are the clinical and community partners who have agreed to taking on nursing students for clinical practicums. Most
of these agencies have a longstanding relationship with the school of nursing. To name a few, these are acute care institutions such as hospitals and urgent care centers, community health clinics, and primary and secondary schools. As part of an ongoing program evaluation effort (set forth in the second decade of the program’s implementation), the program seeks feedback from these agencies related to student and institutional needs. For example, if a psychiatric agency notes that the students lack basic knowledge and skill in de-escalation techniques, it would inform the school of nursing during one such evaluation, who in turn would act upon it by making recommendations for curriculum change to address an identified ‘gap’ in knowledge and skills. A more specific example of this follows.

**The Acute Psychosis Unit: “Students Unaware of Risks.”** In order to begin to appreciate how psychiatric discourse makes its way into nursing education, we need to momentarily step outside the curriculum and take a look at the clinical partners of the university. Specifically, we need to understand, beginning with the relationship between psychiatric agencies and the school of nursing, what the program evaluation, at least in part, achieves.

The program seeks information (Figure 12) from the psychiatric agency related to student competence and preparedness for practice, including areas of challenge and new areas of practice implementation and change. The program is less so interested in the agency’s appraisal of the student’s competence (this is left to the preceptor and the supervising faculty), and more so in trends in student learning needs and agency practice changes.

Let us take an ‘acute psychosis’ unit of a tertiary hospital as an example. In the course of one academic year, the unit preceptors and clinical educator (a nurse hired by the clinical agency who is responsible for the educational needs of the unit staff) note a knowledge and skill ‘deficit’ in the students. They notice that the students often engage, in close proximity, in idle
conversation with the patients. They conclude that the students lack the knowledge on how to assess clinical risk level, specifically, risks posed by the ostensibly volatile and unpredictable mental patient. This information is then fed back to the school of nursing via surveys, questionnaires, and verbal feedback from supervising faculty, which is then taken up by the overall program committee and incorporated into the local curriculum administration process (Figure 12). This would in turn inform the curriculum-change recommendations that the overall program committee would make to the curriculum-specific committee. If authorized (and they almost always are), the curriculum-specific committee would fan out communications (often during end-of-year meetings) to course leaders, advising them to incorporate the appropriate material in an effort to respond to the identified ‘gap.’

Here is where we can see one dimension of the intrusion of the problematic psychiatric discourse we examined in the previous chapter. What we have here is curriculum being directly influenced by the clinic. We have a curriculum colonized by a well-known efficiency-driven and fiscally-oriented Canadian health care regime. Herein we have a good glimpse of how the institution ‘prepares’ its graduates for nursing practice. We begin to see that ‘preparedness’ does not necessarily mean the preparation of empathic, sensitive, and critically thinking nurses, rather those who are trained to conform to institutional clinical practices in part produced by a reactive, status-quo, and colonized curriculum. What we have here is a discursive-institutional overlap between the clinic and the academy whereby the work knowledge of students is in part being constructed by the clinic’s institutional needs rather than the academy itself, per se. This process of ‘community consultation’ (see ellipse in Figure 11) can be conceived of as a mid-range mechanism in this process of governance whereby local work and knowledge are directly affected by the arm’s-length clinical partner agencies. This process seems to have redefined
faculty to assume the role of institutional messenger. What we can also see at this point is a compounding and systematic exclusion of college faculty, first by the terms set out in the Contract, and second, in the local processes of curriculum administration.

Let us redirect our attention to another simultaneous institutional process whose origin are traced to a major event: The program accreditation review. It is this program review which set in motion a cascade of sub-processes which would further drive out faculty input and more deeply entrench psychiatric discursive colonization into nursing education.

**Looking Beyond the ‘Partnership’: Extralocal Influences**

The Canadian Association of Schools of Nursing (CASN) is the national accrediting body of nursing schools in Canada. Accreditation is said to “promote excellence and is recognized worldwide as an important, objective method to assess professional education programs” ([http://www.casn.ca/accreditation/](http://www.casn.ca/accreditation/)). Professional programs are assessed against a set of standards set by CASN. These standards take into account such aspects as the mission, goals, and the philosophy of the educational institution and professional standards of practice and entry-to-practice competencies set by the profession’s governing body. In the winter of 2014 (fictitious date), the nursing program underwent an accreditation review. It is this review and its subsequent findings which rippled through the program with enduring consequences on teaching and learning work and curriculum integrity.

**“Deficiency in Mental Health Content”**

A substantial amount of work went into preparing the program for the review. A number of committees were struck and frequent accreditation-specific meetings took place. Over the year preceding the accreditation review, updates on the accreditation preparedness process were included into the agenda of every regularly-scheduled faculty meeting. The program strategic
plan was ‘updated’ and was circled among management personnel and faculty members. Priorities shifted to focus on ‘lining up,’ the program as closely as possible with the CASN accreditation standards. Needless to say, the accreditation review prompted a flurry of activity which would continue indefinitely.

Among a long list of evaluative goals, it is said that “accreditation identifies strengths and opportunities for improvement” (http://www.casn.ca/accreditation/casn-and-accreditation/). The accreditation reviewers found, among others, two major problems: A mental health ‘gap’ in the curriculum, and an alarmingly high registration exam failure rate of its graduates. And based on certain criteria set by CASN, the reviewers suggested various recommendations, and among them were a number of curriculum-specific ones. One of the recommendations made based on the 2014 program review was to redress a ‘gap’ in mental health content. Given the implications of accreditation and the need to meet accreditation standards, the program needed to readily and aggressively respond to the identified problem, which may place it at risk for failing to secure accredited status.

The school of nursing began a set of initiatives as a response to the accreditation review. At the time that the data collection for this dissertation project came to an end, the school of nursing was in full swing preparing for a complete program overhaul and curriculum redevelopment. Therefore, it is unclear exactly how this ‘gap’ will be redressed. However, if we recall the discourse analysis from the previous chapter, we can logically conclude that given the degree of colonization, any attempt to address a ‘mental health gap’ will result in further colonization of nursing by psychiatry. More psychiatry-colonized literature will be introduced. More psychiatry-specific clinical agency partners will be secured for student practicums. On a discursive level, this clearly augments the discourse of psychiatry and its superimposition further
onto nursing education. On an institutional level, the status quo will continue to be maintained, and the CASN recommendations ‘tick box’ will have received its check mark. Then onward it is with the production of psychiatry-colonized nurses and with the reproduction of mental illness.

**Student Registration Exam Failures: A Program ‘Vulnerability’**

The accreditation reviewers also identified the high rate of registration exam failures as a ‘vulnerability’ of the program. Given this was also a previously-identified problem in an earlier self-initiated program review, it makes its resolution even more urgent and that much more necessary.

The College of Nurses of Ontario (CNO) makes available to the public school-specific statistics on the nursing registration exam pass rates in the province. In 2015, the CNO published a report outlining provincial (Ontario discussed here) average pass rates along with the pass rates of all nursing programs in the province. Ontario’s 2012/2013 provincial average pass rate was 82% whereas that of the program for the same period was just over 65%. The accreditation review took into account this demonstrably low passing rate and waved a stern warning finger at the program, recommending aggressive remediation. What is more is in January of 2015, a completely new registration exam was implemented (the National Council Licensure Examination-RN, or NCLEX, for short [pronounced en-kleks]). The NCLEX is designed and delivered by the National Council of State Boards of Nursing (NCSBN), an American-based institution. The NCSBN “is a not-for-profit organization whose members include the boards of nursing in the 50 states, the District of Columbia and four U.S. territories”

[https://www.ncsbn.org/about.htm](https://www.ncsbn.org/about.htm).

The implementation of the NCLEX would further drive the program’s pass rates to the ground¹⁰, and for obvious reasons, this was cause for concern and for immediate action. In 2011,
schools of nursing were informed of the oncoming change to the NCLEX. In 2013, a concerted institution-wide effort went into responding to the new implementation and the alarmingly low success rate of the program’s graduates. It included the striking of committees to conduct NCLEX-relevant research, attendance of faculty at various NCLEX conferences, the purchase of exam preparatory materials in support of students, and an active discussion among leadership and faculty around curriculum revisions to reflect the NCLEX.

The program, since 2013, has made its priority the exam registration pass rates. Given the reputational risks associated with their publication as well as the implications around program accreditation, this is hardly surprising.

As the program is under redevelopment subsequent to the accreditation review, how exactly the NCLEX will shape curriculum is unclear at this point. However, there are a number of characteristics to the exam that when closely examined, we can draw fairly accurate predictions on its impact on nursing curriculum. Let us take the topic of ‘mental health’ as an example.

**Psychosocial Integrity? Not Exactly!**

The Canadian Council of Registered Nurse Regulators (CCRNR) put out the first full-year publication of the NCLEX exam pass rates since its early 2015 implementation (CCRNR, 2016). In this publication, specified are various topics covered on the exam. Among the four broad categories is one peculiarly identified *Psychosocial Integrity*, defined as “nursing care that promotes and supports the emotional, mental and social wellbeing of the client experiencing stressful events, as well as clients with acute or chronic mental illness” (CCRNR, 2016, p. 6). Questions from this category, according to this report, comprise approximately 10% of the
NCLEX. Following are some sample questions from this category, retrieved from a mock exam document I used last year (NCLEX Masters, 2015):

1. A client has been taking perphenazine (Trilafon) by mouth for two days and now displays the following: head turned to the side, neck arched at an angle, stiffness and muscle spasms in neck. The nurse would expect to give which of the following PRN [‘as needed’] medication?

2. A young woman is transferred to a psychiatric crisis unit with a diagnosis of a dissociative disorder. The nurse knows which of the following comments by the client is MOST indicative of this disorder?

3. A 59-year-old woman with bipolar disorder is receiving haloperidol (Haldol) 2 mg PO tid [two milligrams by mouth, three times per day]. She tells the nurse, “Milk is coming out of my breasts.” Which of the following response by the nurse is BEST?

4. The nurse recognizes which of the following as a positive response to fluoxetine HC (Prozac)?

I have not included the answers to the above questions, as the questions in themselves are telling enough. Note the discursive overlap between pharmacology and psychiatry—the two discourses with a relatively strong partnership, as we saw in the previous chapter. Note also the linguistic confusion between psychosocial and psychopharmacological. There is little question that the registration exam’s ‘psychosocial integrity’ section stems out of psychiatric discourse and psychiatry-supported discourses. I am less interested in the language here, however, and more so in the institutional implications of this NCLEX category. That is, its authorization of a certain type of knowledge for nursing students and a specific work organization for the educator.
Little needs to be said about the impact of these questions on the knowledge of the nursing student, for it is clear that the discourses in question are those already examined in the previous chapter. It is the institutional reinforcement of such discourses, however, that is the focus here.

The CCRNR establishes a material reality which reorganizes the teaching work of undergraduate nursing educators across the province (and other provinces). It dictates that 10% of the NCLEX will consist of material generally represented by the above four sample questions. Again, given its recent implementation, the full consequences of the NCLEX on the program cannot be fully understood. However, given one of the program’s top priorities is the remediation of the high failure rate, it is logical to assume that it will very closely line up its curriculum to the NCLEX. In the 2014/2015 academic year, some consequences were indeed felt by the program faculty. Student evaluations were being redesigned to reflect ‘NCLEX-style’ testing and certain class time became regularly devoted to such NCLEX exercises as mock exams and discussion periods related to it. Near the end of my tenure with the program, I was regularly conducting NCLEX-type quizzes and tests and carrying out biweekly discussions with my students on various NCLEX-related topics. At the time, faculty and program leadership were envisioning a new curriculum, set for full implementation in the very near future. A curriculum whose growing mental health content will predictably retain even more pronounced biomedical, pharmacological, and psychiatric paradigms.

**Everyday Work and Other Extralocal Influences**

Recall the course-specific curriculum development work I discussed earlier—the sort of work in part understood as ‘academic freedom.’ It is important that at this point I return to it and situate it in what we so far have discovered about the institution. At first it would appear that
under the auspices of what is known as academic freedom, faculty (university faculty, at least) reserve the ability to modify their course content as they wish. We did see, however, that while to some degree they are able to, they are also subject to the process deployed by the curriculum administration outlined in Figure 12. Moreover, to whatever degree that they are able to influence curriculum, this influence is not without various extralocal checks and balances.

Already discussed is the CNO’s publication of the exam pass rates and its rather consequential influence on the program and its curriculum. Moreover, the College of Nurses puts out two additional ‘regulatory’ documents that heavily figure into nursing education. These are: The Professional Standards of Practice and the Competencies for Entry-Level Registered Nurse Practice. The standards, the CNO states,

outline the expectations for nurses that contribute to public protection. They inform nurses of their accountabilities and the public of what to expect of nurses. The standards apply to all nurses regardless of their role, job description or area of practice.


The Competencies document outlines the practice expectations of a registered nurse upon initial and ongoing registration with the College. These competencies, the CNO states,

serve as the criteria against which entry-level registered nurses are measured upon initial registration with the College and entry to practice in Ontario. The competencies are also used to guide the assessment of members’ continuing competence for maintaining registration with the College. (CNO, 2014, p. 3)

Given their importance, these two documents became historically woven into nursing curriculum. I have already demonstrated in chapter two, how the Competencies text becomes woven into nursing curriculum and along with it, psychiatric discourse (Figure Two).
professional standards, while they do not necessarily factor into curriculum as ‘content’ in themselves, they are to various degrees used as evaluative constructs in clinical practicum courses. The professional standards and their indicators for successful application are the criteria against which the fourth-year nursing student is assessed and whose performance accordingly in clinical practice is evaluated. One such standard is the professional standard of *ethics* (CNO, 2002). This standard outlines a number of indicators which guide the ethical nursing practice of registered nurses in clinical, education, administrative, and research environments. Faculty across the program have found this standard to be too vague to use as an evaluative component and thus have augmented it with the Code of Ethics for Registered Nurses put out by the Canadian Nurses Association (CNA) (CNA, 2008).

While the College of Nurses and the Canadian Nurses Association are not directly implicated in drawing in psychiatric discourse, they allow for a certain sanctioning of its concepts and ideas in nursing education. Take for example the following statement from the code of ethics: “Nurses respect the wishes of capable persons to decline to receive information about their health condition. Nurses recognize and support a capable person’s right to refuse or withdraw consent for care or treatment at any time” (CNA, 2008, p. 11). Knowing what we know thus far about linguistic construction and the discursive colonization of nursing literature, we can just about predict how such concepts as consent and capacity are understood. The CNA defines an incapable person as someone who “fails to understand the nature of the treatment decisions to be made, as well as the consequences for consenting to treatment or [declines] treatment” (CNA, 2008, p. 26). Little analysis is needed here to appreciate the inherent paternalism and medical-centrism of this definition. Based on this definition, capacity assessments in the case of mental health patients, it would appear, is understood through a
medical (read psychiatric) framework. Thus, a patient deemed in a ‘psychotic state’ could never be ‘capable.’

The College factors in the sanctioning of psychiatric discourse from yet another dimension. One of the standards of practice put out by the CNO known as Restraints, outlines that the first nursing responsibility lays in “understanding the client’s behavior, [given it] is essential for accurately determining the need for restraints” (CNO, 2009, p. 5). Restraints (CNO, 2009) is a standard of practice around which the College expects nurses to organize a certain amount of their work, especially in psychiatric settings. Correspondingly, faculty have picked it up and incorporated elements of it into their clinical evaluations of nursing students. Though the College currently has no jurisdiction over students, thus cannot enforce on them such a standard, it is by way of the academy that it so does. By way of textually-mediating and organizing the educator’s work, the CNO drags psychiatric discourse and embeds it into nursing education.

Another institution whose publications have come to play a major role in nursing curriculum is the Registered Nurses’ Association of Ontario (RNAO). The RNAO is “the professional association representing registered nurses, nurse practitioners and nursing students in Ontario (http://rnao.ca/about). It is said to have “advocated for healthy public policy, promoted excellence in nursing practice, increased nurses’ contribution to shaping the health-care system, and influenced decisions that affect nurses and the public they serve” (http://rnao.ca/about). In partnership with the Ministry of Health and Long Term Care, the RNAO put out its now nationally-acclaimed Best Practice Guidelines Program. The program involves a publication of a number of comprehensive documents in specific clinical areas, each said to outline “clinical excellence, using the latest research to inform practice and optimize outcomes” (http://rnao.ca/sites/rnao-ca/files/iaBPG_brochure_Engl.pdf). Since the program’s
launch in 1999, the RNAO has published a number of these guidelines, among them are a few titled: *Assessment and care of adults at risk for suicidal ideation and behaviour, engaging clients who use substances*, and *interventions for postpartum depression*. Evident in their liberal use of psychiatric concepts and theories, these practice guidelines suffer from the same discursive colonization as the nursing literature we previously examined, thus no further analysis of their language is needed here. These guidelines and others related to them have long been integrated into nursing curriculum as foundational, evidence-based pieces of work (for example, in the second year practice and theory courses).

The College of Nurses of Ontario, The Canadian Nurses Association, and the Registered Nurses’ Association of Ontario come together as a triad of extralocal structures which influence local teaching work and nursing curriculum. Faculty, in their effort to develop their respective course curricula, draw on these institutions’ texts. These are texts which have long parroted psychiatric discourse—directly or indirectly. Faculty construct student evaluation documents based on these texts in order to appraise student clinical performance. Students, by virtue of their repeated application, take in these texts and incorporate them into their consciousness as they practice (for example, the CNO standard on restraints). This sort of textual activation, then, becomes second nature and automatic for the student—in its own right, a successful and efficient mode of institutional ruling.

**Undergraduate Nursing Education: An Inter-institutional Circuit**

We have examined a number of seemingly separate institutions and explicated their impact on nursing curriculum. These are institutions with power over curriculum design, program accreditation, licensure, regulation, and professional ‘representation.’ Taken together, we can begin to see how teaching work is organized and how nursing education is shaped. We
can then begin to draw conclusions about how the institutional reproduction of mental illness plays out. Below is a depiction of this institutional circuit:

Figure 13. The inter-institutional circuit and undergraduate nursing education

It is becoming clearer at this point that very little ‘curriculum development’ governance is educator-driven. Most of the influence which shapes and establishes nursing curriculum is externally driven and whose jurisdiction lays in the institutional and the textual. In the case of the program analyzed here, we can see the multi-institutional convergence on nursing mental health knowledge as a multi-dimensional system with various interests, each claiming a piece of the pie of nursing mental health discourse, effectively squeezing out what is known as ‘academic
freedom.’ As a tight-knit and well-controlled functional complex, this inter-institutional circuit can be imagined as exerting centripetal forces on nursing curriculum and nursing knowledge. By injecting its political interests into nursing education disguised under such concepts as ‘excellence,’ ‘best practices,’ and ‘student success,’ this complex achieves a certain status quo. It organizes and reorganizes teaching and learning work. It authorizes what nursing educators and administrators do. It dictates what learners learn. It is a complex made up of synchronized information transfer and ongoing work modification based on this information. In the end, what this functional complex constructs is a curriculum that is representative of and responsive to extralocal political interests. In so doing, teaching and learning become inherently political and economic constructs—mere vehicles by which critical thought is trampled as institutional mandates are carried out.

Seven different provincial and federal institutions substantially weigh in on undergraduate nursing curriculum in Ontario. This sort of institutional management is not dissimilar to that which plays out in other provinces. All other provinces (with some exceptions to Québec) are subject to the same federal institutions and their own provincial regulatory bodies and professional associations. They are all subject to very similar ruling processes, hooked into similar inter-institutional relations to those which we see here.

**The Nursing Academy and Psychiatric Discourse: The Textual Relations**

Let us briefly return to the language analysis from the previous chapter. Recall psychiatry’s linguistic colonization of nursing education and nursing’s liberal use of its various hybrids. We traced, by way of examining the structure and function of language, how the nursing mental health assessment comes to be created as a facsimile of that of psychiatry. It would be inadequate, however, to suggest that this colonization comes to be as a result of linguistic work
alone. As we can see in the institutional analysis here, various institutional interests weigh in on the governance of curriculum in general. Correspondingly, we need to explicate how these institutions impact curriculum in order to understand how specifically mental health content factors in, then we can trace how they perpetuate psychiatric discourse. In order to understand how the academy reproduces psychiatry, we must turn our attention to an important medium by which it achieves this: Its texts and their relationship to one another. It is by way of these texts that some of the institutions analyzed here deploy their organizing regime en masse. Several hundred nursing students filter through these texts each semester, several thousand nationwide. These texts possess far-and-wide geographic and temporal reach. Thus, it is important to contextualize them here in order to understand their function and their institutional consequences.

**Undergraduate Nursing and Mental Health Education: Rule by Text**

Thus far we learned a number of things about a number of institutional texts and textual mechanisms. We examined the Registered Nurses’ Association of Ontario’s Best practice Guidelines and their role in curriculum governance. We began to appreciate how their insertion into the program authorizes psychiatric content to be injected into the curriculum. We saw how the code of ethics for nurses of the Canadian Nurses Association as well as the standards of practice and entry-to-practice competencies of the College of Nurses of Ontario sanction and introduce psychiatry into nursing curriculum. We also came to see how the national registration exam plays a significant role in the reproduction of psychiatric discourse. The program accreditation review report, a rather consequential text, also came to be understood in terms of its contribution to the reproduction of psychiatric discourse by nursing education.
Some of these texts are actual, material texts, such as the CNO’s Competencies, while others function more like ‘mechanisms,’ as in the case of the NCLEX, an exam generated from a pool of tens of thousands of questions whereby no two students write the same exam. In this case, the NCLEX is not examined as a discrete text which is ‘activated’ in the way Smith (2006a) theorized. It is rather understood as an authorizing intermediary text (see Figure 14 below).

Another text not yet discussed, but one which we must take into consideration and which came to be created in response to the preparations for the accreditation review is the program strategic plan. The strategic plan outlines a number of priority program objectives and the activities and timelines by which to achieve them. While the strategic plan does not directly address mental health content in curriculum, it draws in psychiatric discourse in three indirect ways. Among many objectives, identified in the strategic plans are the following three: Adapting the curriculum to reflect NCLEX; completing a gap analysis of the curriculum; and responding to identified gaps using the Entry-to-Practice Competencies. Looking at the first objective, we can begin to appreciate an intertextual relationship between the strategic plan and the NCLEX, whereby one dictates and the other reinforces. We can also see this relationship between the strategic plan and the accreditation review report, both of which use the same language of deficiency to refer to ‘missing’ content in the curriculum. Recall that one of the identified gaps in the accreditation review was specifically a ‘deficiency in mental health content.’

A second intertextual relationship linking the program to the College of Nurses can also be seen. Forged between the program’s strategic plan and the College’s Competencies document, this relationship came into existence partly in response to curricular ‘gaps.’ A document as central as the strategic plan functions as an authorizing text in its own right. It directly dictates
what faculty and administrators should be doing in order to propel the program towards its set goals. But it also impacts the program in another indirect way by acting as a reinforcing mechanism for other institutional texts. The strategic plan and the various other institutional texts and textual mechanisms discussed above came into existence at various temporal points by forging relations between a seemingly heterogeneous variety of institutions. Aside from their ability to influence mental health content, at face value, these texts have little in common. And aside from a seemingly lateral intertextual relationship, these texts may also appear as discrete and otherwise isolated phenomena across time and space. While a number of them may have a ‘lateral’ intertextual relationship to one another, what is of peculiar interest here is rather the vertical relationship they possess, once located among other relevant institutional and discursive texts. In order to reveal this vertical relationship (or intertextual hierarchy), we will need to briefly return to the working of language and bring in the critical discourse analysis from the previous chapter.

**Undergraduate Nursing and Mental Health Education: The Intertextual Hierarchy**

Little needs to be said at this point about the obvious psychiatric colonization of nursing discourse. The colonization can be linguistically understood, as we have seen, and institutionally explicated, as discussed above. Nursing mental health literature draws heavily on psychiatric discourse and biomedical notions of ‘psychosocial’ analysis. In fact, nursing mental health discourse appears to be existentially dependent on that of psychiatry, whose textual hub is the Diagnostic and Statistical Manual of Mental Disorders (or DSM for short). The DSM offers a common language and standard criteria for the classification of mental disorders. It is used, or relied upon, by clinicians, researchers, psychiatric drug regulation agencies, health insurance companies, pharmaceutical companies, the legal system, and

Time and again, we have seen nursing’s reproduction of psychiatric discourse, whether directly by way of the insertion of its language into nursing mental health literature, or indirectly by institutionally perpetuating its reproduction. All the various elements of the nursing academy which impact the mental health knowledge of the student draw on some aspect of psychiatric discourse and adopt concepts from the DSM. Whether immediate curriculum literature, practice ‘competencies,’ or ‘best practice’ guidelines, all the mental health dimensions of the nursing academy extensively draw on and are effectively colonized by the DSM.

While we identified the local texts in chapter four as those that immediately interact with and impact teaching and learning work, we also came to explicate those institutional texts which draw upon psychiatric discourse and institutionally maintain its colonization of nursing education. Now, having arrived at the apex of these textual relations, locating the DSM, we can plot a hierarchy, at the top of which it resides as its ‘boss text.’ This hierarchy is depicted below.
The DSM—the boss text—presides over this hierarchy in two distinct ways: Institutionally and discursively. We examined in the previous chapter how nursing mental health language is constructed in such a way that imitates and directly cites language from psychiatry, ergo language from the DSM. If we set aside the middle row of texts in the above diagram for a moment, we can appreciate how the DSM discursively controls and shapes the lowest level texts, depicted in this diagram as Curriculum Literature. This sort of ‘direct’ textual ruling is evident in the entire corpus of the nursing mental health literature, of which the Mental Health Assessment is one example. Others include literature on promoting patients’ quality of life (discussed in chapter one), guidelines on building therapeutic relationships with patients and families, and literature on nursing assessment and intervention with suicidal patients, to name a few. They all draw on psychiatric concepts. They all draw on the DSM.
We can also appreciate a more ‘indirect’ sort of textual ruling, however, once we bring in the middle row of texts. This row of intermediary texts comprises those texts which while drawing on theories and concepts from psychiatry, also authorize and shape the lower level curriculum literature.

The *Best Practice Guidelines* document, for example, dictates what constitutes ‘best practice’ when assessing and caring for people ‘at risk’ for suicide, and while the 122-page document would be too extensive for a course reading, elements of it are extracted and integrated into the curriculum by way of articles, adaptations, and so on. The Guidelines document in this way quite literally authorizes mental health content, that which is to be inserted into nursing curriculum. In a rather mechanical way, the Guidelines document takes psychiatric practice and reinterprets it as a nursing ‘assessment’ and ‘intervention’ and sets it as ‘best practice’ for nurses.

The *Code of Ethics*, in biomedically framing such values as *competence* and *health*, also falls short of stepping outside psychiatric discourse. The Code reinforces that such values are important, in fact foundational to nursing practice, and they indeed ought to be. But while the *Code of Ethics* text deploys such hollow concepts as *competence* and *health*, other texts such as the *Best Practice Guidelines* and various colonized curriculum literature step in and populate them with a variety of psychiatric terminology.

It is also important to note here the inconsequential role of the university curriculum policy. Many times, I recall this policy and its ostensible institutional red tape being cited by managers as a source of difficulty for college faculty to influence curriculum. While it certainly has jurisdiction over curriculum, it is not the sort of jurisdiction which would govern any curriculum change of relevance here. In other words, the sort of curriculum influence that college faculty need to make in order to substantially (and radically, if it were possible) alter curriculum
is not subject to the approval channels set out by this policy. Thus, its complete disappearance from the institutional picture.

These textual relations are a tightly closed system of discursive and institutional authorization. The Intermediary texts are highly established and extensively activated regulatory (institutional and discipline-specific) documents which have had an enduring presence in the nursing academy. Nurse academics and curriculum administrators consider them foundational documents that shape nursing education and practice. The point is that these intermediary texts will always factor into teaching, learning, and curriculum development work in nursing education. Their reinforcement of psychiatric discourse by an already-linguistically-colonized profession functions as a ready-made and seemingly impenetrable system of the reproduction of psychiatry—a sort of protective mechanism of the status quo.

We have examined the institutional and the textual relations which reproduce the discourse of psychiatry using nursing education as the vehicle for this reproduction. We explicated a number of textually-based practices, beginning with the program’s very formation and the division of teaching work among the college and university partners. We mapped out the institutional intertextual relations and fleshed out the hierarchy which authorizes and effectively constructs the nursing mental health discourse. There is, however, yet another institutional domain begging exploration. Specifically, the classroom. In the classroom, we need to explore teaching and learning practices—those institutionalized and routinized modes of teaching and disciplinary practices (Foucault, 1977/1995) highly characteristic of professional education. It is these to which I next turn my attention in order to examine how they too claim a role in the reproduction of psychiatric discourse.
Nursing Education as ‘Discipline’: Imprinting Psychiatry onto Nursing

I begin with a short narrative of an observation period from a nursing lecture on mood disorders:

The setting is a large one-level classroom and seated are approximately 60 second-year nursing students. The faculty member begins the lesson with the statement: “I am always struck by how mental illness is portrayed by the media, particularly how it perpetuates stigma.” She then shows the class a YouTube music video titled I’m Crazy for You. In the video, depicted are a straitjacketed patient in a cell and a nurse dressed in white latex, both taking turns singing. Following the video, the professor asks a series of open-ended questions related to the media’s portrayal of the mentally ill, leading to the question and its corresponding PowerPoint slide: What is a mood? She then introduces the DSM out of which she reads out the definitions for Major Depressive Disorder, Manic Episode, and Hypomania. Then, another music video: Here, the protagonist–also the lead singer–while being dragged away by two guards, appears at times as a disheveled young woman and at other times as a Marilyn-Monroe impersonator. The professor pauses the video halfway and asks: “What is a delusion?” Several students provide fragmented answers. She then states that it is “a fixed, false belief.” The lesson proceeds well-fashioned with a variety of instructional methods and classroom discussions designed to solicit the sharing of student clinical experiences as ‘application’ exercises.

The narrative above represents a very small cross-section of these students’ learning during their Pathothereapeutics course (see appendix C). Next, they would attend a theory class, which would further reinforce, for example, how delusions occur and what the nurse ought to do about them. The students would also go through a series of repetitive exercises (group work for
application purposes), large and small group discussions to share clinical experiences and ‘apply’
the theory, more videos, role play activities, and case studies. In their clinical practicums, they
would be observed by their preceptors as they complete mental health assessments, formulate
nursing diagnoses, and carry out psychiatric interventions. They would be repeatedly observed
doing so (and for every nursing skill), until deemed ‘competent’ by the preceptor and supervising
professor. This is a sort of ‘normalizing gaze’ of which Foucault (1977/1995) speaks, “a
surveillance that makes it possible to qualify, to classify and to punish” (p. 184).

Practicum students are closely supervised, their actions are monitored, documented, and
evaluated. They are frequently verbally quizzed in clinical practice so as to ensure ongoing
‘competence,’ or the very least, clinical ‘safety.’ They are instructed to engage in reflective
thinking said to enhance their critical thought process, and by extension, their practice. They are
tested on their clinical knowledge, their pharmacological knowledge, their knowledge of
institutional policy, professional guidelines and standards of practice, and are administered a
clinical test twice a term on which they must achieve a grade of 80 percent. These students are
evaluated at various intervals throughout these courses, whose overall passing grades are 63
percent. Failure in two nursing courses results in the student’s permanent withdrawal from the
program. Needless to say, the disciplinary nature of the nursing program is just about palpable.
And while it is likely the case that most, if not all professional programs are similarly
‘disciplinary,’ what we need to do here is understand nursing ‘discipline’ in the context of the
discourse and the institutional analyses.

The practice of repetition plays a vital role in the inscription of psychiatric discourse on
nursing knowledge. Repetition is cleverly practiced in a multipronged, and arguably efficient and
effective fashion in the nursing academy. For example, nursing students are introduced to a
concept in a given class. They are instructed on the concept in multimedia, using a variety of instructional methods. They apply the concept in clinical practicums. They engage in reflective analysis exercises with it. They encounter it in different courses. They absorb it, reflect on it, reabsorb it, and processes it right down to the cellular level in order to ensure the sort of ‘competence’ that the CNO’s Competencies text authorizes. All the while, these students are closely observed by professors and preceptors, vested with institutional authority to reward and/or punish them. This ‘hierarchized observation,’ Foucault (1977/1995) notes, is a sort of “relation of surveillance, defined and regulated, [and] inscribed at the heart of the practice of teaching . . .” (p. 176). With a variety of colonized institutional texts at their fingertips, these professors and preceptors observe, evaluate, reward, and punish the emerging nursing student, all from within an overriding psychiatric framework.

There is more. We saw how the NCLEX authorizes a certain quantity of psychiatric material. It does so by way of testing a certain amount of psychiatric content. Therefore, in order to maximize success on the NCLEX, we know that students will have to be well versed in psychiatric discourse. Before the NCLEX, however, and before nursing students even begin to appreciate the institutional power of the NCLEX and its implications on their education and career trajectory, they are subjected to other sorts of ‘examinations’ throughout their educational careers.

At every year in the program and in every course exists a meticulously-designed examination protocol. Classroom-based courses follow an NCLEX-logic-type examination. They are structured to mimic the questions students will encounter on the NCLEX. Classroom-based courses administer exams at various intervals throughout the academic year so as to ensure graduated ‘competence’ in order for the student to move forward. Repeat testing and
examination is not permitted. Clinical-based courses follow a different process whereby they too
test students using NCLEX-based methodology, but also include performance testing, evaluated
against a checklist of items. This performance testing is subject to similar hierarchal observation
as the clinical practicums are, and may take the form of role-play or make the use of simulation
mannequins. A student being examined on a mental health topic may be given a broad subject
area such as bipolar disorder, for example, then be presented with an actor playing the role as the
student is evaluated for the competent execution of a number of steps found in the mental health
assessment (analyzed in Chapter Four). In the simulation lab, the role-play exercise is observed
from behind a two-way mirror by the examining professor and often video recorded to be
replayed later for more detailed scrutiny of the student’s performance. The student’s overall
performance and eventual success in the practical exam hinge on the accurate application of
nursing performance checklists (read psychiatric texts) with perfect or near-perfect execution.

There is little doubt that these disciplinary teaching practices construct a ‘knowledgeable’
clinician. Though this begs one question: Knowledgeable in what? Knowing what we have
discovered thus far, little more needs to be said about the consequences of these sorts of
institutionalized instructional practices on nursing knowledge and practice.

We already know that on a discursive level, ideology circulates best when taken for
granted or when written and spoken about in a common-sense way. This was the focus in chapter
four. We also know that on an institutional level, ideological inscription on consciousness and its
ongoing reproduction also function best through a docile and an obedient institutional agent. This
is the sort of docility and obedience created by these teaching practices and the linguistic reader-
writer relations which we saw in chapter four. They produce a certain type of ‘professional’
nurse which locates him or her as the locus of institutional control, whose body and mind
become a well-oiled machine of obedience. These sorts of disciplinary teaching practices produce what Foucault (1977/1995) terms a docile body—a docile nurse, one who is well-trained in the perfect execution of institutional and linguistic commands. This is the nurse who simultaneously strives to be recognized as both a critical thinker while at the same time kneeling to the disciplinary whip.

Year after another, course after course, students are subjected to psychiatrically-saturated literature. They are immersed in rigid institutional relations, multi-institutional interests are deployed by powerful texts that penetrate their consciousness, and disciplinary perfection-seeking teaching tactics are exercised over their bodies and their minds. At the same time, nursing students are incessantly taught to engage in critical thinking in a variety of classroom and clinical environments. They are encouraged to continue ongoing reflection during and after clinical experiences. They are evaluated on their ability to critically reflect and critically think in a number ways whereby the concept of critical thinking, short of becoming a buzz word in the nursing academy, became worked into student evaluations as a grading criterion.

While it is beyond the scope of this project to examine the sort of tension which would undoubtedly arise for the student at the juncture between critical thinking and docility, it is worth noting here. Given the disciplinary (punitive and corrective) nature of the teaching practices substructed by rigid institutional relations, it would be logical to assume that in order to succeed, the student would have to portray both institutional constructions: The docile nurse and the critical thinking one. But how so, given the paradoxical nature of such a characterization? Before I partially engage with this question in the next chapter, I would like to return to the local, the everyday experiences and difficulties which launched me into this project. As we revisit these
difficulties in light of what we now know about the institution, we can politically situate them, perhaps even think of possibilities of resistance to their ruling relations.

**Revisiting the Disjuncture and Concluding**

It is at this point that we can loop back and re-locate some of the difficulties and contradictions I experienced while teaching many of my nursing lectures. At this juncture, we can likewise situate my experience as a nursing student partaking in ECT ‘treatments’ while being hopelessly caught in the institutional order of the clinic and the academy.

My student’s reflective paper (chapter one) can now be understood as the effective work of psychiatric colonization into nursing knowledge. Her taking for granted the ‘patient’s illness’ and dangerousness as well as the necessity for immediate medical intervention are evidence of psychiatric ideology that has permeated nursing language, thought, and practice. It is evidence of the workings of an efficient and successful ‘common-sense-making’ machine of psychiatric discourse. In essence, the successful nursing student must function as a ‘mini psychiatrist,’ as it were, as she simultaneously maintains close ascription to the discourse and to the institution. It is in this very same discursive and institutional context that I too was educated as a nursing student, more than a decade prior. It is indeed the very same context for hundreds, if not thousands of other students across the province and across the country today.

We also came to explicate how the critical educator is caught in the same discursive-institutional hold, that despite all attempts at critiquing problematic and colonized curricular material, the institutional and textual order pre-establishes a certain work trajectory for him or her. This work trajectory is always in line with serving local program-specific interests, but overwhelmingly, also serving those of other institutions and discourses, largely situated extralocally and often beyond reach. We saw how the college faculty member comes to be
doubly excluded from curriculum influence, first by the foundational textual processes of the
program, beginning in its very inception, and second, by a complex and seemingly impenetrable
inter-institutional circuit. Hence, it is now clear how my attempts at injecting a critique into my
lectures rendered little success, for in so doing, I was also futilely colliding with powerful
discourses only to be returned, time and again, to my place—that where the small hero resides.

I began this dissertation with the everyday work as problematic while drawing on
teaching and learning experience, both mine and my students’. I intentionally politicized this
experience, investigated its difficulties and conundrums, and arrived at an understanding of the
institutional and discursive logic which gave rise to it. To some degree, I hope to have made
some traceable connections between the everyday difficulties and the ‘invisible’ institutional
navigators which are often effectively concealed from view for the everyday person. More
importantly, I hope to have provided an opportunity for further critique, for the possibility of
resistance, and for the development of a counter-narrative to begin a discursive shift. But before
we theorize resistance and before we can imagine a world in which nursing can talk back to
psychiatry, we must look at how nurses critically think, for at this juncture, the concept of critical
thinking is begging further examination. In the next chapter, I focus on critical thought in the
nursing academy and specifically, how ‘critical thinking’ factors in teaching and learning and
how it is understood and used in nursing.
Chapter Six

‘Critical Thinking,’ Psychiatry, and the Institution: Toward a Radical Direction in Nursing Education

Having arrived at a troubling tension between ‘docility’ and ‘critical thinking,’ my intent for this chapter is to expand on the latter concept and examine its implications for nursing. I generally engage with the following two questions here: How does the nursing academy conceptualize and deploy the concept of critical thinking? How does this much-used concept leave nurses uncritical of psychiatry? In an effort to understand how critical thinking actually figures in teaching and learning work, I first present the dominant nursing theories on critical thinking followed by the perspectives of students and faculty on the concept. I also draw on my own experience while I map out how I have integrated the concept into one of my courses. I then discuss how critical thinking is theorized in the nursing academy, situating this discussion in what we thus far have discovered about the institution. I close with some general recommendations for nursing and questions to be addressed in the following and final chapter.

Dominant Theories of Critical Thinking in Nursing

The concept of critical thinking appears in three foundational nursing textbooks, one of which served as the source for the mental health assessment analyzed in chapter four (Jarvis, 2014). The other two are used in a number of courses across all four years of the nursing program and these are: *Medical-Surgical Nursing in Canada: Assessment and Management of Clinical Problems* (Lewis, Heitkemper, Dirksen, O’Brien, & Bucher, 2014); and *Canadian Fundamentals of Nursing* (Potter, Perry, Stockert, & Hall, 2014).

Two major theories on critical thinking appear in the nursing literature. The first is drawn from a clinically-based framework that inextricably ties critical thought to clinical reasoning
This framework links problem solving, clinical care, and critical thought together. Jarvis (2014) further elaborates on this framework, suggesting that critical thinking comprises a set of learnable skills, 17 such skills, to be exact. They are:

1. Identifying assumptions
2. Identifying an organized and comprehensive approach to assessment
3. Validation of the reliability of data
4. Distinguishing normal from abnormal
5. Making inferences and hypotheses
6. Clustering data
7. Distinguishing relevant from irrelevant
8. Recognizing inconsistencies
9. Identifying patterns
10. Identifying missing information
11. Promoting health
12. Diagnosing actual and potential problems
13. Setting priorities
14. Identifying patient-centered expected outcomes
15. Determining interventions
16. Evaluating and revising thinking
17. Determining a comprehensive plan

Critical thinking, according to the above framework, appears to be overwhelmingly theorized as a biomedical concept. That, however, we already knew. Of particular interest here is
skill number 16, identified as *evaluating and revising thinking*. At its simplest, this ‘skill’ appears to demand some meta-cognitive work form the learner. That is, it calls for thinking about thinking, promisingly inviting the learner to critique his or her own logic, thought process, and cognitive framework. This skill is further defined as the *observation of the actual outcomes (of medical interventions) while comparing them to the expected outcomes*. It involves the analysis of whether or not the interventions were successful and includes thinking about what could have been done differently or better (Jarvis, 2014). While this in itself is promising, the problem remains, however, that the only non-clinical ‘skill,’ seems to also be understood solely in the context of the clinic. As such, it is only ‘clinical thinking’ that is evaluated and revised. In other words, according to this theory, the student is said to be a critical thinker if she simply reconsidered and changed how she administered a certain oral medication to a patient in response to the patient’s inability to swallow it, for example. It would therefore seem that this framework is entirely clinical, by which critical thinking is *only* to be understood in a clinical context.

The above ‘critical thinking’ model appears to be suspiciously similar to that of the Canadian Nurses Association (CNA). The CNA defines critical thinking as

“a complex, active, and purposeful process encompassing the essential skills of interpretation and evaluation and requiring the RN to go beyond the role of performance of skills and interventions.” According to the CNA, critical thinking “compels the RN to identify and challenge assumptions, use an organized approach to assessment, check for accuracy and reliability of information, distinguish relevant from irrelevant, normal from abnormal, and recognize inconsistencies, cluster related information, identify patterns and missing information and draw valid conclusions based on evidence, identify different
concurrent conclusions and underlying causes, set priorities, and evaluate and correct thinking.” (CNA, 2007, as cited in Jarvis, 2014, p. 4)

The second major theory on critical thinking is likewise narrowly defined in the context of the clinic. In this framework, a model is said to guide the nurse’s clinical decisions about patient care (Potter et al., 2014). This conceptualization of critical thought involves three ‘levels’ (basic, complex, and commitment) and five ‘components’ (standards, attitudes, competencies, experience, and a specific knowledge base). It posits that the clinician’s ability to critically think is said to grow with experience, hence the three ‘levels.’ Critical thought hinges on “safe, effective nursing care” (p. 143) that is ultimately achieved by the effective application of its five ‘components.’ Refer to Appendix E for a diagram of this model.

At this point, we can begin to draw some general conclusions about what we know of critical thinking in nursing. Minimally, we know that critical thinking appears to be theorized from within a clinical framework. It is only applied in patient care contexts, for purposes of executing ‘safe,’ ‘effective,’ and ‘evidence-based’ care. Moreover, critical thinking is theorized as a skill or a set of linearly applied skills that can be refined with time and experience. To that effect, critical thinking in nursing appears to be understood as a mechanical and predictable idea, contextualized to fit the discourse of the clinic.

In my pursuit of understanding the experiences and work knowledges of my student and faculty participants, I also examined the concept of critical thinking with them. I wanted to understand how they in turn understood it and how students demonstrated it in clinical practice. Correspondingly, following are their perspectives.
Faculty and Students on Critical Thought: The Local Perspectives

In some instances, faculty and student perspectives on critical thinking overlapped, and in others, quite markedly diverged. Faculty members generally articulated a scientific and linear conceptualization of critical thought, much like the two models examined above. Students, however, while also locating critical thinking in the discourse of science, quite markedly diverged from faculty in their application of the concept.

The Clinic and the ‘Science’ of Critical Thinking

While discussing critical thinking, faculty drew on such ideas as ‘analysis,’ problem-solving, ‘balance,’ and ‘objectivity,’ often citing the thinker’s necessity to ‘connect data’ and synthesize clinical conclusions. Take for example the following in response to my asking: What is critical thinking?

I think critical thinking is basically common sense. It’s very hard to teach because a lot of our students are very concrete learners. But part of our challenge is for us to get them to think outside of the box and to ensure they follow this process and collect all their data and analyze information to make the best judgment. (Faculty Member)

Note the contradiction in the above response between the idea of ‘common sense’ and ‘thinking outside the box,’ for common sense is hardly thinking outside anything. This is especially true given what we know about discursive colonization and the common-sense-making strategies deployed in language. Recall our problematizing of ‘common-sense’ as a discursive and an institutional ideology-transmitting process in chapters four and five, respectively.
Other faculty articulated the concept as something rather linear while theorizing the patient as a ‘case study,’ squarely confining critical thought to the context of clinical care.

Consider the following two responses:

**M**: It’s very difficult for students to integrate all the different concepts around mental health, particularly when the content isn’t named as such and it is unnamed as we talked about before. I think that students do have the capacity to think critically about mental health issues if they had the opportunity to apply it from a case-study perspective. I think that helps them put the pieces together. (Faculty Member)

**Simon**: How do you know when a student is critically thinking?

**L**: In clinical practice, when students question the orders. Questioning the orders, drawing connections, doing the assessment data, and then the subsequent intervention that they need to do. (Faculty Member)

Evident in L’s response above, critical thinking is so narrowly constricted to one part of the clinic that it is only understood in the context of reading, following, and executing physician orders. Here, the student is said to be critically thinking simply by ‘questioning’ such orders.

Peculiar is this concept of ‘questioning,’ an idea that also happens to be rather popular in nursing education and clinical nursing discourses. The logic behind it is that nursing students (and nurses) are expected to review physician orders for completeness, and while so doing, raise questions if the orders are found to be ‘incomplete.’ It is necessary that at this juncture we take a closer look at this idea of ‘questioning physician orders.’

In one of its standards of practice documents, the College of Nurses of Ontario (CNO, 2008) dictates a mandated medication administration practice for every nurse in the province. In this mandate, the College outlines that prior to administering medications to patients, nurses
must meet this standard by, among other things, “verifying the right client, the right medication, the right reason, the right dose, the right frequency, the right route, the right site, and the right time” (p. 6). These are known as the ‘eight rights’ of medication administration for nursing in Ontario. It is these eight physician order characteristics which must be met for a physician’s order to be deemed complete, thus, safe, executable, and ‘unquestionable.’ It is also these eight ‘rights’ that the nurse must ensure are in place before carrying out a medication administration order in every clinical context. Should the nurse find that one or more ‘right’ is missing or unclear, he or she is expected to ‘question.’ The sort of ‘questioning’ nurses and nursing students are expected to do is navigated by this CNO mandate in that it is only done if it deviates from these textually pre-established ‘eight rights.’ It is in this context in which the above faculty member deploys the idea of ‘questioning,’ and in this context that it must be understood. Given its textual and institutional capture, ‘questioning,’ then, appears to carry little to no resemblance to critical thought, whatsoever.

What is more is that this sort of ‘questioning’ treads dangerously close to reproducing and reinforcing psychiatric discourse. Take the following simplified clinical example: A nursing student in a psychiatric practicum placement comes across a physician’s order that reads: Give Ativan, 10 milligrams by mouth, once. The student notices that the physician has ordered ten times the amount of the drug, subsequently ‘questions’ the order, and has it corrected to read Give Ativan, 1 milligram by mouth, once. This is the sort of ‘questioning’ which serves as critical thinking in the nursing academy. What we really have here, however, is a nursing student acting as a fail-safe double-check for the psychiatrist. One who helps ensure the medical/legal integrity of the institution and the physician’s practice. In place of a critical thinker, what we have is an
arm’s-length psychiatric institutional agent, who instead of questioning the logic of the intervention altogether, refines it and ostensibly makes it ‘right.’

Another faculty member viewed critical thinking as a ‘state of mind,’ a sort of high-order thinking about thinking. She stressed that it must involve the thinker’s ability to be restlessly dissatisfied with ‘answers’ and to pursue further questions. This faculty member seemed to conceptualize critical thinking in broader, perhaps even creative terms. Consider the following in that regard:

Critical thinking to me is about asking the question *why?* To me, critical thinking is about asking who, what, where, when, and how, and keeping those questions on the table. It is also not necessarily being satisfied with what you think is the answer, because today’s answer may be tomorrow’s ignorance. So to me, critical thinking is a state of mind, state of feeling life, state of looking at the world, it’s a state of looking at oneself, always inquisitive, being quite comfortable with a state of uncertainty, a state of questioning. I know what I know today, but tomorrow, I could be quite wrong. (Faculty Member)

This is perhaps one of the most promising responses given by faculty. In her articulation of the concept, she appears to have liberated it from the confines of the clinic, and seemingly, the institution altogether. I ask that my reader momentarily bracket this last faculty response. We will return to it shortly.

The faculty members I interviewed overwhelmingly located critical thought in the discourse of science, often within clinical practice. A number of them reported that it involves clinical data collection and analysis. Some faculty specifically defined it in the context of bedside caregiving. We saw how the idea of ‘questioning,’ incorporated by one faculty member as a critical thinking characteristic is hooked into an institutionally-managed medication
administration practice that is textually governed by the College of Nurses. Next, we examine the perspectives of students on critical thought.

“Those With Means and Wealth are Eccentric and Those Without are Delirious”

When asked about the concept of critical thinking in the context of mental health, students took it to a more critical level than did faculty. For obvious reasons, this came to me as a surprise. This surprise is in part due to the fact all but one of the students I interviewed had never been taught by me. The one student I had taught had taken a theory course from me two years before the interview took place. One can understand, thus, how students can be more critical than faculty, when a faculty member so personally invested and institutionally entrenched in a particular subject area would carefully tread around critiquing it, if at all. While some students indeed did articulate a colonized and at best, a reformist understanding of mental health, others politicized, even radicalized the concept. Consider the following in that respect:

I think there is also a lot of critical thinking that we don’t utilize. Let’s take knowledge that is passed down from generation to generation. What if the first idea of mental illness was wrong? How we tend to categorize and how we label, and no one bothered to challenge it, right? So now we have a whole ideology of what mental illness is and no one bothered to critique or question it, until now, and now we’re trying to repair it.

(Nursing Student)

The student above begins a dialogue with her peers in the focus group while she very astutely deconstructs this idea of transgenerational psychiatric colonization. She quite pointedly asks whether or not we ‘have it right’ and casts doubt on the entire discourse, particularly its being transgenerationally ‘passed down’ from expert to novice, or educator to student.
In response to my asking how critique can be introduced into mental health nursing content, one student supported the idea of client subjectivity and intersectionality:

We need to be pointed in the direction where we can find more information about mental health, especially around behavioural issues. I don’t want to say ‘hallucinations’ or ‘delusions.’ I don’t want to say ‘solid psychiatry’ versus ‘behavioural mental health,’ but I feel like the behavioural ones are far more subjective and depend on the context of the person, the situation, and the status of the individual. People with means and wealth can be eccentric. People without means and wealth are delirious, and so on and so on. Yeah, I think more concentration on social intersections. We only had one small lecture on intersectionality^12. Ok, I understood it because I spent a whole previous degree understanding, utilizing, and implementing it. But a group of students who did not have that exposure may not truly understand how to implement intersectionality in their practice. I think more of an overarching focus on that and exposure to different lenses when it comes to mental health would help in our education. (Nursing Student)

Agreeing with the above response, the following two students not only took issue with the overwhelmingly biomedical approach to mental health, but also with the sort of institutional governance we examined in the previous chapter, specifically around the NCLEX. Following is a short excerpt from my focus group interview with them:

G: But we are also writing the NCLEX and that’s very patho [pathophysiology] based. The mental health is all from the DSM-V. Even though the DSM-V has been proven to have some faulty aspects, our profs said we have to know it and study it to pass the NCLEX. So we’re kind of forced to learn it even if we don’t agree with it.

Simon: If you don’t learn it, you might fail the NCLEX and can’t pracice as a nurse.
K: Exactly! So, at the end of the day, we still have to learn the medical model.

At its most extraordinary point, the critical thought processes of students took on a political, even a radical bent. Students put on the table issues of scientific validity, medicalization, and institutional interests. Evidence of this can be seen in the following two responses:

F: When you have science, it increases validity. It’s like a truth. There is a right and a wrong. It’s proven by science. By making mental illness biological, it makes it a science, it makes it a truth, even thought we know it isn’t. It makes it more tangeable. It makes the professor and psychiatrists look more credible, because they are backed by science. We don’t question things backed by science, they are just correct and credible. By making it biological, they are making it more rigorous, truthful, scientific, even though they are conflicting. Even though we know some things aren’t scientific at all! (Nursing Student)

K: I feel like it’s mostly a biomedical approach so that if we can see it, we can treat it. It’s less unknown and more definite. Now we know what it is, so let’s treat it. And I feel it’s always about treating it. We don’t look at the root. (Nursing Student)

Most of these students questioned psychiatric treatment, nursing’s glaring oversight of the phenomenological dimension of human suffering, and the overwhelmingly biomedically-driven nursing mental health curriculum. They demonstrated remarkable insight into how psychiatry achieves scientific validity while also recognizing certain problems with its boss text—the DSM. They noted how in turn the DSM vis-à-vis the NCLEX hooks them into its institutional rule. These students’ critical thought process exceeded that of the faculty, at the same time substantially departing form the dominant theories on critical thinking in nursing education—an important and a promising discovery.
Having thus far presented the main theoretical conceptualizations on critical thinking in nursing and the perspectives of faculty and students, next, I examine a brief example of how the concept of critical thinking is institutionally embedded into nursing education. Correspondingly, I present an example from my own teaching practice of how critical thinking is understood, deployed, and evaluated in the academy.

**Tracing Critical Thinking in Nursing Education: A Case Example**

Nursing students are regularly tested on their ability to critically think. Critical thinking is a frequently-discussed concept that is solidly grounded in undergraduate nursing education. As a second-year nursing theory course instructor, I have used it as an evaluative category for a course assignment. While integrating ‘critical thinking’ into the assignment marking scheme as an evaluative construct, it became a necessary component of the course curriculum and the student’s learning overall in the course I taught. (See Appendix F for the assignment instructions and marking scheme).

In order to understand how my own teaching work was also hooked into problematic institutional relations, let us begin with the institutional texts which organize it. First, and as discussed above, the dominant theories on critical thinking emerge out of three foundational nursing textbooks. These, as it were, can be conceived of as the boss-text triad of an institutional intertextual hierarchy. Residing at the top as the authorizers of critical thinking theory, to a certain degree, they dictate certain content found in the lower level text. This lower level text (or intermediary text), in this example, is a university policy on grading assignments. In it, specifically outlined is the criterion for critical thinking, effectively making it a necessary component of all nursing course assignments. Below the university policy, located on the lowest level of the hierarchy, is my evaluative rubric. In it, I have incorporated the idea of critical
thinking as an evaluative construct, in this example, as part of the analysis section of a paper I have asked my students to write. Following is a helpful diagram of this intertextual hierarchy:

![Figure 15. The intertextual hierarchy of critical thinking](image)

It is important to note that faculty do not fully apply the above-discussed theories on critical thinking. In fact, many do not, and those who do, they do so to various degrees. However, from what we learned about how they conceptualize and operationalize the concept, we can at the very least conclude that its use will always retain an overwhelmingly clinical bent. What is more is that there is also an institutional order which would ensure that critical thinking is tested for and evaluated in the learner in a particular way. This is the institutional/textual order which would ensure that critical thought is understood as a scientific idea with concrete, linear, and measureable characteristics.

Let us look at the university policy on grading assignments (the intermediary text from figure 15). In it, explicitly outlined are the criteria for an A/A+ paper, some of which are:

*Excellent/exceptional capacity for critical thinking, excellent/exceptional capacity for creativity,*
ability to organize ideas logically, and ability to analyze, synthesize, and express ideas logically. It is clear from the language that students are expected to engage in creativity and critical thinking. What is linguistically dominant, however, is the discourses of ‘science’ and ‘logic,’ those which ensure a linear and an institutional status-quo understanding of critical thinking. The ‘science’ and the linearity of the policy are marked by such verbs as analyze and synthesize, and such adverbs as logically. And while it is beyond the scope of this project to conduct a discourse analysis on this dimension of the institution, the policy’s telling language steers the faculty and student together in the direction of the ‘logical,’ and the scientific, instead of the artistic and the creative. This relegates critical thinking to a mechanical and predictable discursive-institutional process, rather than a creative, courageous, and authentic one.

We can now begin to appreciate how critical thinking is largely an institutionally-defined concept, whose establishment in curriculum is substructed by traceable textual relations. It is likewise narrowly defined as a clinical concept and to that effect constricted in its application in nursing education.

Next, having discovered what we have thus far, I draw in mental health discourse as I discuss the implications of this conceptualization of critical thought for nursing.

**Critical Thinking and the Discourse of Mental Health**

At the outset, we minimally know that critical thinking in nursing is designed for the clinic. Theoretically, the student is instructed to follow a series of steps said to apply the critical thought process. Faculty, when articulating the concept of critical thinking, draw on such scientific terms as ‘data,’ ‘application,’ and ‘synthesis’ and such institutional concepts as ‘questioning orders.’ This sort of faculty understanding of critical thinking effectively situates it within the rigid confines of bedside care. It is the sort of thinking that is at best capable of
reformist discursive and institutional change, if any at all. It is indeed the same sort of critical thinking leveled by the nursing scholars I discuss in chapter one—those whose analysis from which I had long departed. This sort of critical thinking can only be viable when deployed from ‘within the discourse,’ for it is not at all designed to critique the discourse itself. In other words, it is not the sort of critique that encourages self-critique, despite the lip service paid to it by nursing scholarship in that regard. The sort of ‘thinking about thinking’ advanced by nursing comes to be engulfed by the discourses of the clinic and the institution. It is thus simply clinical reasoning that is thought about and subsequently ‘improved.’ Therefore, and given its obvious predetermined, linear, and robotic conceptualization, it would be more fitting to call this sort of thinking clinical thinking or clinical reasoning instead, for that is more accurately what it is.

Mental health discourse—its theories, its practices, and its very foundation, as discussed in chapter one are flawed, therefore, problematic. We know that psychiatry is problematic for the everyday person, for nursing, and for society. In order for the average nursing student to recognize this, he or she will not only need to be inspired to do so by a critical faculty member, a different and a more emancipated conception of critical thinking must be offered him or her. Students will need to be equipped with the sort of critical thinking that will permit them to step outside the discourse and level a critique at it instead of mechanically consuming institutionalized ‘skills’ disguised as critical thought. Indeed we saw a glimmer of this sort of emancipated critique in a student’s response above, whereby she laments the overreliance on medical ‘treatment’ and the glaring oversight of the root causes of ‘mental illness.’ This is the sort of analysis nursing needs—a radical analysis.
Critical Thinking: Where We are Now

We have thus far discovered a certain divergence between the thinking of students and faculty. To that effect, we have also come to see that the faculty member situates critical thought within the framework of the clinic, largely a consequence of at least two processes: The influence of the dominant theories on the educator and the governance of the institutional-textual relations discussed above. Evident in the following response, even the most critical of faculty, it would seem, also appear to be caught in the institutional-textual net of psychiatry:

I think part of it is the DSM. I think it is one important way of categorizing what we see, what we observe, what we experience, that is very hard to work with and hard to help. I don’t see it as the only piece of the puzzle. I think it’s an important piece and it has something to offer. But to look at that outside of the entire human being and to label someone as a schizophrenic is to make their entire being about schizophrenia and that’s not accurate. That’s like saying “Jill, the diabetic.” Well, Jill is more than diabetes. It is part of the picture, not the whole picture, but I do understand that there needs to be very reductionistic ways of narrowing things down to begin to understand them. I would like to believe that 50 to 100 years from now, our understanding will be much better than it is today. It’s not a perfect picture but it’s an important part. For me to say that there is no such thing as depression, which is in the DSM, that’s silly. Although I also know that there are cultures that say it does not exist. Some cultures would say “just buck up! Get on with life and deal with it!” (Faculty Member)

Note her legitimating of depression with the DSM—an utterly mechanical and textual logic, irrespective of the fact she agrees that the DSM categories are insufficient in understanding the entirety of the human being. Also note the sort of all-or-nothing logic by
which a person is either mentally ill (depression) or “it does not exist.” It is the sort of thinking by which the human condition is readily pathologized and necessarily located in the DSM. It is either in the DSM or nothing. Herein is a consequence of the sort of linguistic legitimation we saw in chapter four. This faculty member also happens to be the same one quoted above in response to a question on critical thinking, suggesting that “today’s answer may be tomorrow’s ignorance,” advancing that critical thinking is “a state of looking at oneself, always inquisitive, being quite comfortable with a state of uncertainty, a state of questioning.”

It would seem that no matter how ‘critical,’ even verging on radical that faculty members may appear to be, they seem to fall back on the textual and the institutional. In the case of this faculty member, while she gave a promising conceptualization of critical thinking earlier, her return to the DSM and its psychiatric categories is evidence of her being linguistically captured, effectively contradicting herself. She serves as an example for other faculty members I interviewed, who also very liberally conversed in psychiatric theory and concepts and cited psychiatric texts as a legitimate “part of the picture.” It is for this very reason that educators are plotted where they are on the figure below.

Figure 16. Continuum of ‘critical thinking’

What also corresponds to the level of criticality plotted above are the discursive colonization and institutional ruling. That is, the more colonized and the more institutionally
entrenched the social actor, the less radical he or she is. We can see this in the divergence between the faculty and students, whereby faculty appeared to more closely ascribe to liberal notions of mental health and illness than did students. We can perhaps theorize that this has something to do with the faculty’s long term commitment to an area of practice and research which further entrenches them into the discursive and institutional relations, a commitment to which students are fortunate to be relatively immune.

In the case of students, while they too are institutionally and linguistically captured, they are captured to a lesser degree, however. They demonstrated higher levels of discomfort with psychiatric concepts and categories and threaded critical social perspectives into the discourse of mental health. Students went as far as critiquing the institutional ruling processes that located them as learners of arbitrary information, simply “because it is on the NCLEX.” They theorized how mental health knowledge can be transgenerationally colonizing. They demonstrated evidence of a radical critique of psychiatry, citing science as its political lynchpin claim to legitimacy. Students—surprisingly and promisingly—demonstrated a higher level of critical thinking (plotted in Figure 16), hence their being positioned closer to the radical end of the continuum.

There is also some notable significance to the unidirectional arrow in the above diagram. The rightward direction of the arrow represents a sort of slippery slope—a somewhat hazardous direction which faculty and students are at risk for taking. This is a direction, that if taken, nursing thought can easily slip into more liberal, ‘moderate,’ and potentially conservative conceptualizations of critical thinking/mental health. It is a direction in which many nursing scholars have unfortunately gone, a number of which remain plotted near the middle and toward the right end of the political spectrum.
Radical Thinking: Where We Need to Go

The term *radical* comes from the Latin word *radix*, which means *root*. At some point, it became a bad word (read discursive hybridity), conflated with such others as *drastic, extreme,* and *dramatic*. My use of the term retains its original meaning, such that, in the context of nursing mental health discourse, it compels the thinker to interrogate the sociopolitical root of a given issue.

Recall the perspectives of faculty and students from chapter one—those perspectives which helped launch me into this project. Recall the hopeful critical attempts that faculty made at deconstructing ‘mental illness.’ Their grappling with its ‘biological origin’ and its ‘legitimacy,’ at least in the interviews, is evidence of the possibility of a promising shift in nursing. As daunting and as discouraging the institutional and linguistic capture may be, change is possible. While the students leveled a higher critique than did faculty, taken together, both groups rose to the occasion to talk back to psychiatry. That said, there is substantial work to be done.

The only way for nursing to disengage from the discourse of psychiatry is by way of radical thinking. If ‘critical thinking’ remains to be theorized and reproduced in the way it currently is in nursing, nursing will not only remain hopelessly entangled with psychiatry, it will continue slipping into more and more liberal (read biomedical) notions of human care. It will continue to fracture ‘patients’ into concepts and categories dissonant with holistic caring, dissonant with the human condition. What nursing needs to do is resist. It needs to repair its ethics in relation to mental health care by rejecting the medical model which currently frames it.

Nursing has a long and obvious history resisting various discourses, medicine especially, of which psychiatry is one branch. In this struggle, however, nursing has also become an expert in self-propagation, rife with hegemonic rhetoric that selfishly serves its own political interests.
That nursing ought to rupture out of ‘critical thought’ and emancipate its consciousness is long overdue. Nursing ought to actually attend to the human being in the way that is advanced by a number of its important theorists.

It is only by way of radicalization that the profession can turn a truly critical gaze at the discourse—at psychiatry—instead of its ‘assessments,’ its ‘interventions,’ its ‘labels,’ and so on. Where nursing needs to go, as one student articulated, is to the root of psychiatry, in order to effectively begin dismantling it.

**Conclusion**

Despite the academy’s arduous docility-producing disciplinary tactics, the students, at the end of their program of study, retained a promising level of institutional and discursive critique. Despite the level of linguistic colonization of their curricular literature and the rigid institutional ruling processes which bound them to psychiatric discourse, still they were able to deploy the beginnings of an important counter-narrative. And although critical thought in nursing is largely caught in the textual-institutional world, narrowly understood from within the framework of the clinic, its emancipation is very much possible.

Together, nursing students and faculty demonstrated various events of resistance to psychiatry and to its supporting institutional relations—resistance that can pave the way for a new way to do ‘critical thinking’ and a new way to do ‘mental health nursing.’ But what exactly are these events of resistance and how can they be harnessed in order to generate institutional change? How can the nursing academy initiate a discursive shift and begin cleaving away from psychiatry? Is it even possible to radicalize nursing education? If so, how so? In the next and final chapter, I engage with these questions and offer the beginnings of some answers so as to re-envision a new way to think and to practice ‘mental health nursing.’
Chapter Seven

Toward a Shift in Nursing Thought and Praxis: Recommendations for Change

“Neuroscientific-psychiatric accounts of human behavior generally—and of mental illness and their chemical treatment, in particular—are, prima facie, erroneous. I say this because in the hard sciences we use the same laws to explain both what we deem as proper function and as malfunction: we use the same physical laws to explain why airplanes fly, and why they crash; the same chemical laws to explain why substances are soluble in water, and why they are not; the same physiological laws to explain why people live and why they die. In the case of human behavior and mental illness, we adopt a diametrically opposite principle. We use one type of explanation for the behaviors of individuals we consider mentally healthy, and another type of explanation for the behaviors of individuals we consider mentally ill: we attribute normal or sane behavior to reasons (choices, decision), and abnormal or insane behavior to causes (diseases, physical and chemical processes in the brain). This divided approach is patently fallacious.” (Szasz, 1996, p. xiii)

This project is neither the first to critique psychiatry nor will be the last. Psychiatry has long been theorized as oppressive and damaging. It has been critiqued by academics and professionals (psychiatrists included) as fundamentally flawed and likewise by survivors and consumers as a power-abusing institution of social control. Since the early 1960’s, these critiques have been forcefully shaking psychiatry to its base. Psychiatry is the only branch of medicine against which whole international resistance movements have long been aimed. Some of these include the antipsychiatry, the psychiatric survivor, and the Mad movements, to name a few.
Psychiatry Must be Abolished. Here is Why:

The quote with which I opened this chapter is taken from the work of the late psychiatrist Thomas Szasz, one of many critics of the system. His long career generated a powerful mass of literature and lectures charged at fundamentally critiquing psychiatry.

Time and again, psychiatry has been found to be scientifically flawed and based on theory and ideology rather than on science (for evidence of these flaws and the ideological framing, see Szasz, 1970, 1974, 1987, 1996, & 2007/2010; Breggin, 1991; Whitaker, 2002 & 2010; Burstow, 2015; Warme, 2006; Woolfolk, 2001). For example, through the deconstruction of language, one can easily find that ‘hysteria’ becomes nothing more than a method for people by which to communicate sadness, pain, and despair (Szasz, 1974). Furthermore, and as demonstrated by many critics in the distant and recent past, psychiatry is more about language, semantics, metaphors, abstractions (Szasz, 1996 & 2003; Burstow, 2015; Edelman, 1974), and social control (Foucault, 1965/1988; Fabris, 2011; Burstow, 2015; Chapman, 2014; Minkowitz, 2014) than it is about science and medicine.

Psychiatry is a label factory (Goffman, 1961). It is a problematic discourse comprising of strategic linguistic devices that deploy labels which inherently and necessarily produce and perpetuate stigma. Its ‘treatments’ have long been established as ineffective at best, overall doing far more harm than good. In that respect, psychiatric drugs have been shown to cause brain damage and other irreversible chemical imbalances in the body (Breggin, 2008a; Burstow, 2015; Lehmann, 1998). Psychiatric drugs have likewise been found to be implicated in an institutional-political business complex, rife with private interests having little to do with ‘patient’ well-being (Healy, 2012; Whitaker, 2002; Breggin, 2008a; Burstow, 2015). Other psychiatric ‘treatments’ have also been found to disable people (Breggin, 2008a; Fabris, 2011; Sackeim, Prudic, Fuller,
Kielp, Lavori, & Olfson, 2007; Funk, 1998). To that effect, a relatively recent study demonstrated that those diagnosed with schizophrenia fared better without medication than did those on antipsychotics (Harrow, 2007).

The damage of other psychiatric ‘treatments’ is also well documented (Burstow, 2006; van Daalen-Smith, 2011; van Daalen-Smith et al., 2014; Funk, 1998; Andre 2009) and this body of evidence is exponentially growing and piquing the interest of the general public, the health care industry, and legislators. Canadian drug policy, along with the pharmaceutical industry’s aggressive profit-driven interests are partly to blame for what Rochon Ford and Saibil (2010) call a massive ‘push to prescribe.’ This is the sort of ‘treatment’ which is often critiqued as emerging out of an economic and political logic rather than a scientific and medical one, per se. That psychiatry must be abolished is so much an established position that whole bodies of alternatives to psychiatry have been theorized (Chamberlain, 1978; Burstow, 2015) and implemented (Stastny & Lehmann, 2007; Oaks, 2011; Breggin, 2016, http://www.empathictherapy.org/index.html#.WA46WeUrLxk).

Moreover, psychiatry’s early neurotransmitter hypotheses (Schildkraut, Gordon, & Durell, 1965; Feer, 1967; Greenspan, Schildkraut, Gordon, Baer, Aronoff, and Durell, 1970; Whybrow & Prange, 1981), remain at the very best highly speculative today, some 50 years later (Ackenheil, 2001; Murphy et al., 2013; Wegerer et al., 2013), with nothing to confirm and much to suggest that they are not correct. Psychiatry remains in the realm of the theoretical and the speculative, yet simultaneously continues to push a biological and scientific agenda. Under the guise of ‘objectivity’ and science, psychiatry successfully achieves the fusion of objective discourses (neurochemical hypothesis, for example) with the theoretical and the speculative. In recalling chapter four, we were able to see other ways in which psychiatry is hybridized with
other discourses in order to achieve legitimacy and the status of medicine. Overwhelmingly, the psychiatric literature which aims to support the neurotransmitter hypothesis routinely finds mere “relationships between” and “associations with” neurotransmitter level and behaviour, none with definite cause, none with absolute (scientific) certainty, moreover, none of it providing viable explanations. A quick linguistic comparative literature review between the 1960s and today would reveal its highly speculative and theoretical nature.

Thus, psychiatry is not based on science. It is a theoretical discipline which has had its fair share of time, yet still fails to establish scientific and objective roots. What is not unrelated, it has also been found to be more of an institution of behaviour control, categorically implementing normative social practices under the auspices of ‘medical assessments’ and ‘interventions.’

While such is not the focus of this dissertation—and were it, more elaborated proofs and discussion would be necessary—I hope that at this point, readers have some understanding of my position that psychiatry, along with its various discursive and institutional branches and affiliations, including all nursing-related mental health discourses and institutions, must go. We know that very little—if anything at all—form what currently constitutes ‘mental health’ is indeed salvageable. As such, an obvious course of action—perhaps a mandatory one—and the one that I wish to explore in closing their chapter is going down the long route of psychiatry abolition.

This direction puts in question nursing’s role in the dismantlement of psychiatry and the consequences of psychiatry’s abolition to nursing, especially to ‘mental health’ nursing. Correspondingly, in this chapter, I engage with recommendations on how nursing can participate in resisting psychiatry with the ultimate goal of dissolving it. I discuss strategies relevant to nursing students, scholars, academic leaders, and legislators. I then theorize on what might be the
resulting impact of psychiatry’s abolition on nursing. Finally, I close with some concluding thoughts and questions for further reflection and action.

**Riding the Waves of Psychiatric Reform: What is at Stake**

If nursing continues to participate in ineffective, and arguably counterintuitive ‘mental health’ reform work, it will continue to compromise its ethics and risk its humanity. Nursing will continue to reproduce problematic constructions of ‘the mentally ill.’ It will continue to perpetuate stigma, sanction professional violence, and reinforce psychiatric oppression. Nursing will remain a partner to the pharmaceutical and carceral discourses and will continue to be psychiatry’s most efficient correctional officer.

In the name of ‘care,’ people will continue to be constructed as violent and to-be-feared and controlled psychotics. By way of nursing ‘interventions,’ people will continue to lose their rights, their identity, their dignity, and their freedom. In its parasitic attachment to psychiatry, mental health nursing will continue to push the biological psychiatry agenda, along with its destructive consequences that send devastating shockwaves into the everyday world of people and communities. Consequently, nursing will continue supporting the exponentially-growing psychiatric colonization of social life, infecting such unsuspecting spaces as child daycare centres, primary and secondary schools, retirement homes, the family, and so on and so on.

It is for this morally compelling reason that not only nursing ought to disengage from psychiatry, it must also actively resist it and partake in the fight to fully dissolve it. Next, I discuss how nursing can begin to do this.

**Institutional Resistance: Dissolving the ‘Collaboration’**

The first order of things, it seems, is to begin to disentangle the faculty member from institutional relations. These are the relations which, as we saw, came to confine the
consciousness and restrain the creative courage of the radical educator. Let us begin with the college/university nursing education partnership.

The current ‘collaborative’ partnership structure in which undergraduate nursing programs are delivered, as we saw, creates unfair work distribution and unequal power relations. To begin etching away at these problems, the most obvious answer is to dissolve such college/university partnerships. Admittedly, I cannot appreciate the full implications of such a recommendation, though I know that dissolution is possible and viable. The dissolution of college/university nursing program partnerships has occurred in Canada in the not-too-distant past (For example, the Collaborative Nursing Education Program of Saskatchewan).

Under the Post-Secondary Education Choice and Excellence Act, colleges may seek Ministerial (MTCU) consent, and if approved, may offer up to 15 percent of their programs as degrees (https://www.ontario.ca/laws/statute/00p36). Thus, it is technically and theoretically possible that the ‘collaboration’ be dissolved and that the college offer stand-alone nursing degrees.

Dissolving the collaborative partnership helps redistribute the power imbalance across educational sites and allows for more balanced decision-making and jurisdictional power over curriculum for the college. By way of gaining more autonomy over its nursing program, the college will have been freed of the sort of classist division of teaching work we saw in chapter five. The faculty will then gain access to teaching a full array of nursing and elective courses, and accordingly, can exercise a relatively higher degree of academic freedom and influence over curriculum. They can likewise insert critiques of ‘mental health’ into nursing education by way of teaching elective courses or introduce new ones altogether.
In my interviews with faculty and students, I saw glimmers of resistance—resistance to biomedical dominance over nursing curriculum and specifically, resistance to psychiatry’s rigid categorization of the human condition. In a nursing program free from ‘collaborative’ power relations, faculty resistance can materialize in a number of ways. Faculty will be able to insert their own critiques of the institution, free from the obstructive review and approval processes that currently overwhelm college/university partnerships. Without this sort of institutional red tape, both university and college faculty will gain a higher degree of freedom over curriculum and to whatever degree, weave in critiques of biomedicine and psychiatry into it.

**Institutional Resistance: Working from Within the ‘Collaboration’**

From within a college/university ‘collaborative’ structure, local resistance and change, albeit limited, are also possible. We saw in chapter five how the Contract, as a key governing text, comes to predetermine division of labour and the organization of teaching work for faculty members across the partnered institutions. In the Contract is also a renewal clause which stipulates that the Contract becomes open for re-negotiation and/or dissolution every four years. Taken as an opportunity to facilitate local change, the possibility to re-negotiate the terms of the Contract can open up a myriad of other potentials for change. At the very least, an important discussion around how teaching work can be reorganized and made more equitable across the educational partners can begin the shifting of power relations. Faculty in the ‘collaborative’ structure can harness this opportunity and request to revisit and revise the contract at any given four-year juncture. Alternatively, a case can be made for the dissolution of the partnership at the four-year review point. As a precursor to the dissolution, a four-year trial may be undertaken, during which renegotiated terms in favour of more equitable division of work would be implemented.
Linguistic Resistance: Discarding the Discourse

We saw in chapter four how the problem of subjectivity comes to be constructed. We were able to examine a portion of a nursing mental health text to explicate the problematic nature of the concept of ‘patient subjectivity’ and how it is understood in the nursing academy. In fact, we saw how professional subjectivity can come to replace that of the patient altogether. If we temporarily return to some of the responses of faculty members and students, especially around the concepts of critical thinking and mental health, we can see how their understanding, to some degree, flies in the face of this notion of ‘subjectivity.’ That is, while on the one hand, patient subjectivity is linguistically constructed to mean little more than the subjectivity of the nurse, on another, faculty and students described mental health as a state of holistic being, a sense of well-being, and a subjective patient-led phenomenon. While this promising conception of subjectivity falls by the wayside as soon as psychiatric discourse enters, it is nonetheless a possible site of discursive resistance.

This is the sort of ‘discursive resistance’ I came to discover in faculty and students. It is a sort of re-interpretation–in their own words, as it were–of the idea of ‘mental health.’ Albeit colonized, it is an inching toward the humanization of an otherwise biomedical and problematic understanding of the concept in the nursing literature. It is evidence of an escape from a problematic language, a monologic genre. It is likewise evidence of the possibility of the entry of other genres with which to describe the human condition. Correspondingly, faculty members discussed inserting their own ‘twist’ into the mental health content and how this made it more holistic and more palatable to them.

No matter how promising the work of liberal faculty may appear to be, however, we know that psychiatric liberalism and reform are at best inadequate. Consequently, faculty will
need to radicalize their views, their language, and their teaching, for without a radical
consciousness, the discourse and the institution will both remain at status quo. Faculty not only
have to continue doing away with psychiatric labels and diagnoses, they need to go further. In
fact, they need to return to a simpler form of language with which to describe the human
condition. They need to return to the language of the everyday person, the language of human
feelings and emotions, arising from a material and a sensual body. Faculty will have to radicalize
their ‘mental health’ language and replace such institutional concepts as ‘depressive disorder’
and ‘anxiety disorder’ with such human-based language as sadness and fear, for example.
Faculty must also continue to problematize psychiatric vernacular as they slowly shift away from
it, replacing it with humanistic language. Nursing faculty must also be reminded of their role in
person-centered care, which recognizes that in every context, care is led by the person, not the
professional. Correspondingly, they must also accept that the person may choose a worrisome
way of life and that despite this, the person must never be labeled as disordered or ill. Minimally,
faculty need to separate the concept of medical disorder from human suffering and not take them
up and teach them as synonymous ideas.

While the institution often succeeds in stomping their empathic abilities, nursing faculty
possess an important characteristic which can help position them as experts in humanistic
compassionate care. Exercising empathy involves the substitution of the self or a loved one for
the sufferer in order to attempt to understand his or her perspective as closely as possible. Quite
simply put, empathy can be used by faculty as a vehicle for teaching and using this ordinary,
everyday language.
Other Recommendations for the Faculty Member and the Nursing Scholar

Nursing faculty can introduce and teach new courses, those which challenge existing psychiatric doctrine and its supporting discourses. Critiques of psychiatry, Mad perspectives, and antipsychiatry scholarship can be taught to nursing students in a variety of courses throughout their undergraduate studies, including field placement. Nursing students will be taught to use ‘ordinary language,’ along with critical theories in their clinical practicums, which will set them apart from psychiatric hegemony. At the graduate level, nursing scholars can also encourage research projects and supervise theses critical of mental health and psychiatry. Herein lays a rich potential for nursing practice to begin cleaving off from psychiatry by way of fostering an authentic relationship with ‘the patient,’ rooted in humanistic language and supported by critical social theory. But nursing must go further.

Mad people, psychiatric survivors, radical therapists, and activists must take on an active role in the educating of nursing students. Theirs is an authentic, grassroots perspective which cannot be replaced by any other ‘theorist’ or scholar. As co-developers of curriculum, they would also be regularly invited speakers, mentors, and potential student supervisors. Mad people, survivors, radical therapists, and activists can bring in both the phenomenological, everyday experience of the survivor into nursing as well as the political and radical alternative to the clinic.

Nursing scholarship needs to develop in a direction that includes perspectives from survivors, Mad people, and antipsychiatry discourses. Nursing scholars, researchers, and activists must encourage and actively promote scholarly work in this area. More survivor-perspective research and publications are needed and more consciousness-raising within nursing discourses is necessary in order for nursing break out of psychiatric hegemony and psychiatric ruling.
Nursing scholarship must stop viewing the nurse or the professional as the expert in ‘mental health’ and relinquish this ‘expertise’ to those actually possessing the experience—the Mad and the survivor. It is only then that nursing can forge an authentic partnership with survivors and Mad people, learn from them, and more broadly inform nursing ‘mental health’ discourse.

**Recommendations for Leaders and Other Relevant Organizations**

In the case of new and existing college/university partnerships, academic nursing leaders must take into account fairness and equity when negotiating and implementing such institutional agreements as the ‘Contract.’ Such negotiations must include an equitable number of faculty representation from all the educational partners involved. Academic leaders must likewise be open to the renegotiation of such agreements and must be sensitive to their respective site faculty members’ concerns around its politics and be prepared to revise or dissolve it if necessary.

Influential organizations such as the Canadian Council of Registered Nurse Regulators (CCRNR), the Canadian Nurses Association (CNA), and the Registered Nurses’ Association of Ontario (RNAO) must also recognize their role in the reproduction of psychiatric discourse. They must recognize how their legislation, their ‘guidelines,’ their ‘codes’ and ‘standards’ enslave nursing to psychiatry by way of dragging psychiatric discourse into nursing education and practice. They must understand that as they draw on nursing mental health literature, they are also inadvertently pulling in the biomedical and the psychiatric. Not only this, but they must also act on this recognition.

The Canadian Association of Schools of Nursing (CASN), while maintaining its important role of program accreditor, must rethink the idea of ‘mental health.’ It must conceptualize it not as something distinct from the individual, thus needing a separate curriculum ‘content area,’ but rather as a social phenomenon that is woven across the lifespan. In essence,
CASN too must do away with psychiatric concepts, ‘mental health’ included, and as such, discard the whole idea of a discrete ‘mental health gap’ in nursing education.

The RNAO, in its development of its very impactful Best Practice Guidelines, must ensure that the guidelines are free of psychiatric colonization. To that effect, the guideline development panel members must actively seek out and emphasize social sciences and critical mental health literature as well as survivor accounts throughout these documents. At the same time, the RNAO must be aware of and actively avoid dependence on biomedical and biomedically-colonized mental health literature. The Guidelines must not be clinical in nature. That is, they should not assume that ‘patients’ and ‘clients’ populate the clinic and who require clinical nursing care led by a list of recommendations, overwhelmingly dictated by biomedicine.

Similarly, the CCRNR must also reconceptualize the idea of ‘mental health’ and in its creation of NCLEX questions, integrate a non-biomedical understanding of ‘mental health.’ The best way for the CCRNR to do this is to integrate the idea of ‘mental health’ as something non-discrete, non-categorical, and non-medical. Within all their domains, NCLEX questions need to incorporate an actual psychosocial component. For example, questions on the topic of pregnancy and childbirth must also include information on the stresses of pregnancy, the psychological and social consequences of childbearing and childrearing, as well as the trauma associated with pregnancy and childbirth. This way, ‘mental health’ is neither categorized as something discrete and separate from the individual nor abstracted or pathologized, leaving no room for such institutional concepts as ‘post-partum depression’ and the like. This way, ‘mental health’ is seen as a natural part of human life and indeed an expected dimension of any individual undergoing a stressful experience such as pregnancy and childbirth.
The CNA must also understand that while law has its strengths in maintaining social order, it can also be highly subjective, limited, and oppressive. For this reason, the CNA should not rely on problematic legislation in its definition of consent and capacity, and so on. Such definitions strip the person of autonomy and agency and relegate the professional role to that of carceral officer. The CNA must rewrite the nursing Code of Ethics such that to remove all language of social control and replace it with person-centered and person-led care language.

In order to begin cleansing nursing of psychiatry, all of these various institutional branches (those examined in chapter five) must simultaneously resist psychiatric discourse and psychiatrically-colonized discourses. They must examine their influential texts–those that have come to shape nursing curriculum and nursing education in general–for evidence of psychiatric colonization, and to that effect, redesign them in order to generate a psychiatry-free nursing discourse. Taken together with the local resistance work I discuss above, these very influential organizations and institutional factions can indeed begin the powerful and necessary reversal of psychiatric colonization. At the very least, with this shift, nursing can radically set itself apart from other medical and health disciplines, leading them towards a more sensitive, humanistic, ethical, and psychiatry-free approach to working with people in psychosocial and emotional distress.

**What Does the Abolition of Psychiatry Mean for Nursing and Nursing Education?**

But if psychiatry were to be abolished, then where will mental health nurses go? What will become of mental health nursing education? At this juncture, it would seem, I am faced with having to wrestle with these questions, for I have posited recommendations radical enough to demand some answers to them.
If nursing has any interest in person-centered holistic care, then we know that it needs to rethink its relationship to the broader mental health discourse. We thus far understand that nursing needs an abolitionist consciousness by which to contribute to the larger antipsychiatry/psychiatric survivor movement in dissolving psychiatry. That said, there are consequences to nursing which might be considered detrimental to the profession, particularly for the specialty of mental health nursing. I, however, see these consequences as opportunities, as possibilities for nursing’s emancipation, and in fact as the only ethical way to do ‘mental health nursing.’

The most obvious and pressing question here is: Where will mental health nurses work if psychiatry were to disappear? Of course, the answer is neither simple nor one which can adequately be addressed in any one chapter. Given the establishment of such a powerful institution as psychiatry came to be in well over a century, its complete dissolution may take just as long. The short answer is that there will be no such specialty as mental health nursing.

In phasing out psychiatry, I see mental health nurses gravitating towards social studies and therapy work—that which necessarily centers the phenomenological experience of the sufferer. I see former mental health nurses having evolved to understand that psychological confusion, emotional pain, and existential distress are responses to social problems, often perpetuated by trauma and a world that is unfair, unjust, sexist, racist, sanist, and so on. I see former mental health nurses as advocates, having entered the domain of sociopolitics with forceful advocacy efforts geared towards disenfranchised people and communities. Theirs is a role, which unlike the current professional one they possess, considers the sufferer, the family, and the community as key figures in the healing process. I see them working as community-based therapists and healers, not clinicians.
I see other nurses, who while caring for their chronically and acutely ill and injured patients, necessarily considering the impact of illness and injury on the psychological, the social, the emotional, and the spiritual dimensions of their patients. I see such nurses integrating the idea of well-being not as a distinct ‘mental health’ concept, but rather as a natural part of the human condition. These nurses working in such diverse areas as general medicine, surgery, emergency, oncology, obstetrics, and so on, will not only depathologize behaviour, they will expect their sick and injured patients to experience psychological and emotional distress, and at certain times, to very acute degrees.

Medical/surgical nurses and former mental health nurses will gradually radicalize and gradually abandon ‘mental health’ nursing as it fades along with all of psychiatry. In place of ‘mental health’ nursing skills, these nurses will have become equipped with effective advocacy strategies, radical therapy and community work, and an overall humanistic philosophy to human suffering.

Nursing education would naturally be the vehicle by which this transformation in consciousness and practice would come to be. Led by critical and radical scholars and survivors, the nursing academy will usher the health sciences into a new era where ‘mental health’ is not only de-medicalized, it is largely deprofessionalized. While nursing can offer education in radical therapy, activism, and community healing strategies, this will be led by survivors, Mad people, radical therapy workers, and other members from these constituencies. Former ‘mental health’ nursing education will be replaced by Mad, psychiatric survivor, and antipsychiatry perspectives, where psychiatry and ‘mental health’ are taught as obsolete and distant historical phenomena.
Conclusions

We began this investigation in an everyday experience from my teaching practice, and informing that experience by the perspectives of nursing students and faculty members, we delved into the minutiae of mental health language and into the complexities of the institution in order to understand how this experience is linguistically and institutionally constructed. We came to trace, by way of analyzing language, how the ‘patient’ becomes the least significant source of information about him/herself. We also discovered that by the way language is structured, psychiatric discourse is legitimated and made an inarguable scientific reality by the nursing academy. We also walked through various institutional events and traced the connections between various institutions, connections which when taken together, form a ruling functional complex into which the resisting faculty and student are caught. We came to an understanding of how faculty and students take up the concepts of ‘mental health’ and ‘mental illness.’ We explored the critical thinking process of both faculty and students and came to discover that students exercised a higher level of critical thought about ‘mental health/illness’ than did faculty.

When I launched this research project, I did so in an effort to feed my own curiosity and to address unanswered questions that the initial disjuncture raised for me. Later, I realized that this dissertation is more than a research project aimed at answering a researcher’s questions, for it quickly gained new meaning as the research unfolded and as its implications grew in clarity. In that respect, this dissertation is written for nurses. It is written for the nursing educator, the nursing scholar, and the nursing leader, in whatever capacity and in whatever context. It is written for the nursing student, indeed for any student pursuing ‘mental health’ studies. It is for the non-specified mental health professional whom I trust is able to relate to much of what has been written here. It is written for whomever may find it useful in sensitizing his or her language,
practice, and way of thinking about the human condition and about teaching and learning ‘mental health.’

In closing, I leave my reader with some reflective questions: What are your visions for a psychiatry-free world and for a world in which ‘mental health’ is neither pathologized nor professionalized? How will you participate in this discursive and institutional reversal? What can you do today to help the world move in that direction? And what is your understanding of the long term meaning for nurses?
References


Ejaredar, M. & Hagen, B. (2014). I was told it restarts your brain: Knowledge, power, and women’s experience of ECT. *Journal of Mental Health*, 23(1), 31-37.


Murphy, D. L., Moya, P. R., Fox, M. A., Rubenstein, L. M., Wendland, J. R., & Timpano, K. R. (2013). Anxiety and affective disorder comorbidity related to serotonin and other neurotransmitter systems: Obsessive-compulsive disorder as an example of overlapping
clinical and genetic heterogeneity. Philosophical Transactions of the Royal Society B: Biological Sciences, 368, 20120435.


What older adults, their families and friends need to know about… Depression

Adapted from Improving our Response to Older Adults with Substance Use, Mental Health and Gambling Problems © CAMH 2008

If you have a sad, despairing mood that lasts for more than two weeks, it may be depression.

Depression is not the same as sadness, though it can be triggered by the sadness caused by loss (e.g., loss of a loved one, loss of hearing), stress or major life change (e.g., retirement, moving). Depression can also be caused by some medical conditions, such as chronic pain, thyroid problems, stroke or Alzheimer’s disease. Certain medications and alcohol use can cause depression as well. Depression may also develop for no apparent reason.

People who are depressed cannot just “get over it.” Depression is a biological illness caused by a chemical imbalance in the brain. It affects thoughts, feelings, behaviour and physical health.

Older adults who are depressed may have had episodes of depression throughout their lives, or they may have their first episode late in life.

Depression can affect anyone at any age, but is often not recognized in older adults. This is because some signs of depression can be mistaken for signs of aging, and also because older adults who are depressed may not complain about feeling low. When left untreated, depression may continue for weeks, months or even years. Untreated depression is the main cause of suicide in older adults.

What are the signs of depression?

People often think that depression in older adults is a normal response to the losses of aging. When they say, for example, “It’s no wonder he’s depressed, he’s 82,” or “If I had arthritis, I’d probably be depressed too,” they may mean well, but depression is not normal.

An older adult may be severely depressed if he or she:

- does not get dressed
- does not answer the phone or the door
- loses interest in activities he or she used to enjoy
- expresses feelings of worthlessness and sadness
- has unusual outbursts of crying, agitation or anger, or shows little emotion
- sleeps poorly or too much
- eats more or less than usual
- complains about physical symptoms that do not have a cause
- lacks energy, is often tired
- seems confused
- has difficulty concentrating
- has trouble remembering things
- has trouble making decisions or following through with plans
- spends more time alone
- talks about suicide

What can I do about depression?

Get help: Depression deserves the same care and attention as any other medical condition. There is no shame in seeking help. Treatment options for depression include antidepressant medications, available from a family doctor, and counselling. Both can be very effective. Older adults who are contemplating suicide should speak to their doctor or go to the nearest hospital emergency department.

There are also many things older adults can do on their own or with family and friends to prevent or lessen the effects of depression.

Be active: Exercising the body helps to lift the mood. Even taking a short stroll or joining a local aquaFit class can help to make the world seem a brighter place.

Think positively: Instead of thinking about what you could have done differently in life, think about what you’ve done right. Remember your strengths and how you overcame challenges in the past.

Eat well: Food is your fuel. When you eat nutritious healthy foods in the right amounts, it can boost your strength and help you feel well.

Get involved: When you enjoy what you’re doing, you enjoy life. Rekindle your interest in activities you used to enjoy or find new ones.

Manage stress: Think back on stressful times in the past and how you got through them. Can you use the same techniques again, or is it time to try something new?

Avoid alcohol: Having a drink may seem to make you feel better for a short while, but alcohol can actually worsen depression. Being active, enjoying others and eating well can give you a natural high that won’t have negative effects.

Spirituality: Seeking answers about life and coming to peace with the past and the present can improve your perspective on life. Exploring...
your faith can involve returning to your roots, finding fellowship in an organized religion or seeking understanding outside a traditional religion.

Where can I get help or get more information?

For information and referral to mental health services available in Ontario, contact the Mental Health Service Information Ontario toll-free at 1-800-292-5505 or online at www.mhsion.on.ca. This free and confidential service is open 24 hours a day, seven days a week.

Information about depression and other mental health problems, and about resources and support available in your community is available from the Canadian Mental Health Association, Ontario; 1-800-558-2876, www.cmha.on.ca, and the Mood Disorders Association of Ontario; 1-866-488-4230, www.mooddisorders.on.ca.

For more information on addiction and mental health issues, please contact CAMH's Information Centre, Ontario toll-free: 1-866-488-4273, Toronto: 416-595-5000.
Appendix B
The Mental Health Assessment Chapter

CHAPTER 6
Mental Health Assessment

Written by Kathryn Weaver, PhD, RN

OUTLINE
Significance of Mental Health Assessment for Canadians
Mental Health Nursing Assessment
Screening
Mental Health Assessment: Adults
Detailed Mental Status Examination
Supplemental Mental Status Examination
Functional Assessment (Including Activities of Daily Living)
Risk Assessment
Global Assessment of Functioning
Assessing Patient Attitude Toward the Examiner/Assessment

SIGNIFICANCE OF MENTAL HEALTH ASSESSMENT FOR CANADIANS

The World Health Organization (2008) estimates that mental disorders such as depression, alcohol use disorders, and psychosis (e.g., bipolar disorder and schizophrenia) are among the leading causes of disability globally. Of all Canadians, 20% personally experience a diagnosed mental illness during their lifetime (Health Canada, 2006), and one per three are expected to experience a mental health problem at some point in their life (Public Health Agency of Canada [PHAC], 2011); thus mental illness is not only a global health issue but also a major public health concern for this country.

A variety of factors influence a person's mental health. Some are internal, such as emotional problems; some come from within the person's social network and include the development of values, self-knowledge, self-control, and common sense (which helps us to learn from experience and plan for the future); and others are related to the person's broader community. This "broader community" extends to the health care and mental health care systems and also to other sectors such as employment, education, and housing.

No single circumstance influences mental health; rather, people are affected by a complex series of interacting factors. Strategies to improve the mental health of Canadians therefore require active involvement from all community sectors.

In addition to internal, familial, and community influences, larger social issues such as poverty, racism, and other forms of discrimination influence mental health. Canada's population includes many immigrant groups, as well as a large number of Aboriginal groups. People who are members of these groups often face unique challenges in maintaining cultural, social, and economic integrity. Without adequate social resources or access to needed services, the stressors experienced by some ethnocultural and social groups in Canada can lead to increases in mental illnesses and suicide.

For example, although there are great variations across communities, bands, and nations, the suicide rate among First Nations communities is at least twice as high as that of the general population, and the rate among Inuit is 6 to 11 times higher than that of the general population (Kirmayer, Bass, Holton, Paul, Simpson, & Tait, 2007; PHAC, 2006). These
disturbingly high rates stem from the complex interplay of social determinants of health, intergenerational and historical traumas, and ongoing discrimination.

**Defining Mental Health and Mental Illness**

Mental health is a crucial dimension of overall health and an essential resource for everyday living. Broadly defined, mental health is the capacity to feel, think, express emotions, and behave in ways that enhance personal capacity to manage challenges, adapt successfully to a range of demands, and enjoy life (PHAC, 2011). The World Health Organization (2007) described mental health as a relative and ongoing state of well-being in which individuals realize their abilities, cope with the normal stresses of life, work productively, and contribute meaningfully to the community. Characteristics indicative of mental health include finding balance in all aspects of life—social, physical, spiritual, economic, and mental—and developing resilience, flexibility, and self-actualization (Canadian Mental Health Association, 2008). Some individuals are more mentally healthy than others, and, depending on life circumstances, mental health even for the same individual can vary over time across a continuum of optimal and minimal mental health described by Epp (1986). Optimal mental health entails satisfaction within work, caring relationships, and the self; it draws on a learning process in which individuals can greatly benefit from developing positive coping, assertiveness, interpersonal, and time management skills.

**Mental disorder** is the medical term for mental illness and is defined and diagnosed in Canada according to criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-V) by the American Psychiatric Association (APA; 2000). Mental disorders are depicted as constellations of co-occurring symptoms that may involve alterations in thought, experience, and emotion that are serious enough to cause distress and impair functioning, cause difficulties in sustaining interpersonal relationships and performing jobs, and sometimes lead to self-destructive behaviour and suicide (PHAC, 2011). Multiple factors—including the physical environment, genetics, biology, personality, culture, socioeconomic status, and life events—may contribute to the development of a mental disorder. Men and women, young and old, and people of all ethnic groups and economic brackets may be affected. Mental illnesses account for a large percentage of hospital stays every year, causing as many lost days of work as physical problems such as cancer, heart attack, or back pain.

Mental disorder is not positioned on the same continuum as mental health. Rather, mental disorder is represented as a level of impairment and distress ranging from absence of to maximal illness (Epp, 1988). When mental health and mental illness were assigned to two disparate continua, the intent was to highlight the importance of each. Indeed, a person without mental illness can experience minimal mental health (Healey-Ogdon, 2010).

A major detriment for persons with a mental illness is stigma and its associated cycle of alienation and discrimination, which affect the abilities to seek and obtain help and support in the community (Canadian Alliance on Mental Illness and Mental Health, 2007; Canadian Medical Association, 2008). Reducing stigma is a responsibility shared by health professionals, communities, and people with mental illness. As a nurse working within this population, you need to self-monitor for stigmatizing behaviours and beliefs.

**MENTAL HEALTH NURSING ASSESSMENT**

The nurse–patient relationship is directed toward advancing the best interest and best health outcome of the patient (Canadian Nurses Association, 2012). To this end, the purpose of the mental health nursing assessment is to understand the patient’s health and illness experiences, problems and deficits in daily living, and strengths and resources in relation to mental health. Nurses accordingly partner with patients to assess the full scope of the patient’s mental health, patient interactions with service providers and other professionals, any risk of violence posed by the patient, the patient’s needs, and needed intervention. Because there is a lack of peer-reviewed publications describing what and how information should be collected as part of a comprehensive mental health nursing assessment, gaps exist, particularly in the areas of social and physical health (Coombs, Curtis, & Crookes, 2011). Barratt (1989) found that mental health nursing assessment in practice means different things to different nurses. In addition, the assessment skills of nurses are often developed in settings in which mental illness has already been identified by the psychiatrist and heavily influenced by the medical judgement, which may focus on “the ‘cure’ of patients…potentially discounting their experiences” (Hamilton, Manias, Maude, Marjoribanks, & Cook, 2004, p. 886).

**Methods and Components**

To provide comprehensive mental health nursing assessment, you will integrate close observations and routine social interactions into the collection of information about the patient’s circumstances. You will combine (a) observation, (b) interview, (c) examination, (d) physical assessment, and (e) collaboration with others. Observing the patient at different times of the day and in differing situations provides information about hygiene, grooming, attire, facial expressions, gestures, and interactions with others. Identify disturbances in perception and thought and any inconsistencies between what the patient states and what you notice. Analyze findings from physical, mental, cognitive, and diagnostic examinations to reveal symptoms and potential problems in self-care. Through interviewing, you will build rapport with the patient, clarify the patient’s perceptions and meanings, and gather factual knowledge. Collaborate with the patient’s family and with other members of the health care team to develop and
evaluate treatment plans and risk of harm. The development of trust within the therapeutic relationship is crucial (O'Brien, 1999); trust builds through making yourself available, expressing interest in the patient as a person, and being accountable. Mental health nursing assessment may include the methods and components described in the following sections (Table 6-1).

Sources of Information
Patient information can be subjective (symptoms reported that are not directly observable or measurable) and objective (signs directly observed and measured, such as diagnostic test results). Although the patient is ideally the primary provider of information, collaboration with secondary sources (including family, health care providers, and patient records) is needed for children and when the patient is at risk of harm to self or others.

Indication for Comprehensive Mental Health Nursing Assessment
The full comprehensive mental health examination with its accompanying components for mental status assessment, as outlined previously, rarely needs to be performed in its entirety. Usually, you can assess mental health through the context of the health history interview; hence, the mental health nursing assessment follows the major subjects of the complete health history (see Chapter 5), and this approach is recommended for most situations. You will collect ample data to be able to assess mental health strengths and coping skills and to screen for any dysfunction.

A distinguishing component of the mental health assessment is the mental status examination (Box 6-1). Mental status is an aspect of mental health that involves emotional and cognitive functioning. Mental status assessment is a structured way of observing and describing a person’s current state of mind, under the domains of appearance, behaviour, cognition, and thought processes. It is beneficial to assess mental status when you sense that something is “not quite right.” If, for instance, you see a person whose speech is slow and unclear, whose eyes do not focus, whose clothes are soiled and disheveled, and whose thoughts are confused, you suspect that something is wrong. If the person smells of alcohol, then you begin to form an opinion about the cause of the abnormal mental status. On the other hand, if there is no such odour, you eliminate it from the wide range of other possible causes of the person’s behaviour. As additional symptoms are identified, it is possible to more fully understand the impairment and subsequently design support intervention.

It is necessary to perform the mental health assessment when you discover any abnormality in mood or behaviour and in the following situations:

- Family members are concerned about a person’s behavioural changes, such as memory loss or inappropriate social interaction.
- Brain lesions (trauma, tumour, stroke): A mental health assessment documents any emotional, cognitive, or behavioural change associated with the lesion. Not recognizing these changes hinders care planning and creates problems with social readjustment.
- Aphasia (the impairment of language ability secondary to brain damage): A mental health assessment documents...
DEVELOPMENTAL CONSIDERATIONS

Children and Adolescents

The maturation of emotional and cognitive functioning is described in the Evolve Online materials for this book. All aspects of mental health are interdependent. For example, the concept of language as a social tool of communication occurs around 3 to 5 years of age, coincident with the child’s readiness to play cooperatively with other children. School readiness coincides with the development of the thought process; around age 7, thinking becomes more logical and systematic, and the child is able to reason and understand. Progression through developmental stages toward independence and the full range of health determinants affects the experience of adolescence (Kidder & Rogers, 2004; World Health Organization, 2007). At this time, multiple cellular, molecular, and anatomical modifications contribute to pronounced changes in cognition, behavior, and temperament; risk taking and novelty seeking are perhaps the greatest changes (Kelley, Schochet, & Landry, 2004). Abstract thinking—the ability to consider a hypothetical situation—usually develops between ages 12 and 15, although a few adolescents never achieve it.

The leading cause of mortality among youth in Canada is unintentional injuries, at a rate of 21.3 per 100,000 population (Statistics Canada, 2010). For adolescents aged 15 to 19 years, suicide (intentional self-harm) is the second leading cause of death. Another increasing trend is homicide; in fact, the rate of mortality from firearms among Canadians younger than 15 years is one of the highest in the world, with Canada ranking fifth, behind the United States, Finland, Northern Ireland, and Israel (Adolescent Health Committee, Canadian Paediatric Society, 2005).

The most common mental health disorders among adolescents include depression, anxiety disorders, attention-deficit/hyperactivity disorder, and substance use disorder; half of diagnosable mental health disorders over the lifetime begin by age 14 (Knopf, Park, & Mulye, 2008; PHAC, 2011). Eating disorders represent the third most common chronic illness among Canadian female adolescents (National Eating Disorder Information Centre, 2005); 34% of adolescent girls in grades 6 to 10 described themselves as too fat, whereas only 13% of those grade 10 girls were actually overweight, according to their self-reported heights and weights (PHAC, 2008). Adolescent girls tend to have poorer self-confidence (a measure of mental health), and higher rates of depression and experience more sexual harassment than do adolescent boys (Ge, Conger, & Elder, 2001; PHAC, 2008). Youth who are Aboriginal, immigrant, homeless, and within a sexual minority (those who identified as lesbian, gay, bisexual, transgender, or questioning) in Canada were more likely to experience discrimination, stigmatization, harassment, bullying, less sense of belonging to their school community, and a lack of appropriate education, services, and protective measures and policies—all of which increase their risk for mental health problems (Birkett, Espelage, & Koenig, 2009; Evenson & Barr, 2009; Mental Health Commission of Canada, 2012; Statistics Canada, 2009; Taylor et al., 2008).
Young Adults

A task of young adulthood is adopting health behaviours while facing different types of health challenges, which may include experiencing social isolation (Cacioppo et al., 2006) and adjusting to disabilities and academic stressors during postsecondary education programs. Of all Canadians aged 15 years and older, young adults report the highest percentage of smoking and the highest incidence of depression. By age 34, 75% of mental health disorders diagnosable over the lifetime have begun (Knopf et al., 2008; PHAC, 2011). Many young adults also begin their working lives in debt from their years in postsecondary education. In 2009, 45% of college graduates owed an average $31,600, and 60% of university graduates owed twice as much (Berger, 2009; Canadian Council on Learning, 2010).

Middle-Aged Adults

People in their 40s, 50s, and early 60s commonly process information more slowly and are more vulnerable to distraction than in their youth. They use experience to compensate for age-related deficiencies in memory and reaction time. There is evidence that the brain can remain strong and even improve its performance well through the middle-age years, a period of maximum performance for some of the more complex, higher order mental abilities, such as inductive reasoning, spatial orientation, and vocabulary (Schaie & Willis, 2011). Moreover, middle age may also bring more confidence, more skill at quick assessment, and adaptability. Men reach their peak performance in these abilities in their 50s and women in their early 60s.

Challenges during middle age require skills in organizing, problem solving, and multitasking. For example, family obligations peak for middle-aged adults who have good health and numerous elderly relatives and whose children are just moving out and establishing their own families. The effect of being “caught in the middle,” albeit not a typical experience for most Canadian adults, may be severe (Rosenthal, Matthews, & Matthews, 1996).

High demands and low social support within the workforce can cause the development of depressive symptoms among middle-aged workers. Job loss caused by firings or layoffs reduce health, self-esteem, and the sense of control (Clark, 2005). Concurrently, daily stressors directly affect emotional and physical functioning, and the accumulation of persistent irritations and overload may result in more serious stress reactions such as anxiety and depression. Middle-aged adults with high mastery (e.g., successful problem-solving skills) reported less emotional reactivity to stressors (Neupert, Almeida, & Charles, 2007).

Biological changes related to menopause or late onset male hypogonadism may influence cognition and well-being. Middle-aged people tend to reassess their achievements in terms of ideals and may subsequently make significant changes in day-to-day life or situations, such as career, work-life balance, marriage, romantic relationships, large expenditures, or physical appearance (Lachman, 2004).

Older Adults

The aging process leaves the parameters of mental health mostly intact. There is no decrease in general knowledge and little or no loss in vocabulary. Because it takes a bit longer for the brain to process information and react to it, performance on timed intelligence tests may be poorer for older adults. The slower response time affects new learning; older adults have difficulty responding to a rapidly paced new presentation (Birren & Schaie, 2005). Recent memory, which requires some processing (e.g., medication instructions, 24-hour day recall), decreases somewhat with aging. Intelligence and remote memory are not affected.

Age-related changes in sensory perception can affect mental functioning. For example, vision loss (as detailed in Chapter 15) may result in apathy, social isolation, and depression. Hearing changes are common (see the discussion of presbycusis in Chapter 16). Age-related hearing loss involves sounds of high frequencies. Consonants are high-frequency sounds, and so older adults who have difficulty hearing them have problems with normal conversation. This problem produces frustration, suspicion, and social withdrawal, and it makes the person look confused. Data analyzed from a large Canadian study suggested that older adults with overall functional impairment (e.g., inability to perform housework) exhibited more cognitive impairment 5 years later than did those without functional impairment (Tuokko, Morris, & Ebert, 2005).

Meanwhile, the era of older adulthood contains much potential for loss of loved ones, job status and prestige income, and resilience of the body. The grief and despair surrounding these losses can affect mental health and result in disorientation, disability, or depression.

SCREENING

In 2005 the Canadian Task Force on Preventative Health Care concluded that there is fair evidence to support routine screening for depression in primary care settings as a way of improving detection rates (MacMillan, Patterson, & Wathen, 2005). Screening is effective if it successfully identifies depressed patients who are not already identified and treated and if the number of people incorrectly labelled as possibly depressed is minimized (Thombs et al., 2012). In studies in which the screening process was linked to an integrated system of treatment and follow-up, patients outcomes improved. More extensive patient education about depression, alertness and response to symptoms of depression, and targeting of specific at-risk groups, including older individuals, is recommended (National Collaborating Centre for Mental Health, 2010; O’Connor, Whitlock, Gaynes & Beil, 2009).

A number of screening tools are available; however, Dowrick (2004) cautioned that the use of screening instruments may encourage practitioners to take a reductionist, biomedical approach, which would divert attention from a broader biopsychosocial approach to identifying depression.
Mental Health Assessment: Adults

Patients can perceive the mental health assessment as threatening even though their cooperation is necessary for its success. Although many nurses find it desirable to establish some degree of rapport first and thereby place the patient at ease, some nurses assess mental health before working with the patient so that the findings can serve as a template against which to measure the accuracy of the rest of the health history. The successful clinician must develop a style in which much of the mental health assessment is performed through relatively unstructured observations made during the history taking and physical examination. The way in which patients relate the history of the current situation and interact in the clinical setting reveals much about their mental health.

Identification/Biographical Information

Note the primary language spoken by the patient, the name the patient prefers to be called, legal name, address, telephone numbers, birthdate and birthplace, gender, relationship status, ethnicity, education, and employment. Usually questions about this information are nonthreatening and thus a safe way to begin.

Reason for Seeking Care

Record the patient's explanation verbatim to describe the reason for the visit. Be knowledgeable of the psychiatric diagnoses (DSM-V) provided by the attending physician/psychiatrist. Ask what the patient understands about the need to visit your agency.

Past Health

Past Illness, Injury, Hospitalization

Note childhood diseases, surgeries, and trauma (especially if any resulted in concussion or loss of consciousness). Ask about parental use of alcohol and drugs, birth trauma, any pattern of injury suggestive of childhood abuse or neglect, and any obstetrical history. Ask specifically, "Have you ever experienced or witnessed anything that threatened your life or safety or the life and safety of a loved one?" If the answer is yes, ask for details, keeping in mind that psychological trauma is associated with many mental disorders (e.g., anxiety and depression).

Chronic Illnesses

The stress of chronic illnesses, even when well managed, may affect mental health.

Family Health History

Ask the age and current health of close relatives (e.g., partner, children, parents, siblings, grandparents, aunts, and uncles). If the patient reports a family member's death, ask for the date, the cause, and the effect on the patient. Ask about any illnesses that "run in the family" because many mental disorders are genetically linked and family health history provides information about the patient's risk factors. Ask about any history of postpartum depression because this can induce maternal physical, marital, social, and vocational difficulties, impair maternal-infant interactions; and affect an infant's cognitive and emotional development (Poobalan et al., 2007). Assessing family health identifies sources of social support, family stress, coping ability, and resources.

Developmental Considerations

Ask about the achievement of developmental and developmentally appropriate tasks and milestones that may indicate attention, interpersonal, or behavioral problems. Ask specifically about parental death or separation at an early age because these are often associated with issues of attachment and later relationships. The past Canadian government practice of sending Aboriginal children to residential schools perpetuated social and psychological trauma among First Nations people.

Current Health

Using a systematic approach to ensure comprehensiveness, sort and cluster information about conditions that affect patient mental health, overall functioning, and quality of life. In addition to asking the patient to describe the critical characteristics of specific concerns outlined in Chapter 5, note the following:

1. Known allergies, type of reaction, and usual treatment and relief measures.
2. Status of immunizations, human immunodeficiency virus (HIV), infection, and hepatitis infection. Persons experiencing mental illness may often dwell in poverty, lack knowledge and supports for health promotion, and have lifestyles that put them at risk for communicable diseases.
3. Current medications. Specify the name of the medication, purpose, usual dose, frequency, effectiveness, side effects, name of prescriber, duration of taking the medication, and any over-the-counter and herbal preparations. This information helps identify health maintenance behaviours, drug interactions, and potential knowledge deficits.

Detailed Mental Status Examination

The mental status examination, an integral subset of the comprehensive mental health nursing assessment, involves a sequence of steps that form a hierarchy in which the most basic functions (consciousness, language) are assessed first. Accurate assessment of the first steps ensures validity for the steps that follow; that is, if consciousness is clouded, then the patient cannot be expected to have full attention and cooperate with new learning. If language is impaired, subsequent assessment of new learning or abstract reasoning (which requires language functioning) can yield erroneous conclusions. Strive to ask questions that can be corroborated, to enhance reliability.
PREPARATION
Record the exact time and date of the mental status examination because the mental status can change quickly, as in delirium.

Normal Range of Findings

Appearance
Posture. Posture is erect, and position is relaxed.

Body Movements. Body movements are voluntary, deliberate, coordinated, smooth, and even.

Dress. Dress is appropriate for setting, season, age, gender, and social group. Clothing fits and is put on appropriately.

Grooming and Hygiene. The patient is clean and well-groomed; hair is neat and clean; women have moderate or no makeup; men are shaved, or beard or moustache is well-groomed. Nails are clean (though some jobs leave nails chronically dirty). Use care in interpreting clothing that is dishevelled, bizarre, or in poor repair; piercings; and tattoos, because these sometimes reflect the person’s economic status or a deliberate fashion trend (especially among adolescents).

Behaviour
Level of Consciousness. The patient is awake, alert, and aware of stimuli from the environment and within the self and responds appropriately to stimuli.

Facial Expression. The expression is appropriate to the situation and changes appropriately with the topic. There is comfortable eye contact unless precluded by cultural norm, e.g., for members of some Aboriginal cultures.

Speech. Judge the quality of speech by noting that the patient makes laryngeal sounds effortlessly and makes conversation appropriately. Note whether the voice is raised or muffled, whether the replies to questions are one-word or elaborative, and how fast or slow the patient speaks.

Normally, the pace of the conversation is moderate, and stream of talking is fluent.

EQUIPMENT NEEDED
Pencil, paper, reading material (occasionally)

Abnormal Findings

Sitting on edge of chair or curled in bed, tense muscles, frowning, darting eyes, and restless pacing occur with anxiety and hyperthyroidism. Sitting slumped in chair, walking slowly, and dragging feet occur with depression and some organic brain diseases.

Restless, fidgety movements may occur with anxiety.

Apathy and psychomotor slowing may occur with depression and organic brain disease.

Abnormal posturing and bizarre gestures may occur with schizophrenia.

Facial grimaces may be associated with such conditions as cerebral palsy, chorea, hypocalcemia, tetanus, tardive dyskinesia, tic disorder, and Tourette’s syndrome.

Dress can be inappropriate with organic brain syndrome. Eccentric dress combination and bizarre makeup may occur with schizophrenia or manic syndrome.

Unilateral neglect (total inattention to one side of body) may occur after stroke. Inappropriate dress, poor hygiene, and lack of concern with appearance occur with depression and severe Alzheimer’s disease.

Meticulously dressed and groomed appearance and fastidious manner may occur with obsessive-compulsive disorders.

Note: A dishevelled appearance in a previously well-groomed patient is significant.

Altered levels of consciousness may include coma (unresponsiveness); stupor (responsiveness to pain), and lethargy (drowsiness; Table 6-2 on page 98).

Expression may be flat and masklike, with parkinsonism and depression.

Dysphonia is abnormal volume and pitch. Patient may monopolize the interview or may remain silent, secretive, or uncommunicative.

Speech may be slow and monotonous with parkinsonism and depression. Speech may be rapid-fire, pressured, and loud with manic syndrome.
Normal Range of Findings

Articulation (ability to form words) is clear and understandable.

Word choice is effortless and appropriate to educational level. The patient completes sentences, occasionally pausing to think.

Mood and Affect. Judge this by body language and facial expression and by the answer to the direct question “How do you feel today?” or “How do you feel most days?” Ask about the length of a particular mood, whether the mood has been reactive or not, and whether the mood has been stable or unstable. The affect (expression) should be appropriate to the mood and change appropriately with topics.

<table>
<thead>
<tr>
<th>Cognitive Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orientation.</strong> You can discern orientation through the course of the interview, or you may ask for it directly but tactfully: “Some people have trouble keeping up with the dates while in the hospital. Do you know today’s date?” Assess the patient’s orientation:</td>
</tr>
<tr>
<td><strong>Time:</strong> day of week, date, year, season</td>
</tr>
<tr>
<td><strong>Place:</strong> where person lives, present location, type of building, names of city and province</td>
</tr>
<tr>
<td><strong>Person:</strong> who examiner is, type of worker</td>
</tr>
<tr>
<td><strong>Self:</strong> person’s own name, age</td>
</tr>
<tr>
<td>Many hospitalized patients normally have trouble with the exact date but are fully oriented on the remaining items.</td>
</tr>
</tbody>
</table>

**Attention Span.** Check ability to concentrate by noting whether the patient completes a thought without wandering. Note any distractibility or difficulty attending to you. An alternative approach is to give a series of directions to follow in a correct sequence of behaviours, such as “Please put this label on your keys, place the keys into the brown envelope, and give the envelope to the clerk for safe keeping during your admission.”

**Immediate Memory.** Immediate memory enables making sense of what is going on. For example, it is used during reading to recall what happens sentence by sentence. Assess by asking the patient to recall a statement you just made.

**Recent Memory.** Assess recent memory in the context of the interview by the 24-hour recall or by asking what time the patient arrived at the agency. Ask verifiable questions to screen for the occasional person who confabulates (makes up) answers to fill in the gaps of memory loss.

**Remote Memory.** In the context of the interview, ask the patient about verifiable past events; for example, ask to describe historical events that are relevant for the patient.

Abnormal Findings

Dysarthria is distorted speech. Misuse of words; omitting letters, syllables, or words; and transposing words occur with aphasia.

Unduly long word-finding or failure in word search occurs with aphasia.

Table 6-3 lists mood and affect abnormalities. Wide mood swings occur with manic syndrome. Altered mood states are apparent in schizophrenia. Heightened emotional activity and severely limited emotional or elicited responses (e.g., “OK,” “Rough,” and “Don’t know”) necessitate further questioning for clarification of mood.

Disorientation occurs with organic brain disorders, such as delirium and dementia. Orientation is usually lost in this order: first to time, then to place, and rarely to person and self. Disorientation to personal identity is associated with post-epileptic seizure states, other dissociative disorders, and agnosia (loss of the ability to recognize sensory inputs).

Attention span is commonly impaired in persons who experience anxiety, fatigue, drug intoxication, or attention-deficit/hyperactivity disorder. Impairment is conveyed as confusion, negativism, digression from initial thought, irrelevant replies to questions, or being “stimulus bound” (i.e., any new stimulus quickly draws attention).

Head injury, fatigue, anxiety, and strong emotions can affect immediate memory. The individual affected may demonstrate repetition (e.g., asking the same question) and difficulty finding words during conversation which may lead to frustration.

Recent memory deficit occurs with organic disorders, such as delirium, dementia, amnesia, or, in chronic alcoholism, Korsakoff’s syndrome.

Remote memory is lost when the cortical storage area for that memory is damaged, as in Alzheimer’s dementia or any disease that damages the cerebral cortex.
### Normal Range of Findings

**New Learning: The Four Unrelated Words Test.** This test assesses the patient’s ability to acquire new memories. It is a highly sensitive and valid memory test that avoids the danger of unverifiable material.

Say to the patient, “I am going to say four words. I want you to remember them. In a few minutes I will ask you to recall them.” To be sure that the patient has understood, repeat the words. Pick four words with semantic and phonetic diversity:

1. brown  
2. honesty  
3. tulip  
4. eyedropper

After 5 minutes, ask the patient to recall the four words. To test the duration of memory, ask for a recall at 10 minutes and at 30 minutes. The normal response for persons younger than 60 years is an accurate three- or four-word recall after a 5-, 10-, and 30-minute delay (Osaka & Logic, 2007).

**Additional Testing for Patients With Aphasia**

**Word Comprehension.** Point to articles in the room, and ask the patient to name them.

**Reading.** An awareness of a patient’s reading and writing impairment is important in planning health teaching and rehabilitation. To assess reading, ask the patient to read available print, being careful not to test just literacy.

**Writing.** Ask the patient to compose and write a sentence. Note coherence, spelling, and parts of speech (the sentence should have a subject and verb).

### Abnormal Findings

**People with Alzheimer’s dementia score a zero- or one-word recall.** Ability for new learning is also impaired with anxiety (because of inattention and distractibility) and depression (because of a lack of interest or motivation).

**Aphasia is the loss of ability to speak or to understand speech, as a result of a stroke.** Speech and language dyslexia, a neurological disorder or learning disability, may create difficulty understanding what other people say (developmental receptive language disorder) or difficulty using spoken language to communicate (developmental expressive language disorder).

**Aphasia may limit ability to understand written words.** Speech and language dyslexia may create difficulty producing speech sounds (developmental articulation disorder). The individual might mispronounce certain letters or letter combinations. With academic learning dyslexia, the individual cannot identify different word sounds.

**Aphasia may limit ability to write coherently.** Dyslexia may affect writing abilities, and performance in written language exams will be very poor. With developmental writing disorder, or dysgraphia, the individual has problems with handwriting or with creating sentences that make sense to others.

**Many mental illnesses are associated with varying levels of insight.** For example, people with obsessive-compulsive disorder (OCD) often have relatively good insight that they have a problem and that their thoughts and actions are unreasonable, but they are nonetheless compelled to carry out the thoughts and actions (Marková, Jassari, & Berrios, 2009).
### Normal Range of Findings

#### Insight and Judgement

Insight is the ability to recognize one’s own illness, need for treatment, and consequences of one’s behaviour as stemming from an illness. Patients exercise judgement when they compare and evaluate the alternatives in a situation and reach an appropriate course of action. To assess judgement in the context of the interview, note what the patient says about job plans and social or family obligations; plans for the future; and capacity for violent or suicidal behaviour. Job and future plans should be realistic, in view of the patient’s health situation. To assess insight into illness, ask whether patients believe they need help or whether they believe their feelings or conditions are normal.

Further assess insight by asking patients to describe their rationales for personal health care and how they decided about whether to comply with prescribed health regimens. The patient’s actions and decisions should be realistic.

#### Thought Processes, Thought Content, and Perceptions

**Thought Processes.** Ask yourself, “Does this person make sense? Can I follow what the person is saying?” Note whether the patient responds directly to the questions or deviates from the subject at hand and has to be guided back to the topic more than once.

The way a patient thinks should be logical, goal directed, coherent, and relevant. The patient should complete a thought.

**Thought Content.** What the patient says should be consistent and logical. To identify any obsessions or compulsions, ask such questions as these:

- “How often do you wash your hands or count things over and over?”
- “Do you perform specific actions to reduce certain thoughts?”

Explore ritualistic behaviours further to determine the severity of the obsession or compulsion.

To identify any fears that cause the patient to avoid certain situations, ask if he or she has any fears, such as fear of animals, needles, heights, snakes, public speaking, or crowds.

To determine whether a person is having delusions, ask, “Do you have any thoughts that other people think are strange?” or “Do you have any special powers or abilities?”

### Abnormal Findings

Persons with Alzheimer’s disease, schizophrenia, or various psychotic conditions tend to have poor awareness that anything is wrong with them (Markova, Breines, & Hodges, 2004). Judgement is impaired (unrealistic or impulsive decisions) with intellectual disability, emotional dysfunction, schizophrenia, and organic brain disease.

<table>
<thead>
<tr>
<th>Table 6.4 lists examples of abnormal thought processes.</th>
</tr>
</thead>
</table>

Persons with OCD often demonstrate both obsessions (obsessive thoughts, ideas, or fears) and compulsions (repetitive rituals to reduce anxiety and stress in response to obsessions). Obsessions are annoying, fearful, at times harmful, and driven by different motives (e.g., fear of being hurt or hurting others, fear of infections or contamination, and need to make everything clean and orderly). Obsessions may have a religious, medical, sexual, or sadistic underpinning. Compulsions bring temporary relief but do not eliminate the obsessions. For example, if a person is afraid of germs and washes hands again and again, every washing does not make the person believe that hands are already clean enough and that there is no danger of receiving germs anymore; thus repeated washing continues. Table 6.5 lists examples of disordered thought content.

Delusions are false beliefs that occur when abnormal significance is attached to a genuine perception without rational or emotional justification. Types of delusions include grandiose (delusions of grandeur, entitlement), religious (belief that one is a [or the] deity), persecution (belief that someone wants to cause the patient harm), erotomania (belief that someone famous is in love with the patient), jealousy (belief that everyone wants what the patient has), thought insertion (belief that someone is putting ideas into the patient’s mind), and ideas of reference (belief that everything refers to the patient).
Normal Range of Findings

Perceptions. The patient should be consistently aware of reality, and his or her perceptions should be congruent with yours. Ask the following:
- "How do people treat you?"
- "Do you feel as if you are being watched, followed, or controlled?"
- "Is your imagination very active?"
- "Have you heard your name when you're alone?"

If the responses to these questions suggest that a person is experiencing hallucinations, ask some of the following questions: "Do you ever hear voices when no one else is around?" "Can you sometimes see things that no one else can see?" "Do you have other unexplained sensations such as smells, sounds, or feelings?"

If command-type hallucinations are experienced, always ask what the person will do in response. For example, "When the voices tell you to do something, do you obey their instructions or ignore them?"

SUPPLEMENTAL MENTAL STATUS EXAMINATION

The Montreal Cognitive Assessment (MoCA: Nasreddine et al., 2005) is quick, includes standard sets of questions, has standardized administration methods, requires only 10 to 15 minutes to administer, and is free for nonprofit use (Figure 6-1). The MoCA is useful for initial and serial measurements, and so you can use it to demonstrate worsening or improving cognition over time and with treatment. The MoCA includes a clock-drawing test (also see p. 93).

With its sensitivity of 90% for detecting mild cognitive impairment and specificity of 87% (Nasreddine et al., 2005), the MoCA is considered a good screening tool to detect dementia and delirium and to differentiate these from psychiatric mental illness. The MoCA demonstrated adequate psychometric properties as a screening instrument for the detection of mild cognitive impairment or dementia in Parkinson's disease (Hoops et al., 2009; Zadikoff et al., 2008), in transient ischemic attack and stroke (Pendlebury, Cunhbertson, Welch, Mehta, & Rothwell, 2010), and in psychiatric rehabilitation (Aggarwal & Kean, 2010). The validity of the MoCA has been established in memory clinic settings (Smith, Gildeh, & Holmes, 2007).

FUNCTIONAL ASSESSMENT (INCLUDING ACTIVITIES OF DAILY LIVING)

Record the dates of the most recent medical examination, eye examination, and dental examination. Ask the patient to describe a typical day and what the patient does on a daily, weekly, and annual basis to promote and maintain health. Assess self-care abilities, including activities of daily living such as bathing, hygiene, dressing, toileting, eating, walking, housekeeping, shopping, cooking, communicating with others, social relationships, finances, and coping. In particular, note the following:

Nutritional Patterns. Record the dietary intake recalled by the patient over the past 24 hours (Chapter 12). Ask whether any recent dietary changes have occurred. Note any dissatisfaction with body size, weight, or shape, as well as practices directed at weight loss, particularly if the patient is female, an elite athlete, or engaged in an occupation that emphasizes physical appearance, inasmuch as these factors contribute to eating disorders.

Sleep/Rest Changes. Ask about sleep onset (how much time it takes to fall asleep), sleep maintenance (frequency of waking and returning to sleep), early awakening (before the patient needs to be awake), sleep hygiene (measures to promote sleep, such as avoiding caffeine at bedtime), and sleep satisfaction (feeling rested and refreshed). Alterations in sleep are common in many mental disorders (e.g., mania, depression, schizophrenia).

Activity/Mobility. Withdrawal from usual activities may signal illness. Avolition (lack of motivational drive and energy) is a symptom of depression, schizophrenia, and chronic marijuana use. Excessive pursuit of physical activity may be associated with mania and eating disorders.

Abnormal Findings

Illusions (misinterpretation of a true visual, auditory, tactile, or olfactory sensation). For example, a brown sock on the floor appears to be a mouse.

Hallucinations (perceptions occurring while the patient is awake and conscious and in the absence of external stimuli). Auditory and visual hallucinations occur with psychiatric and organic brain disease and with ingestion of psychedelic drugs. Tactile hallucinations occur with alcohol withdrawal.

Normal Range of Findings

The maximum score on the MoCA is 30; scores above 26 indicate no cognitive impairment.
**MONTREAL COGNITIVE ASSESSMENT (MOCA)**

**Version 7.1 Original Version**

<table>
<thead>
<tr>
<th>NAME</th>
<th>Education</th>
<th>Date of birth</th>
<th>NAME</th>
<th>Education</th>
<th>Date of birth</th>
</tr>
</thead>
</table>

- **VISUOSPATIAL / EXECUTIVE**
  - Copy cube: Draw CLOCK (Ten past eleven) (3 points)

- **NAMING**

- **MEMORY**
  - Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

- **ATTENTION**
  - Read list of digits (1 digit/sec.). Subject has to repeat them in the forward order [ ] 2 1 8 5 4
  - Subject has to repeat them in the backward order [ ] 7 4 2

- **MEMORY**
  - Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65

- **LANGUAGE**
  - Repeat: I only know that John is one to help today. [ ]
  - The cat is under the couch when dogs are in the room. [ ]
  - Fluency: Name maximum number of words in one minute that begin with the letter F [ ] (N ≥ 11 words)

- **ABSTRACTION**
  - Similarity: e.g. banana - orange - fruit [ ] train - bicycle [ ] watch - ruler

- **DELAYED RECALL**
  - Has to recall words with no cue [ ] FACE [ ] VELVET [ ] CHURCH [ ] DAISY [ ] RED

- **ORIENTATION**
  - Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City

---

© Z. Nasreddine, MD
www.mocatest.org

Administered by: __________________________

Add 1 point if ≤ 12 yr ed.
CRAZY MAKING

UNIT 1 Assessment of the Whole Person

Elimination. Psychotropic medications may lead to constipation and urinary retention. People may misuse laxatives and diuretics in an attempt to lose weight.

Interpersonal Relationships and Resources. Assess the patient's role in family and social networks to identify sources of stress and support. Any withdrawal from usual relationships could indicate declining mental health.

Self-Esteem/Self-Concept. Ask the patient to rate self on a scale from 0 to 10, on which 10 represents the best possible way to feel about self. Ask about values, beliefs, practices, and accomplishments that are most important to the patient.

Spirituality. Ask questions to understand the meaning of faith, spirituality, and religion:

“What is it that gives your life meaning? What gives you joy?”
“What if any religious activities do you participate in?”
“Do you feel connected with the world?”
“Do you believe in God or a higher power?”

Coping and Stress Management. Ask about major stressors to understand and evaluate current coping behaviours.

Smoking, Alcohol/Drug Use, and Problem Gambling. Inquire about usual patterns of alcohol use, drug use, and gambling and about any recent changes to those patterns. Ask whether persons close to the patient would believe that alcohol, drug use, or gambling is a problem in the patient’s life.

Home and Environmental Hazards. Ask about safety issues associated with meal preparation, bathing, walking in the home and community, lighting, home heating, transportation to health care clinics, social and commercial services, and social events.

RISK ASSESSMENT

Screen for Suicidal Thoughts

It is difficult to question patients about possible suicidal wishes, especially for novice examiners who may fear invading privacy and may have their own normal discomfort with death and suicide. However, the risk is far greater if you skip these questions; you may be the only health care provider to detect clues of suicide risk.

When the patient expresses sadness, hopelessness, despair, or grief, assess any possible risk that the patient will cause physical harm to himself or herself. Begin with more general questions; if you hear affirmative answers, continue with more specific questions:

“Have you ever felt so blue you thought of hurting yourself?”
“Do you feel like hurting yourself now?”
“What would happen if you were dead?”
“How would other people react if you were dead?”

Inquire directly about specific plans, suicide notes, family history (anniversary reaction), and impulse control. Use a matter-of-fact tone of voice and open posture, and attend with interest (e.g., lean toward the person). If you are unsure whether the patient is at high risk for suicide, get help from an experienced health care team leader.

Important clues and warning signs of suicide are as follows:

• A precise suicide plan to take place in the next 24 to 48 hours with the use of a lethal method (constitutes high risk)
• Prior suicide attempts
• Depression, hopelessness
• Social withdrawal, running away
• Self-mutilation
• Hypersomnia or insomnia
• Slowed psychomotor activity
• Anorexia
• Verbal suicide messages (deafness, failure, worthlessness, loss, giving up, desire to kill self)
• Death themes in art, jokes, writing, behaviours
• Saying goodbye (giving away prized possessions)

You are responsible for encouraging the patient to talk about suicidal thoughts and for obtaining immediate help. Determine whether the patient will agree to make a commitment to treatment and living and to contract for safety by agreeing to implement a plan such as calling a crisis hot line or going to the emergency department.

Although you cannot always prevent a suicide, you can often buy time so that the patient can be helped to find an alternative solution to problems. As soon as possible, share with the health care team any concerns you have about a person’s suicide ideation.

Screen for Assaultive or Homicidal Ideation

In addition to assessing suicide threat, inquire about past acts of self-harm or violence:

“Do you have any thoughts of wanting to hurt anyone?”
“Do you have any feelings or thoughts that you wish someone were dead?”

If the reply to either question is positive, ask about any specific plans to injure someone and how the patient plans to control these feelings if they occur again.

Screen for Eloquence Risk

Elopement from psychiatric facilities increases risk of injury for patients and others in the community and increases the potential for litigation against the facility (Jayaram, 2009). To reduce risk, check the following:

• Are the doors locked? Are they unlocked manually (not electronically) so that the patient does not slip out with visitors?
• Is the patient restricted to the unit, or does the patient have off-unit privileges?
• Does the patient have an adequate understanding of the need for hospitalization?
• Does the family have adequate knowledge of the risk of elopement?
Should the patient be placed in hospital clothing, with street clothing and shoes removed, to discourage elopement?

Has the patient been placed on increased observation status?

GLOBAL ASSESSMENT OF FUNCTIONING

Global assessment of functioning is performed by the psychiatrist or qualified clinician. It is used to estimate overall psychological, social, and occupational functioning within any limitations imposed by patient physical and environmental factors. The findings are scored from low functioning (0 to 10) to high functioning (91 to 100); the scores change over time, and scoring is calculated at the start of treatment, during treatment, at discharge, and at any time after (Table 6-6).

Additional content on mental disorders is listed in Tables 6-7 (delirium and dementia), 6-8 (schizophrenia), 6-9 (mood disorders), and 6-10 (anxiety disorders).

ASSESSING PATIENT ATTITUDE TOWARD THE EXAMINER/ASSESSMENT

Record whether the patient appears hostile, defensive, guarded, or uncomfortable. Often, the patient is willing to cooperate and appears interested, friendly, relaxed, or perhaps bored with the interview process.

DEVELOPMENTAL CONSIDERATIONS

### Normal Range of Findings

#### Children and Adolescents

Essentially, you will follow the same guidelines (assessing appearance, behaviour, cognition, and thought processes) as for adults, with an emphasis on developmental milestones. Thorough knowledge of developmental milestones, as presented in the online Evolve resources accompanying this book, is critical. Although not exclusively to mental health assessment, the Nipissing District Developmental Screen (see Chapter 2) is a screening tool designed to help parents and caregivers monitor children’s development from birth to 6 years of age. Areas assessed include vision, hearing, communication, gross motor, fine motor, cognitive, social–emotional, and self-help skills.

Other reliable screening instruments (e.g., the Pediatric Symptom Checklist-17) can be given to the parent to assess emotional and behavioural wellness of children aged 4 to 18 years (Gardner, Lucas, Kolko, & Campo, 2007). For adolescents, continue to follow the same guidelines as described for adults.

In consideration of adolescent development patterns, specifically evaluate weight in the appearance assessment; regulation (e.g., self-soothing capacity and anger management skills) in the behaviour assessment; and sleep patterns, eating patterns, interpersonal behaviours (with parents, teachers, and examiner), risk (to self and others), high-risk behaviours (e.g., bullying/fire setting/running away/high-risk sexual activity/cruelty/breaking curfew/lying/stealing/truancy), academic performance (grade, least and most favourite subjects), and substance use with the cognition and thought processes assessments (Canadian School Health Community, 2010).

#### Adults and Older Adults

Always conduct even a brief examination of all older people. Check sensory status before assessing their mental health. It is recommended that you take time, reduce distractions, and minimize sensory impairments to help older people maintain their dignity and perform at their actual level of ability.

Age is the greatest risk factor for Alzheimer’s disease: 10% of people older than 65 and almost 50% of those older than 85 receive a diagnosis of Alzheimer’s disease (Alzheimer’s Association, 2011). By 2050, Canada will have more people aged 65 and older than people younger than 15 (Canadian Institutes of Health Research, 2007).

Follow the guidelines as described for adults with the additional considerations listed in the Older Adult Mental Health Assessment (see next description).

<table>
<thead>
<tr>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormalities are often problems of omission: the child does not achieve an expected milestone.</td>
</tr>
<tr>
<td>Trust is a particular challenge in working with adolescents. Responses to questions in areas of behaviour risk and personal safety are apt to be guarded unless the examiner has developed rapport with the adolescent. When possible, it is preferred that you interview the adolescent first, before meeting with parents/guardians.</td>
</tr>
<tr>
<td>More than 33% of older adults admitted to acute care medical and surgical services show varying degrees of confusion.</td>
</tr>
</tbody>
</table>
**DOCUMENTATION AND CRITICAL THINKING**

**Sample Charting**

**Appearance.** Posture is erect, with no involuntary body movements. Dress and grooming are appropriate for season and setting.

**Behaviour.** Alert, with appropriate facial expression and fluent, understandable speech. Affect and verbal responses are appropriate.

**Cognitive Functions.** Oriented to time, place, person, and self. Able to attend cooperatively with examiner. Recent and remote memory intact. Can recall four unrelated words at 5-, 10-, and 30-minute intervals. Future plans include returning to home and to local university once individual therapy is established and medication is adjusted.

**Thought Processes.** Perceptions and thought processes are logical and coherent. No suicide ideation.

---

**Focused Assessment: Clinical Case Study**

**SUBJECTIVE**

Mrs. Lola P. is a 79-year-old married woman, recently hospitalized for evaluation of increasing memory loss, confusion, and socially inappropriate behaviour. Her daughter, who visits daily, reports that Mrs. P’s hygiene and grooming have decreased; Mrs. P. eats very little, has lost weight, does not sleep through the night, displays angry emotional outbursts that are unlike her former demeanour, and does not recognize her younger grandchildren. According to her husband, Mrs. P. has drifted away from the stove while cooking, allowing food to burn on the stovetop. He has found her wandering through the house in the middle of the night, unsure of where she is. She used to “talk on the phone for hours” but now he has to force her into conversations.

**OBJECTIVE**

During this hospitalization, Mrs. P. has undergone a series of medical tests, including a lumbar puncture, electroencephalography, and computed tomography of the head, all of which yielded normal findings. Her physician suggests a diagnosis of senile dementia of the Alzheimer’s type.

**Appearance.** Mrs. P. is sitting quietly, somewhat slumped, picking at loose threads on her dress. A hooded, zipped sweatshirt top is worn over her dress. Her hair is gathered in a loose ponytail with stray wisps. She wears no makeup.

**Behaviour.** Mrs. P. is awake and gazing at her hands and lap. Her expression is flat and vacant. She makes eye contact when called by name, although her gaze quickly shifts back to her lap. Her speech is a bit slow but articulate; she has some trouble with word choice.

**Cognitive Functions.** Mrs. P. is oriented to person and place. She can state the season but not the day of the week or the year. She is not able to repeat the correct sequence of complex directions involving lifting and shifting a glass of water to the other hand. She scores a one-word recall on the Four Unrelated Words Test. She cannot tell the examiner how she would plan a grocery-shopping trip.

**Thought Processes.** Mrs. P. experiences blocking in train of thought. Her thought content is logical. She acts cranky and suspicious with family members. She reports no suicide ideation.

**Her MoCA score is 16.**

---

**ASSESSMENT**

Confusion
Impaired social interaction
Impaired memory
Wandering

**Nursing Diagnoses That May Be Relevant to Mrs. P.**

Impaired verbal communication related to cerebral impairment, as demonstrated by altered memory and judgement.

Bathing self-care deficit, feeding self-care deficit, and toileting self-care deficit related to cognitive impairment, as demonstrated by inattention to hygiene, nutrition, and sleep needs.

Altered nutrition: less than body requirements as evidenced by reduced intake and weight loss.

Impaired social interaction related to cognitive impairment and withdrawal from others.

Risk for injury related to cognitive impairment, unsupervised cooking, and wandering behaviour.

Risk for self-directed violence and risk for other-directed related to angry outbursts.
All nursing diagnoses can be found on the Evolve Web site at http://evolve.elsevier.com/Canada/jarvis/examination/.

**Overall Goals**

Help Mrs. P achieve her highest level of safety and independence in such areas as nutrition, activities of daily living, grooming, and social interaction.

**Sample Interventions**

Ensure that any aids for vision and hearing are positioned correctly and in good working order. Each time you begin a conversation with Mrs. P., make eye contact, identify yourself, and call her by name. Communicate slowly and clearly through short conversations, single-step instructions, and repetition; reduce background distractions such as television.

Allow Mrs. P. enough time to process questions and formulate responses. Observe her verbal and nonverbal communications, and show interest in what she is communicating. Do not interrupt when she is trying to communicate an idea because this may distract her and cause her to lose her train of thought. Unless you are conducting a supplemental mental status assessment, it may be helpful to supply a word that she is struggling to find. Speak in a low-pitched voice while maintaining an open, calm and friendly communication manner.

It is important to remember to break down tasks into very basic steps (e.g., [1] Pick up hairbrush, [2] brush front of hair, [3] brush back of hair, [4] put hair brush down).

**Evaluation and Reassessment**

Evaluate mental health at least partially during every shift and reassess in full when a change in status is observed.

---

**ABNORMAL FINDINGS**

**TABLE 6-2  Levels of Consciousness**

The terms below are commonly used in clinical practice. To increase clarity, record also:

1. The level of stimulus used, ranging progressively from
   - Name called in normal tone of voice
   - Name called in loud voice
   - Light touch on person’s arm
   - Vigorous shake of shoulder
   - Pain applied

2. The patient’s response
   - Amount and quality of movement
   - Presence and coherence of speech
   - Opening of eyes and making eye contact

3. What the patient does on cessation of your stimulus

**Alert**

Awake or readily aroused, oriented, fully aware of external and internal stimuli and responds appropriately; conducts meaningful interpersonal interactions

**Lethargic (or Somnolent)**

Not fully alert, drifts off to sleep when not stimulated, can be aroused to name when called in normal voice but looks drowsy, responds appropriately to questions or commands but thinking seems slow and fuzzy, inattentive, loses train of thought, spontaneous movements are decreased

**Obtunded**

(Transitional state between lethargy and stupor)

Sleeps most of time, difficult to arouse; needs loud shout or vigorous shake, acts confused when is aroused, converses in monosyllables, speech may be mumbled and incoherent, requires constant stimulation for even marginal cooperation

**Stupor or Semicoma**

Spontaneously unconscious, responds only to persistent and vigorous shake or pain; has appropriate motor response (i.e., withdraws hand to avoid pain); otherwise can only groan, mumble, or move restlessly; reflex activity persists
### Levels of Consciousness—cont’d

**Coma**
Completely unconscious, no response to pain or to any external or internal stimuli (e.g., when suctioned, does not try to push the catheter away); in light coma, has some reflex activity but no purposeful movement; in deep coma, has no motor response.

**Acute Confusional State (Delirium)**
Clouding of consciousness (dulled cognition, impaired alertness); inattentive; incoherent conversation; impaired recent memory and confabulatory for recent events; often agitated and having visual hallucinations; disoriented, with confusion worse at night when environmental stimuli are decreased.


### Abnormalities of Mood and Affect

<table>
<thead>
<tr>
<th>Type of Mood or Affect</th>
<th>Definition</th>
<th>Clinical Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flat affect (blunted affect)</td>
<td>Lack of emotional response; no expression of feelings; voice monotonous and face immobile</td>
<td>Topic varies, expression does not</td>
</tr>
<tr>
<td>Depression</td>
<td>Sad, gloomy, dejected; symptoms may occur with rainy weather, after a holiday, or with an illness; if the situation is temporary, symptoms fade quickly</td>
<td>Saying, “I’ve got the blues.”</td>
</tr>
<tr>
<td>Depersonalization (lack of ego boundaries)</td>
<td>Loss of identity, feeling estranged, perplexed about own identity and meaning of existence</td>
<td>Saying, “I don’t feel real” or “I feel as if I’m not really here.”</td>
</tr>
<tr>
<td>Elation</td>
<td>Joy and optimism, overconfidence, increased motor activity, not necessarily pathological</td>
<td>Saying, “I’m feeling very happy.”</td>
</tr>
<tr>
<td>Euphoria</td>
<td>Excessive well-being, unusually cheerful or elated, that is inappropriate considering physical and mental condition, implies a pathological mood</td>
<td>Saying, “I am high”; “I feel like I’m flying”; or “I feel on top of the world”</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Worried, uneasy, apprehensive from the anticipation of a danger whose source is unknown</td>
<td>Saying, “I feel nervous and high strung”; “I worry all the time”; or “I can’t seem to make up my mind”</td>
</tr>
<tr>
<td>Fear</td>
<td>Worried, uneasy, apprehensive; external danger is known and identified</td>
<td>Fear of flying in airplanes</td>
</tr>
<tr>
<td>Irritability</td>
<td>Annoyed, easily provoked, impatient</td>
<td>Internalizing a feeling of tension, so that a seemingly mild stimulus “sets off” the patient</td>
</tr>
<tr>
<td>Rage</td>
<td>Furious, loss of control</td>
<td>Expressing violent behaviour toward self or others</td>
</tr>
<tr>
<td>Ambivalence</td>
<td>The existence of opposing emotions toward an idea, object, person</td>
<td>Feeling love and hate toward another person at the same time</td>
</tr>
<tr>
<td>Lability</td>
<td>Rapid shift of emotions</td>
<td>Person expresses euphoric, tearful, angry feelings in rapid succession</td>
</tr>
<tr>
<td>Inappropriate affect</td>
<td>Affect that is clearly discordant with the content of the person’s speech</td>
<td>Laughing while discussing admission for liver biopsy</td>
</tr>
</tbody>
</table>
### SPECIAL CONSIDERATIONS FOR ADVANCED PRACTICE

#### TABLE 6-4  Examples of Abnormalities of Thought Process

<table>
<thead>
<tr>
<th>Type of Process</th>
<th>Definition</th>
<th>Clinical Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blocking</td>
<td>Sudden interruption in train of thought, seems related to strong emotion</td>
<td>Unable to complete sentence, saying, &quot;Forgot what I was going to say.&quot;</td>
</tr>
<tr>
<td>Confabulation</td>
<td>Fabricating events to fill in memory gaps</td>
<td>Giving detailed description of a long walk around the hospital although the patient is known to have remained in his or her room all afternoon.</td>
</tr>
<tr>
<td>Neologism</td>
<td>Coming up with a new word; invented word has no real meaning except for the patient; several words may be condensed</td>
<td>Saying, &quot;I'll have to turn on my thinkilator.&quot;</td>
</tr>
<tr>
<td>Circumlocution</td>
<td>Roundabout expression, substituting a phrase when patient cannot think of name of object</td>
<td>Saying, &quot;the thing you open the door with&quot; Instead of &quot;key.&quot;</td>
</tr>
<tr>
<td>Circumstantiality</td>
<td>Talking with excessive and unnecessary detail, delaying in reaching point; sentences have a meaningful connection but are irrelevant (this occurs normally in some people)</td>
<td>Saying, &quot;When was my surgery? Well I was 28, I was living with my aunt, she's the one with psoriasis, she had it bad that year because of the heat, the heat was worse then than it was the summer of '92....&quot;</td>
</tr>
<tr>
<td>Loose associations</td>
<td>Shifting from one topic to an unrelated topic; person seems unaware that topics are unconnected</td>
<td>Saying, &quot;My boss is angry with me and it wasn't even my fault. [pause] I saw that movie, too, Lastel. I felt really bad about it. But she kept trying to land the airplane and she never knew what was going on.&quot;</td>
</tr>
<tr>
<td>Flight of Ideas</td>
<td>Abrupt change, rapid skipping from topic to topic, practically continuous flow of accelerated speech; topics usually have recognizable associations or are plays on words</td>
<td>Saying, &quot;Take this pill? The pill is blue. I feel blue. [sing] She wore blue velvet.&quot;</td>
</tr>
<tr>
<td>Word salad</td>
<td>Incoherent mixture of words, phrases, and sentences; illogical, disconnected, includes neologisms</td>
<td>Saying, &quot;Beauty, red based five, pigeon, the street corner, sort of.&quot;</td>
</tr>
<tr>
<td>Perseveration</td>
<td>Persistent repeating of verbal or motor response, even with varied stimuli</td>
<td>Saying, &quot;I'm going to lock the door, lock the door. I walk every day and I lock the door. I usually take the dog and I lock the door.&quot;</td>
</tr>
<tr>
<td>Echolalia</td>
<td>Imitation, repeats others' words or phrases, often with a mumbling, mocking, or mechanical tone</td>
<td>[In response to the nurse's request to take a pill] Saying mockingly, &quot;Take your pill, Take your pill.&quot;</td>
</tr>
<tr>
<td>Clanging</td>
<td>Word choice based on sound, not meaning; includes nonsense rhymes and puns</td>
<td>Saying, &quot;My feet are cold. Cold, bold, told. The bell tolled for me.&quot;</td>
</tr>
</tbody>
</table>

#### TABLE 6-5  Abnormalities of Thought Content

<table>
<thead>
<tr>
<th>Type of Content</th>
<th>Definition</th>
<th>Clinical Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phobia</td>
<td>Strong, persistent, irrational fear of an object or situation; feeling driven to avoid it</td>
<td>Cats, dogs, heights, enclosed spaces</td>
</tr>
<tr>
<td>Hypochondriasis</td>
<td>Morbid worrying about own health; feeling sick with no actual basis for that assumption</td>
<td>Preoccupation with the possibility of having cancer; belief that any symptom or physical sign means cancer</td>
</tr>
<tr>
<td>Obsession</td>
<td>Unwanted, persistent thoughts or impulses experienced as intrusive and senseless; logic does not purge them from consciousness</td>
<td>Violence (parent having repeated impulse to kill a loved child); contamination (becoming infected by shaking hands)</td>
</tr>
<tr>
<td>Compulsion</td>
<td>Unwanted repetitive act thought to neutralize or prevent discomfort or some dreaded event</td>
<td>Handwashing, counting, checking and rechecking, touching</td>
</tr>
<tr>
<td>Delusions</td>
<td>Fixed, false beliefs; irrational beliefs; clinging to delusion despite objective evidence to contrary</td>
<td>Grandiose delusion: belief that one is God, a famous person, a historical figure, a sports figure, or another well-known person</td>
</tr>
<tr>
<td>Persecution</td>
<td>saying, &quot;They are out to get me.&quot;</td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 6-6 Global Assessment of Functioning Scale

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health illness. Do not include impairment in functioning caused by physical (or environmental) limitations.

<table>
<thead>
<tr>
<th>Scoring Range</th>
<th>Description of Level of Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>100–91</td>
<td>Superior functioning in a wide range of activities; life's problems never seem to get out of hand; person is sought out by others because of his or her many positive qualities. No symptoms.</td>
</tr>
<tr>
<td>90–61</td>
<td>Absent or minimal symptoms (e.g., mild anxiety before an examination); good functioning in all areas; interested and involved in a wide range of activities; socially effective; generally satisfied with life; no more than everyday problems or concerns (e.g., an occasional argument with family members).</td>
</tr>
<tr>
<td>80–71</td>
<td>If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentration after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in school work).</td>
</tr>
<tr>
<td>70–61</td>
<td>Some mild symptoms (e.g., depressed mood and mild insomnia) or some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.</td>
</tr>
<tr>
<td>60–51</td>
<td>Moderate symptoms (e.g., flat and circumstantial speech, occasional panic attacks) or moderate difficulty in social occupational, or social functioning (e.g., few friends, conflicts with coworkers).</td>
</tr>
<tr>
<td>50–41</td>
<td>Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).</td>
</tr>
<tr>
<td>40–31</td>
<td>Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) or major impairment in several areas, such as work or school, family relations, judgement, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats younger children, is defiant at home, and is failing at school).</td>
</tr>
<tr>
<td>30–21</td>
<td>Behaviour is considerably influenced by delusions or hallucinations or serious impairment in communication or judgement (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) or inability to function in almost all areas (e.g., stays in bed all day; has no job, home, or friends).</td>
</tr>
<tr>
<td>20–11</td>
<td>Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) or occasionally fails to maintain minimal personal hygiene (e.g., smears faces) or gross impairment in communication (e.g., largely incoherent or mute).</td>
</tr>
<tr>
<td>10–1</td>
<td>Persistent danger of severely hurting self or others (e.g., recurrent violence) or persistent inability to maintain minimal personal hygiene or some suicidal act with clear expectation of death.</td>
</tr>
<tr>
<td></td>
<td>Inadequate information.</td>
</tr>
</tbody>
</table>


### TABLE 6-7 Comparison of Characteristics of Delirium and Dementia

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Delirium</th>
<th>Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset</td>
<td>Sudden; hours to days</td>
<td>Progressive; months to years</td>
</tr>
<tr>
<td>Course</td>
<td>Acute; temporary; considered reversible</td>
<td>Chronic, with deterioration over time</td>
</tr>
<tr>
<td>Prevalence</td>
<td>Present in 10%–30% of hospitalized older adults</td>
<td>Estimated to affect &gt;30% of people older than 85</td>
</tr>
<tr>
<td>Distinguishing Feature</td>
<td>Presence of an underlying medical disorder (e.g., urinary tract infection, hypoxia)</td>
<td>Age-associated illness with decline in multiple areas of cognitive function, eventually leading to a significant inability to maintain occupational and social performance</td>
</tr>
<tr>
<td>Self-awareness</td>
<td>May be aware of changes in cognition; fluctuates</td>
<td>Likely to hide or be unaware of cognitive deficits</td>
</tr>
<tr>
<td>Activities of daily living</td>
<td>May be intact or impaired</td>
<td>May be intact early, impaired as disease progresses</td>
</tr>
<tr>
<td>Consequences</td>
<td>Contributes to outcomes of longer hospitalization, higher rates of nursing home placement, and possibly higher mortality rate</td>
<td>Major cause of disability, self-neglect, nutrition problems, incontinence, falls, communication difficulties, financial stress from job loss, and caregiver burden and depression</td>
</tr>
</tbody>
</table>

### TABLE 6-8  Diagnostic Criteria for Schizophrenia*

<table>
<thead>
<tr>
<th>DSM-IV-TR</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>At Least One of the Following:</strong></td>
<td></td>
</tr>
<tr>
<td>• Bizarre delusions or</td>
<td>• Thought echo, thought insertion/withdrawal/broadcast</td>
</tr>
<tr>
<td>• Third-person auditory hallucinations with running commentary (voice/voices continuously comment about the person’s behaviour or thoughts)</td>
<td>• Passivity, delusional perception</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td>• Third-person auditory hallucination with running commentary</td>
</tr>
<tr>
<td><strong>Two or More of the Following:</strong></td>
<td>• Persistent bizarre delusions</td>
</tr>
<tr>
<td>• Delusions</td>
<td>• Persistent hallucinations</td>
</tr>
<tr>
<td>• Hallucinations</td>
<td>• Thought disorder</td>
</tr>
<tr>
<td>• Disorganized speech</td>
<td>• Catatonic behaviour</td>
</tr>
<tr>
<td>• Grossly disorganized behaviour</td>
<td>• Negative symptoms</td>
</tr>
<tr>
<td>• Negative symptoms (e.g., flat affect, avolition)</td>
<td>• Significant behaviour change</td>
</tr>
<tr>
<td><strong>AND</strong></td>
<td></td>
</tr>
<tr>
<td><strong>At Least One of the Following:</strong></td>
<td></td>
</tr>
<tr>
<td>• Social dysfunctioning (e.g., relationships, ability for self-care)</td>
<td></td>
</tr>
<tr>
<td>• Occupational dysfunctioning (e.g., work)</td>
<td></td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td></td>
</tr>
<tr>
<td>1 month of characteristic symptoms with 6 months of social/occupational dysfunction</td>
<td>More than 1 month</td>
</tr>
</tbody>
</table>


### TABLE 6-9  Mood Disorders*

The definitions of mood disorders and their primary symptoms can be found in DSM-V (APA, 2013). Please refer to the source document for a complete description of the disorders below:

- Major Depressive Disorder (APA, 2013, pp. 160-162)
- Persistent Depressive Disorder (Dysthymia) (APA, 2013, pp. 168-171)
- Bipolar I Disorder (APA, 2013, pp. 123-139)
- Bipolar II Disorder (APA, 2013, pp. 132-139)

Source: *The reader is referred to the original source listing these disorders (American Psychiatric Association, 2013) or to a psychiatry textbook for further details and categories of anxiety disorders.
### TABLE 6-10 Anxiety Disorders*

Anxiety disorders encompass a multitude of disorders whose primary feature is abnormal or inappropriate anxiety. Patients with anxiety experience an increased heart rate, tensed muscles, and other "fight or flight" processes; these symptoms become a problem when they occur without any recognizable stimulus or when the stimulus does not warrant the reaction.

Anxiety disorders as listed in the DSM-V (American Psychiatric Association, 2013) include the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>308.3</td>
<td>Acute stress disorder</td>
</tr>
<tr>
<td>300.22</td>
<td>Agoraphobia (with or without a history of panic disorder)</td>
</tr>
<tr>
<td>300.22</td>
<td>Generalized anxiety disorder [GAD]</td>
</tr>
<tr>
<td>301.3</td>
<td>Obsessive-compulsive disorder [OCD]</td>
</tr>
<tr>
<td>300.1</td>
<td>Panic disorder (with or without agoraphobia)</td>
</tr>
<tr>
<td>300.23</td>
<td>Social anxiety disorder (social phobia)</td>
</tr>
<tr>
<td>309.81</td>
<td>Post-traumatic stress disorder [PTSD]</td>
</tr>
</tbody>
</table>

*See [http://alpsych.com/disorders/disorders_alpha.html](http://alpsych.com/disorders/disorders_alpha.html). The reader is referred to the original source listing these disorders (American Psychiatric Association, 2013) or to a psychiatry textbook for further details and categories of anxiety disorders.

### Summary Checklist: Mental Health Assessment


1. **Health history**
   - Source of information
   - Identification/biographic information
   - Reason for seeking care (patient's verbatim reason; psychiatric diagnoses [DSM-V])
   - Past health (past illness, injury, hospitalization; chronic illnesses)
   - Family health history
   - Developmental considerations
   - Present health (allergies, immunization/HIV/hepatitis status; current medications)

2. **Mental status examination**
   - Appearance
   - Behaviour (mood and affect, speech)
   - Cognitive function (level of consciousness: orientation to time, place, person, self; memory; attention and concentration; comprehension and abstract reasoning)
   - Thought (perception, content, process, judgement, and insight)

3. **Supplemental mental status examination (if warranted)**
   - Montreal Cognitive Assessment

4. **Functional assessment of activities of daily living**
   - Nutrition patterns
   - Sleep/rest changes
   - Activity/mobility
   - Elimination

5. **Interpersonal relationships and resources**
   - Self-esteem/self-concept
   - Ethnicity/culture
   - Spirituality
   - Coping and stress management
   - Smoking, alcohol and drug use, problem gambling
   - Home environmental hazards

6. **Screen for suicidal thoughts, assaul-
tive or homicidal ideation, and elopement risk (when indicated)**

7. **Treatment plan (global assessment of function)**

Special Considerations for Advanced Practice

DSM-V: Diagnostic and statistical manual of mental health disorders (5th ed.). (APA, 2013); HIV, human immunodeficiency virus.
CRAZY MAKING


Web Sites of Interest

Aboriginal Healing Foundation: http://www.abhf.ca/

Alzheimer Society: http://www.alzheimers.ca/

Canadian Alliance on Mental Illness and Mental Health: http://www.campmh.ca/

Canadian Coalition for Senior's Mental Health: http://www.ccmh.ca/
UNIT 1  Assessment of the Whole Person

Canadian Institute for Health Information: http://www.cihi.ca
Canadian Mental Health Association: http://www.cmha.ca/bins/index.asp
Centre for Addiction and Mental Health: http://www.camh.net/
Mental Health Commission of Canada: http://www.mentalhealthcommission.ca/mhcc.html
Mental Health Glossary, Royal Ottawa Health Care Group: http://www.rohcg.on.ca/resources/glossary-e.cfm

Mood Disorder Society of Canada: http://www.mooddisorderscanada.ca/
National Eating Disorder Information Centre: http://www.nedic.ca/
Psychosocial Rehabilitation Canada: http://www.parpcanada.ca/
Schizophrenia Society of Canada: http://www.schizophrenia.ca/
Seniors Mental Health Web site created to facilitate activities related to supporting seniors’ mental health: http://www.seniorsmentalhealth.ca/index.html
## Appendix C
Undergraduate Nursing Curriculum Overview

<table>
<thead>
<tr>
<th>YEAR I</th>
<th>YEAR II</th>
<th>YEAR III</th>
<th>YEAR IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semester I</td>
<td>Semester II</td>
<td>Semester III</td>
<td>Semester IV</td>
</tr>
<tr>
<td>Nursing theory</td>
<td>Nursing theory</td>
<td>Nursing theory</td>
<td>Professional development</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Professional elective*</td>
</tr>
<tr>
<td>Nursing practice: Introduction to nursing practice</td>
<td>Nursing practice: Acute and chronic care</td>
<td>Nursing practice: Community nursing</td>
<td>Nursing practice</td>
</tr>
<tr>
<td>Health assessment</td>
<td>Pathotherapeutics</td>
<td>Ethics</td>
<td>Professional development</td>
</tr>
<tr>
<td>Human anatomy and physiology</td>
<td>Research</td>
<td>Professionally-related elective</td>
<td>Professionally-related elective</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Professional development</td>
<td>Psychology</td>
<td>Sociology</td>
</tr>
<tr>
<td>Psychology</td>
<td></td>
<td>Liberal studies</td>
<td>Liberal studies</td>
</tr>
<tr>
<td>Liberal studies</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Professional electives
Gerontological and geriatric nursing
Adult health
Women’s health
Family health
Community mental health
End of life care
Appendix D
Systemics Flow Chart and Path of Textual Analysis (in red)
Appendix E
Critical Thinking Diagram

Levels of critical thinking
- Level 3: Commitment
- Level 2: Complex
- Level 1: Basic

Components of critical thinking
- Specific knowledge base
  - Experience
  - Competencies
  - Attitudes
  - Standards
Appendix F
Scholarly Paper Instructions and Evaluative Rubric

Individual Scholarly Paper

**PURPOSE:** Select and explore one of the concepts covered during this course.

**Method of submission:**
Turnitin (e-mail submissions WILL NOT be accepted). The paper must be submitted by 11:59pm the day prior to your regularly scheduled class in week five. Example: if your class is on a Tuesday you must submit your paper by Monday 11:59pm.

***See below about the reference package, which is due in class during week 5.

**Paper Length:** Maximum 5 pages (excluding title page and references).

**References:** You must use at least 3 references that are within 5 years. At least one of these references must be primary scholarly research that is NOT from the course readings.

**PART ONE** consists of your scholarly paper written in accordance with APA (see rubric for details of APA)
- **Introduction**
  - State purpose of paper and provide a brief outline of paper
- **Body of paper**
  - Identify one concept (from the course)
  - Provide definition of the concept using at least 1 primary scholarly research (outside of the course readings). Your definition must include the attributes of the concept.
  - Explain how these attributes of the concept are exhibited in our patient. This involves exploring and analyzing the concept within the context of a real patient you have been assigned in clinical practice.
  - Identify nursing interventions/action related to your patient’s illness experience (and his/her family) related to the chosen concept (must use primary scholarly research to support). Explain how these interventions are applicable to the patient’s experience.
  - Explore how your new understanding of this concept may influence your practice
- **Conclusion**
  - Present final thoughts and leave a final impression on the reader about the topic
Note: Analysis is an important part of this paper. Below are a few key points about analysis:

- Analysis moves beyond description and involves examination of the concept and explanation
- Analysis is a process of inquiry that involves looking at the concept very closely
- Analysis involves not only how the concept appears in the novel, but why it appears that way and what it means/what is the significance

PART TWO consists of a reference package.

1. A title page along with a hard copy of the abstract for each of the references that you use within the paper. If an abstract is not available a copy of the first page of the reference is required. Example: if you use six references used within your paper (and identified within your reference page), you should also be submitting six abstracts as part of your reference package.

2. The reference package is due week 5 during your regularly scheduled class.

3. Reference packages submitted after the end of the regularly scheduled class time in week 5 will be considered late and a late penalty will apply.
Assignment Rubric

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INTRODUCTION and CONCLUSION TO PAPER</strong></td>
<td></td>
</tr>
<tr>
<td>a) Introduction: Clearly and concisely state purpose of paper and provide a brief outline of the paper</td>
<td></td>
</tr>
<tr>
<td>b) Conclusion: Present final thoughts and leave a final impression on the reader about the topic</td>
<td></td>
</tr>
<tr>
<td><strong>BODY OF PAPER</strong></td>
<td></td>
</tr>
<tr>
<td>a) Selected, clearly articulated and explored one concept from the course (using a primary study to define concept). Attributes of concept defined and explanation provided of how the attributes of this concept are exhibited in patient experience.</td>
<td></td>
</tr>
<tr>
<td>b) Discussed the relevance of this concept to patient’s experience.</td>
<td></td>
</tr>
<tr>
<td>c) Identified nursing interventions related to patient’s illness experience (and family) related to the chosen concept (used primary scholarly research to support). Explained how these interventions are applicable to patient’s illness experience.</td>
<td></td>
</tr>
<tr>
<td>d) Explored how your new understanding of this concept may influence your practice.</td>
<td></td>
</tr>
<tr>
<td><strong>HANDBOOK CRITERIA:</strong></td>
<td></td>
</tr>
<tr>
<td>a) Comprehensive, critical and insightful analysis of the concept within the context of the novel</td>
<td></td>
</tr>
<tr>
<td>b) Comprehensive grasp of subject matter and synthesis of ideas</td>
<td></td>
</tr>
<tr>
<td>c) Comprehensive review of the literature and integration of the selected concept</td>
<td></td>
</tr>
<tr>
<td>d) Demonstrates capacity for originality, creativity and critical thinking</td>
<td></td>
</tr>
<tr>
<td>e) Ability to organize and present ideas logically and fluently</td>
<td></td>
</tr>
<tr>
<td>f) Ability to analyze, synthesize, and express ideas logically and fluently</td>
<td></td>
</tr>
<tr>
<td>g) Ability to make critical and insightful evaluation of relevant materials</td>
<td></td>
</tr>
</tbody>
</table>

**PAPER FORMATTING**

Uses APA Publication Manual to guide scholarly writing

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Correct formatting in title page</td>
<td></td>
</tr>
<tr>
<td>b) Correct formatting throughout paper</td>
<td></td>
</tr>
<tr>
<td>c) Correct formatting of in-text citations and reference page</td>
<td></td>
</tr>
<tr>
<td>d) Accurate grammar, sentence structure and spelling</td>
<td></td>
</tr>
<tr>
<td>e) 5 page maximum (exclusive of title page &amp; reference list) using 12 font, Times New Roman (anything over 5 pages will not be read)</td>
<td></td>
</tr>
</tbody>
</table>

Instructor's Comments:
Notes

1. The term *micro analysis* is not to be taken as in a traditional linguistics approach, where language is analyzed in isolation of its social context. My use of the term considers language as a phenomenon that both shapes and is shaped by the social. The term refers to a framework of discourse analysis drawn from Bakhtin (1981 & 1986). Methodologically, I specifically draw on the work of Fairclough (2001 & 2003) and Chouliaraki and Fairclough (1999) in critical language studies.

2. The mental health system is viewed as a multifaceted industry which overlaps with, supports and is supported by the State, the pharmaceutical enterprise and other private investors, research, and cognate disciplines, such as psychology and social work. To that respect, see Whitaker (2002) and Burstow (2015).

3. A Community Treatment Order (CTO) is an order issued by a physician, ‘agreed to’ by the individual or a substitute decision maker. It forces the individual to receive psychiatric medications outside the hospital. Non-compliance with CTOs result in the individual being taken to a psychiatric institution against his or her will and indefinitely rehospitalized. A CTO is ordered for patients who have had repeated psychiatric admissions and who do not voluntarily engage in outpatient follow-up. CTOs have been critiqued for their being inhumane, whose primary goals are social and behavioural control. They are rejected by the antipsychiatry constituency and most of the survivor and Mad constituencies as a method to ‘de-institutionalize’ the psychiatric patient, yet at the same time turn the community into a diffuse psychiatric institution. In that respect, see [http://www.qsos.cc/qspc/nfc/cto.html](http://www.qsos.cc/qspc/nfc/cto.html)

4. While it is necessary at this juncture to differentiate between smith’s concept of institutional capture and what I term ‘linguistic capture,’ it is also important to note that both arise from
material social relations organizing discourse. That is, while for methodological reasons I make a
distinction between the two concepts, both must be understood as having a materialist
ontological orientation.

5 While a specific Foucauldian method of critical discourse analysis has been circumscribed by
Wodak and Meyer (2009), my use of Foucauldian discourse analysis methodology differs and is
not necessarily an ‘identified’ Foucauldian methodology. That is, I make use of Foucault’s
concepts as tools to investigate certain social practices.

6 It is important to note that while I list these three assumptions here, they are all also holistically
applicable to the study. That is, while we will see by way of the critical discourse analysis how
discourse indeed does ideological work and is a form of social action, ideology will also be made
visible in the institutional analysis, by way of examining the relations of ruling and the
disciplinary nature of the teaching and learning practices of the nursing academy. Likewise,
discourse, particularly that which arises out of the resisting faculty member and student, will
emerge as form of social action not only from the critical analysis of language, but also of the
institution as a whole, as my readers will soon see.

7 It may be evident to my reader at this point–at the juncture of inserting a micro language
analysis in an institutional ethnography–that I am making an ontological departure from Smith’s
method. Indeed, in order to interrogate syntax and semantics, it is necessary to briefly depart
from a materialist ontology. However, it is equally important for my reader to understand that the
micro language analysis is to be considered in the context of the ethnography. That is, the
findings rendered by the functional grammar analysis must also be seen as given rise to by the
material relations of the ‘authoring’ and ‘speaking’ practices of everyday people, including
nurses, nursing scholars, and nursing educators.
In order to preserve anonymity, I have assigned pseudonyms to all institutional documents and processes whose original names may otherwise reveal the identity of the institution. Some characteristics that are uniquely attributed to the institution have also been generalized and/or changed in order to maintain anonymity. Appendix C is a generalized version of the program overview document and has received approval from the program’s leadership team for inclusion in this dissertation and publication later on.

Extensive search of and inquiry about previous versions of the program strategic plan did not materialize any. It is for this reason that I believe none existed prior to the 2013 version. This leads me to conclude that this text was specifically created in anticipation of the oncoming program accreditation review.

Falling exam pass rates are in part attributable to what appears to be an inherent problem in the NCLEX exam itself as well as the processes around its introduction in Ontario. The new exam has been criticized by a number of institutions, student bodies included, for its abrupt implementation which did not allow for adequate school preparation and support of students. Given its American basis (The NCLEX methodology is originally American), it has also been criticized for being unrepresentative of the Canadian context. For further reading on critiques of the NCLEX, see https://www.cna-aiic.ca/en/news-room/news-releases/2016/2015-nclex-rn-results-signal-several-major-issues-with-nurse-licensing-exam and http://www.casn.ca/2015/09/new-american-entry-to-practice-exam-a-failure-for-canadian-nursing-students-and-for-canada-ottawa-sept-9-2015/.

While the College of Nurses of Ontario puts out program-specific statistics, the Canadian Council of Registered Nurse Regulators does not. Instead, the Council publishes more general
data, such as province-to-province comparisons and averages, as well as general information around NCLEX content.

12 In my combing through the nursing course outlines and their respective reading lists, I could not find any material on intersectionality theory, which leads me to suspect that the curriculum commented on by this student is that of a non-nursing course (e.g. sociology, psychology).