The language of psychiatric discourse: power and imbalance

SEWELL, Freya

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Freya Sewell Mental health nursing student, Edinburgh Napier University

Correspondence: freya.sewell@gmail.com

Abstract

This paper examines the use and importance of language in mental health nursing. It argues that the language of psychiatric discourse establishes unhelpful power imbalance, difference and distance between persons and mental health nurses, between 'them' and 'us'.

Key words

Language, psychiatric discourse, power, imbalance, relationships, practice

Introduction

Language is an essential way of constructing meaning and communicating in human society. It functions as a social signalling system, and a means of exchanging messages and establishing expectations in relationships (Fine, 2001; El-Mallakh and Doenninghaus, 2016). Choice of language expresses something of speakers' inner thoughts, attitudes and beliefs – it makes the private public (Douglas et al, 2008; Kemp and Howard, 2017).

This paper considers the importance of language in mental health and what it produces in the nurse-person relationship. Relating through language is foundational in mental health nursing (Kemp and Howard, 2017).

Effective communication is an imperative of nursing practice generally (NMC), 2015). In mental health services, psychiatric discourse dominates with its unique language of symptoms, behaviours and diagnosis (Byrne et al, 2016; Turner, 2017). Through language this discourse is transacted, making it a powerful area for enquiry (Brown et al, 1996). If language shapes meaning, it is important to consider how language is used and its intended and unintended consequences (Holtgraves and Kashima, 2008).

Despite the rise of recovery and service user movements and policy 'empowerment', psychiatric discourse – which is inherently hierarchical and categorical – continues to direct care (Scottish Government, 2015).

There is a gap between policy aspirations and practice realities (Hui and Stickley, 2007; Bee et al, 2015). For many reasons the language of psychiatric discourse may be considered useful, and some perspectives are considered in the background section of this paper.

However, in the nurse-person relationship this language is unhelpful and, at worst, damaging. From the literature, three lines of reasoning emerge to support this critical perspective, further explored in the main body of this paper. First, the connection between language, knowledge and power. There is a potential for language to perpetuate power imbalances and hinder nurses and people meeting as equals.

Second, there is a capacity for language to create disabling environments, which are inclusive only of those who speak it and excluding those who do not.

Finally, there is an unhelpful and erroneous social distance between nurse and person created through psychiatric labelling. Both are persons capable of experiencing distress, yet one person's experience becomes abnormal or 'other' through professional re-authoring.

This thematic multiplicity speaks of the myriad ways that language influences mental health nursing practice. Contemporary research in this area is partial and fragmented, appearing in articles secondary to other subjects. More focused research is needed to unfold the significance of language. This paper aims to pull together existing health and social care literature.

Throughout, use of the term 'person' is a reminder of individuals' multi-faceted nature. Persons are unique in a way that broadly grouped 'service users', 'patients' and 'clients' cannot be (Heffernan, 2006).

A survey the by National Survivor User Network (NSUN) (2015) found that people with lived experience prefer 'person' identity markers, reminding professionals 'I am a person first'.

Background

Discourse refers to sets of knowledge that inform understanding and interaction with the world (Foucault, 1994, cited in Hamilton and Manias, 2006).

The dominance of discourse is maintained via strengthening cyclical exchange between knowledge, power and use (Hamilton and Manias,

2006). Knowledge wields power and power lends authority, leading to further investment of research and technology.

Through language, discourse is constructed and disseminated by its practising professionals, those who inhabit the 'specific semantic world' of their discipline (Manor-Binyamini, 2007).

In mental health, psychiatric discourse remains dominant at local and global levels (Byrne et al, 2016; Office of the United Nations High Commissioner for Human Rights, 2017).

Its unique language of mental illness, disorder and symptomatology, borne of 20th century biomedical psychiatry, lends unfamiliar names to emotional, psychological and life experiences (Perkins and Repper, 2001).

This standardised professional terminology assumes supreme status via the European and American diagnostic manuals, International Classification of Diseases and Diagnostic and Statistical Manual of Mental Disorders respectively (Crowe, 2000; Hamilton and Manias, 2006; Kemp and Howard, 2017).

Its influence extends into mental health nursing where psychiatric discourse features prominently in spoken and written language (Hamilton and Manias, 2006; Crowe, 2000).

Like all dominant discourses it has become normative; a socially accepted way of viewing reality (Masterson and Owen, 2006). Meanwhile, recovery-oriented and service user movement discourses, borne of people, remain marginal (Hamilton and Manias, 2006).

To achieve such status, psychiatric discourse must have worth. There are many perspectives to support its professional, practical and social usefulness.

First, psychiatric discourse results from decades of experimental and applied expertise (Larner, 2015). It offers the best available evidence, something which professionals are duty bound to follow (NMC, 2015).

Second, its categorical nature aids organisation and decision making, offering clear inclusion and exclusion criteria for services and treatment (Telles Correia, 2017).

With one in six adults experiencing a mental health difficulty, there is real need for criteria that delimits access to services (Mental Health Foundation, 2016; Stansfeld et al, 2016).

Third, its language smooths interprofessional communication, allowing specific concepts to be shared succinctly; concepts now digitally codable (Hamilton and Manias, 2006).

Furthermore, its apparent scientific rigour incites trust in professional and patient, while simultaneously demarcating the role of each to establish expectations for their encounter (Kalinowski and Risser, 2000; Hamilton and Manias, 2006).

The benefit of psychiatric discourse, and arguably its seat of power, can thus be understood as its utility to the system of mental health services. It is contestable, however, whether such usefulness implicates real value for those who use it.

Psychiatric discourse is not the only means of understanding people's experiences (Crowe, 2000). In mental health nursing, the nurse-person relationship – therapeutic connectedness between two human beings – has immense potential for validation and change (Peplau, 1952; Turner, 2017).

Evidence suggests strong links between the therapeutic relationship and positive outcomes (Chambers, 2005). In this coming together, the usefulness of psychiatric discourse towards developing essential qualities of respect, genuineness, empathy and trust is questionable (Sheldon, 2014).

This paper considers the language of psychiatric discourse in relation to key rights-based mental health policy (Scottish Government, 2015; Scottish Government, 2017a; Scottish Government, 2017b). Power imbalance, exclusion and social distance – all problems of difference – are themes that rights-based approaches seek to redress.

However, as policy attempts to straddle progressive person-centred recovery and existing psychiatry-based organisation, the complexities and challenges of realizing persons' rights in mental health care becomes apparent (Byrne et al, 2016). Relevant literature has been identified with a key terms search for 'psychiat*' or 'mental health' and 'language' or 'discourse' in CINAHL, Psychology and Behavioural Sciences Collection and Psyc INFO. Published date and location parameters were kept open to allow maximum search returns.

From these databases 18 appropriate peer-reviewed articles were retrieved, plus a further three from the Journal of Psychiatric and Mental Health Nursing. Reference lists provided a springboard to further relevant research.

Power imbalance

“He was so busy asking me about my ‘symptoms’ that he forgot to talk to me, you know, the person sitting right in front of him” (Turner, 2017).

Language is fertile ground for embedding values into practice (Kemp and Howard, 2017). In contemporary policy, empowerment is a prevailing theme – realising equality through persons’ increased control over and full participation in care, service development and policy making (Scottish Government, 2015; Scottish Government, 2017b; Scottish Human Rights Commission, 2017).

Despite this, a gap exists between policy and people’s experience of mental health services (Grant, 2009; Bee et al, 2015). Practice is struggling to marry new ideology with existing paternalistic infrastructure – a struggle reflective of the policy documents themselves (Bee et al, 2015).

Scrutiny exposes tension between calls for service user empowerment and simultaneous use of traditional psychiatric discourse that maintains the status quo, although this is now considered a major obstacle to human rights-based approaches (OHCHR, 2017).

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Responsibility and accountability are still pronounced to reside in the nurse who must ‘assess’, ‘provide’ and ‘manage’ (Bee et al, 2015; Scottish Government, 2017a). Apparent yielding of power from professionals to ‘experts by experience’ is thus undermined in the very documents that entreat it (Heffernan, 2006; NES, 2011). Here language reflects an ongoing ethical dilemma for nurses – how to promote persons’ autonomy while adhering to their professional code (NMC, 2015).

The philosopher Michel Foucault produced seminal work emphasising the relationship between power, knowledge and subject (Allen, 2013), and calling for alertness to the distribution of power. In psychiatric discourse,

all significant knowledge is deemed to dwell in the psychiatrist (Byrne et al, 2016). The psychiatrist holds authority to assign diagnoses and, notably, restrict persons' liberty.

It is this judgement that informs nursing approach towards and treatment received by persons (Crowe and Alavi, 1999).

Thus inherent power imbalance is borne between those who give and those who receive; as 'subjects' of the system (Roberts, 2005; Allen, 2013).

Crowe provides a useful critical discourse analysis of a diagnostic manual, the Diagnostic and Statistical Manual of Mental Disorders (DSMIV), crucial to psychiatric judgement (2000). It illuminates the way persons are discredited by psychiatric discourse through its construction of normality.

"LANGUAGE IS FERTILE GROUND FOR EMBEDDING VALUES AND A POWERFUL MEANS OF EXPRESSING THEM"

Crowe argues that the manual delimits normal and abnormal behaviours and, accordingly, shapes what is acceptable in society. Language indicates underlying assumptions that mental disorder is a 'syndrome' in the individual, condemning affected persons to deviant and powerdown subject identities (Crowe, 2000).

The 'deficit-obsessed' language of psychiatric discourse, focused on problems and dysfunctions, negatively colours how these people – fellow citizens – are viewed (Perkins and Repper, 2001). Against this backdrop, one might question how respect and equality can be realised (NES, 2011). Though Crowe considers a now outdated version of the manual, its in-depth analysis provides relevant insight into the diagnostic manuals still in use today.

The healthcare system is hierarchical.

Nurses are constrained by intergroup power dynamics of medical professionals (Crawford et al, 1999; Watson et al, 2015; Turner, 2017). By adopting the language of psychiatric discourse, nurses align themselves with the authority figures of their profession as means of acculturation and survival (Turner, 2017). This process allows nurses to be accepted by the professional in-group while setting them apart from outsiders, namely 'patients' (Tajfel, 1982, as cited in Crawford et al, 1999).

Flattening imbalances of power in the nurse-person relationship is thus incredibly challenging when the professional system in which nurses operate is itself so fundamentally imbalanced.

If language is fertile ground for embedding values, it is also a powerful means of expressing them (Kemp and Howard, 2017). Nurses are well positioned to model how persons might positively understand their difficulties in relation to selfhood.

When nurses use language focused upon diagnostic label, presenting problems and risk they construct subject identities devoid of strengths, personality and hope (Gilfoyle, 2017). If internalised this can bring about damaging self-stigmatisation that reinforces perceived feelings of worthlessness (Turner, 2017).

Language constructs relational nurseperson identities in which persons become subjects of scrutiny to the professional gaze (Crowe and Alavi, 1999; Hamilton and Manias, 2006). Defined by diagnosis, persons thoughts and feelings are attributed to pathology and discounted as irrational or 'lacking insight' (Hamilton and Roper, 2006; Glasby and Tew, 2015).

Believing people, valuing their voice and building mutual trust is crucial for establishing a therapeutic relationship (Brown and Kandirikirira, 2007; Glasby and Tew, 2015). Conversely, distrust generates fear and powerlessness, holding persons in passive 'sick roles' without personal agency (Perkins and Repper, 2001; Hui and Stickley, 2007; Glasby and Tew, 2015).

Such disempowerment is quite contrary to policy rhetoric and denies nurses and persons meeting as equals to form helpful and meaningful relationships (Scottish Government, 2015; Scottish Government, 2017b).

Difference and exclusion

"Why is my voice so unimportant? Secondary to everyone else. Where can I be heard?" (writingbuddies, 2017) Scotland's Mental Health Strategy 2017-2027 expounds ambition's to deliver parity of esteem for mental health (Scottish Government, 2017). It highlights improvement required in service accessibility, a theme underpinning recent health and social care integration (Public Bodies (Joint Working) (Scotland) Act, 2014).

Accessibility – enabling ease of understanding, obtainment or use – demands discussion of language and yet it is absent (Oxford Dictionaries, 2017). Language has powerful potential to include those who speak it and exclude those who do not. It can oppress and disable through textual environments that deny persons' participation in their care, treatment and recovery (Perkins and Repper, 2001).

By applying the social model of disability to the textual environment of language this is explored. Developed by the Union of the Psychically Impaired Against Segregation in the 1970s, the model understands disability not as resultant of persons' perceived difference or 'deficit' but as a social construct (Shakespeare, 2006; National Involvement Partnership, 2014; Owens, 2015).

Organisation of society causes people to be disabled – to experience systemic barriers that restrict liberty (Shakespeare, 2006). The professional-technical language of psychiatric discourse constructs a similarly disabling linguistic environment. It disadvantages those who have not acquired it through formal training (Barker and Buchanan-Barker, 2006; Kemp and Howard, 2017).

Professional jargon makes 'obscurity more opaque' and acts as a barrier, robbing persons of confidence and restricting participation (Howard, 1978 as cited in Barker and Buchanan-Barker, 2006; Shakespeare, 2006).

If information is obscure persons are denied their right to make informed decisions (The Patients Rights (Scotland) Act, 2011). At societal and organisational level, there is a moral obligation to expose and address all such barriers that hold people in a state of disability (Shakespeare, 2006).

The ethics of constructing a textual environment that excludes those of whom it speaks is problematic. It implicates disregard for and devaluation of the very people whose voice should be integral to that landscape.

At micro-level, disabling practices can play out in the nurse-person relationship through nurses' over-reliance on professional jargon and failure to communicate in ways that matches persons' needs (Chambers, 2005).

From the person's perspective, this may result in fear; not knowing what to expect, and shame; associated with stigma, self-stigma and avoiding seeking help (NIP, 2014).

Developing self-awareness of the subtle, often unintended, consequences of language use is an important way for nurses to improve therapeutic relationships (Rungapadiachy, 2008).

The imposing language of professionals, told to persons, is described by Derrida as monolingualism for its non-relational way of interacting (Derrida, 1998 as cited in Larner, 2015). Monolingualism shuts down dialogue, instead establishing an authoritarian environment.

Against this backdrop, Larner (2015) describes professionals' ethical responsibility to work relationally and invite persons into dialogue.

Nurses should consider how language functions to either welcome or deny others to the conversation. Using accessible everyday language is a commonsense approach to increase shared humanness in the therapeutic encounter (Chambers, 2005).

Facilitative approaches of reflecting back, paraphrasing and affirming all help establish a hospitable textual environment in which familiar language is forefront (Larner, 2015; Stickley and Cassedy, 2016).

Taking a relational approach and active construction through partnership echo the progressive principles of co-production (SCIE, 2009).

Enabling persons to explore experiences in their own words increases the potential for personal discovery, growth and self-direction associated with recovery (Morrisey, 2009; Glasby and Tew, 2015).

Co-creating a recognisable textual environment, in which persons define themselves, is an important aspect of enabling this personal journey (Perkins and Repper, 2001; NHS Education for Scotland (NES), 2011).

Policy makers might argue that there have been great strides to increase service accessibility in recent years. Health literacy, for example, is an initiative aimed at improving people's skills and knowledge of the health and social care system (Scottish Government, 2014). An awardwinning resource called the Care and Support Jargon Buster gives a plain English guide to commonly used terminology, demystifying professionals' language (Think Local Act Personal, 2013).

Ideologically, however, such initiatives are questionable. They boost access to the system as it exists rather than addressing inaccessibility at the root level of service design. Emphasis is placed on individuals to develop skills to fit in with services, while services themselves continue unchanged in their use of 'unfamiliar' and 'strange' language (Scottish Government, 2014).

Research demonstrates that engagement improves when practitioner jargon is limited (Harden et al, 2015). Yet while the language of psychiatric discourse reigns, policy and services continue to reinvent the same wheel, posing a major exclusionary barrier to persons accessing services (Byrne et al, 2016).

Distance

“I feel I have this thing inside me, with one hook in my mind, another deep in the pit of my body, searing its tentacles into my spirit, wrapping itself round and crushing my soul” (Driving_Miss_Crazy, 2017). As part of the human community, we all have potential to experience mental health difficulties. Focusing on commonalities of experience – our shared humanity – makes conceptualising and relating to others’ experiences more profoundly possible. This connectness is a valuable starting point for realising equality (NES, 2011).

Equality – upholding persons’ rights and freedoms and recognising their personal potential – is an imperative of contemporary health and social care policy (NES, 2011; Scottish Government, 2015). The Scottish Human Rights Commission aims to embed equality in policy and practice through the principles of participation, accountability, nondiscrimination, empowerment and legality (2017). Yet change is still needed to end ongoing stigma attached to mental health (Goldie et al, 2016; See Me, 2017). Healthcare professionals must examine their role in perpetuating stigma and what they can do to challenge it (See Me, 2017).

Nurses are well placed to champion the health promotion message that mental health is everyone’s business (Chesterson, 2009).

Mental health is something we all have (Mental Health Foundation, 2017). The statistic of ‘one in six’ embraces all people, healthcare professionals and non-professionals alike (Mental Health Foundation, 2016).

When psychiatric discourse labels persons’ experiences and selfhood as ‘mentally ill’ a process of ‘othering’ is effected (Brown et al, 1996). Persons are defined by their diagnosis and distinction drawn between ‘them’ and ‘us’ (Happell, 2007; Hui and Stickley, 2007; Repper and Perkins, 2009).

This is quite contrary to continuum or dimensional models of mental health and considerably impacts the nurse-person relationship (Zubin and Spring, 1977; Rutter and Sroufe, 2000).

One person’s distress is pathologised – made abnormal, uncommon and other, creating social distance between the two parties (Byrne et al, 2016). In this milieu, interpersonal connection, relating and trust are impeded (Camunas, 2008).

The language of diagnostic labels is described by Perkins and Repper as ‘dehumanising’ (2001). Labels direct care towards particular pathways, drawn from evidence-based clinical guidelines such as the National Institute for Health and Care Excellence (NICE). However, they may also function to embark nurses upon caregiving ‘autopilot’.

Script theory posits that through experience routine action sequences for given situations are internalised (Abelson, 1976, as cited in Berger and Bradac, 1982). 'Scripts' provide a guide to expected roles in social encounters (Berger and Bradac, 1982). Though useful in reducing uncertainty these scripts can also lead to 'mindlessness' (Langer, 1978 as cited in Berger and Bradac, 1982). In the nurseperson encounter, unconscious scripts about 'the person with…' hinders nurses attuning to the individual.

Persons may be stereotyped before they are heard (See Me, 2017). Remarkably, it is in the very criteria of psychiatric diagnosis that pejorative person descriptors heard in practice, for example, 'manipulative', 'entitled' and 'inappropriate' are legitimised (Hamilton and Manias, 2006; Royal College of Psychiatrists, 2014; Tyrer et al, 2015).

Translating persons' experiences into the language of symptoms, behaviours and diagnoses encourages misinterpretation, simplification and loss of meaning. Psychiatric terminology communicates concepts succinctly but at the expense of generalisation, and powerful personal narratives are lost.

Capturing the complexity of phenomenology in language is a challenge, one arguably better met by prioritising the voice of lived experience (Turner, 2017).

Supporting persons to describe their experiences authentically, nurses create opportunity for mutual learning and insight – how does the person relate to their experience; what meaning does it have; and what cues could inform a personally meaningful care pathway?

The Scottish Recovery Network has found that telling one's story can be a catalyst towards recovery (2012). Preserving original person narratives, rather than re-authoring through a professional lens, also transforms how nurses view and relate to others (Ashcraft and Anthony, 2006) – that is, as persons more like themselves.

As part of the human community, we all want to be heard, seen and valued. Finding common ground and approaching with a 'person first' attitude helps nurses to relate to persons' experiences and build stronger therapeutic alliances (NSUN, 2015).

Conclusions

Language use is not inconsequential. It has implicit influence in shaping understanding of and interaction with the world (Happell, 2007).

In the changing field of contemporary mental health care, the usefulness of psychiatric discourse requires analysis and discussion. Its longstanding dominance does not preclude it from enquiry. Indeed, it is this very weight and institution that makes examination of its fitness for purpose critical.

Three lines of reasoning regarding effect – power imbalance, exclusion and social distance – signal that this language may be a barrier to recovery-oriented care, particularly in the therapeutic relationship. This has far-reaching implications for future management, practice, education and research. Policy currently provides a philosophically confused vision of future mental health care, one that is simultaneously rooted in traditional psychiatric discourse while aspiring towards radical recovery focus and person empowerment.

Macro-level progress and reform is questionable in such an ambivalent culture, and clearer direction is needed (Byrne et al, 2016).

Used astutely and purposefully, language could be a powerful ally towards changing practice (Gilfoyle, 2017). Experiments have found that it is challenging but not impossible to alter language use (Douglas et al, 2008).

"HAVING A PERSONFIRST ATTITUDE HELPS NURSES TO RELATE TO PERSONS' EXPERIENCES AND BUILD ALLIANCES"

There is something 'human' about practitioners who speak in normal terms (Longden, 2009). In the circumstance of professional encounter, there is always going to be distinction between 'person' and 'nurse'. However, blurring this division and minimising its impact is helpful for developing allied relationships supportive of recovery.

Rather than labels and jargon, nurses who co-produce mutually understood language are better placed to see persons as individuals and to focus on their unique strengths, skills and abilities (Ashcraft and Anthony, 2006; Gilfoyle, 2017).

Kemp and Howard suggest that more focused and systematic research is needed to explore use of language in mental health practice (2017).

This paper proposes that in-depth analysis of nurses' language use in relation to values, power and the therapeutic alliance is now outstanding. Addressing this gap in research will surely make considerable contribution to the future of mental health nursing.

In education, person involvement is a beneficial training strategy at preregistration stage. Studies show that hearing personal accounts in

authentic language develops student nurses' respect for and empathy with lived experience (Jones and Black, 2008; Rush, 2008).

Students are encouraged to connect with commonalities of experience that may help to embed person-centred values (Rush, 2008).

Furthermore, being listened to is an empowering experience for persons – one that affirms the centrality of their voice (Jones and Black, 2008).

If communication is the foundation of mental health nursing, then language that ensures the primacy of the person and their recovery is desirable (Kemp and Howard, 2017).

This is only attainable if management, practice, education and research join forces to identify and address outmoded discourse.

People are first and foremost human beings, not psychiatric 'subjects' (NSUN, 2015). Nurses have the opportunity to embrace this shared humanity in relating positively to every person they walk alongside.

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