Recovery and Reflection: The Role of History in Nursing Education

By Kylie Smith, Ph.D.

I should confess, I am not a nurse. I am an historian, and my area of research is the history of mental health nursing. I am interested in the ways in which nurses have negotiated psychiatric and psychological ideas in their practice, what theories they developed of their own, how they moved between the medicalized discourse of diagnosis and the reality of working with actual people. I am interested in the ways in which nurses have reconciled their own need to help, heal and cure with the sometimes hopeless reality of chronic mental illness. I am trying to unpick the ways that nurses developed their knowledge in the context of a society and culture obsessed with the need to define, categorise, normalise, rehabilitate and control. In my new role as the Mellon Faculty Fellow for Nursing and the Humanities at Emory, my work is focused on understanding the effects of these social contexts on nursing practice, and on using the humanities to continue to expand critical thinking, to facilitate empathic and compassionate care, and enhance ethical nursing practice. In this article, I aim to explore the significance of history for nursing practice, in particular in the area of mental health, which has shared many of the same evolutionary challenges as the broad field of rehabilitation. Psychiatric and mental health nursing has needed to carve out a space for itself in the hierarchies of medical and health sciences, which are often focused on acute care and the business of life saving. Before there were drugs, psychiatric nurses articulated a way of caring for patients that was intensely therapeutic and patient-centred, based on the belief that the role of the nurse was to facilitate a journey to a patient-defined recovery. This history, and its attendant struggles, continues to affect the profession in a myriad of ways. Embedding this history in the curriculum is an essential component of enabling empathic, critical and reflective practitioners.

For many nurses, mental health work is one of the most challenging areas of their practice. It is an area of practice fraught with ethical dilemmas: the difficulty of delivering person-centred outcomes in a health system concerned mainly with risk control; the challenge of maintaining patient and staff safety in the face of difficult behaviours; the questionable role of psychotropic pharmaceuticals and practices of seclusion and restraint often administered against the person's will; the continued clash between biomedical models now favoured by psychiatry versus the inherently therapeutic potential of the nursing relationship. All of this occurs in the context of a complex legal and policy environment, in an understaffed and under-resourced mental health

system, where there is no real guarantee that 'helping people' will lead to recovery or rehabilitation, or anything other than jails, institutions or death. It is little wonder that mental health is one of the least popular specialisations in nursing, with some Schools of Nursing focusing so much on acute care in the biomedical model that they fail to offer mental health or psychiatric nursing as a distinct specialisation at all. This is despite the fact that National Institute of Health data conservatively indicates that at least 18% of the American population in 2014 was living with some form of mental illness.[1] Almost 70 years ago the World Health Organisation defined health as "a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity"[2] yet this connection between mind, body and society remains in the background of current biomedical disease models of medicine and health. This divide has serious consequences for health practitioners who try to work in the grey areas, who see health as existing along a continuum, who recognise the role of the patient as a person who is the expert in their own illness journey, whose job it is to facilitate recovery and rehabilitation at the person's own pace, towards the person's own goals. The health practitioner most often in this role is the nurse, yet mental health nursing has become a practice once again closely tied to the increasingly biological and neuroscience focus of modern psychiatry, with its emphasis on pharmaceuticals as a cure for society's increasing ills.

I am often asked why history matters in the context of contemporary approaches to health. My response is always that nursing history matters because of nursing's history. More than any of the other health professions, nursing practice - the very work that nurses do - has been forged at the intersection of strong social forces over which nurses themselves sometimes had little control.[3] Issues of gender, class and race were instrumental in forming not just the professional structures of nursing, but its educational content, the scope of nursing practice, the roles that nurses could have in modern health care systems, and popular and cultural images of what it means to be a nurse.[4,5]

The current ethical and practice dilemmas within mental health nursing are the legacy of a profession which carries with it the historical stigma associated with 'barbaric and inhumane madhouses', and the 'evil people' who worked there, often portrayed in popular culture through movies and tv programs like *The Snake Pit* (1948); *One Flew Over The Cuckoo's Nest* (1975) and *American Horror Story: Asylum* (2012). The nature of the work itself has always been difficult, with many past psychiatric practices built on physical restraint and violent intervention. This use of force has made the profession more male-oriented, with 'attendants' being the main type of worker right up until the 1950s in the US. Formal graduate nurse training wasn't available in the US until after WWII and it took much negotiation on the part of nurses themselves to wrest control of this training away from the male-dominated psychiatry and psychology professions who saw nurses as unquestioning assistants to their often experimental methods, including psychosurgery, insulin coma, deep sleep and electro-convulsive therapies.* Nurses fought hard in the 40s and 50s to wrestle nurse education and practice away from the 'handmaiden' model, and innovative and influential theories, such as Hildegard Peplau's *Interpersonal Relations in Nursing* emerged in this period.[6] This theory laid the groundwork for the development of modern mental health nursing, especially the concept of the 'therapeutic use of self' and Peplau is one of the most well known nursing theorists not just in the US but in the UK and

Australia. Her theory was a masterful attempt at interweaving Freudian psychoanalysis with Harry Stack Sullivan's theory of interpersonal relations to articulate a framework by which nurses could develop independent and autonomous therapeutic practice. Peplau's theory is also interesting for the strong links it makes between social structures and mental health – indeed in 1958 she called mental illness "the number one social problem of our time".[7] Like many psychiatrists in the post war/Cold War period, she argued that mental health was essential for social stability, that anxiety and stress caused by the threat of nuclear war and the Communist hysteria was problematic for individual and social functioning, and that the role of the nurse was to facilitate a patient's journey towards their own conception of 'health'.[8] She also argued that this was as much a social function as it was an individual or clinical one, that the psychiatric nurse was in a unique position to help whole families and communities and that in doing so she could change the world.[9] Interestingly, later in her writing she also argued that psychiatry's need to define and diagnose people was actually a problem, because it labelled as 'illness' that which was in fact merely difference, and that the whole concept of mental health was little more than an attempt to control behaviour that fell outside rigid social norms.[10] In Peplau, we see one of the most well educated and theoretically informed psychiatric nurses turning a critical lens on the system of which she was in fact an integral part. Even while she continued to teach nurses to be therapists, she taught them to question both themselves and the systems within which they operated.

There is much to learn from a nurse like Peplau, but they are lessons contemporary nursing sometimes forgets. Peplau's ideas about the therapeutic role of the nurse were extraordinary and revolutionary and are a significant reason why mental health nursing still exists at all. To all extents and purposes however, her vision for the full therapeutic role of the nurse appears to have been largely subsumed into the biomedical approaches emerging so forcefully in the late 60s and 70s, the language of which has become almost unquestionable. Yet current practice builds on that which went before, and Peplau's influence lingers in sometimes taken for granted ways. Her way of thinking is so much a part of modern psychiatric nursing as to be almost invisible. Yet she was very much a product of her time. We cannot understand modern approaches to practice without understanding the politics and society within which that practice emerged, the context within which decisions about human health were made. This understanding, this historical perspective, alerts us to the contingency of all health, medical and scientific decisions. There is no objectivity here, the 'facts' do not emerge from the clouds like little gifts on butterfly wings. Rather, agendas are weighed, ideas prioritised, funding allocated, drugs designed or not designed, treatment options explored and discarded, all vulnerable to shifting ideologies and the lobbying of powerful interest groups. History, as a discipline, as a story, has the power to shed light on this 'human' side of health systems, and reminds all of us that no human institutions exist without the thinking of them. They are made by and for humans, and so the humanities are powerful tools by which to critically analyse and question the assumptions and narratives that underpin modern health care practices.

Fairman and D'Antonio[11] have written persuasively about the importance of history in this vein for contemporary nursing practice, yet it is an often overlooked aspect of nurse education. Even as nursing tried to develop its own approaches to theory and practice, it was drawn inevitably into the

dominant paradigm of modern medicine in the late twentieth century.[12] While this has undoubtedly led to advances in disease management and health outcomes (often measured through a cost-benefit paradigm) and a flourishing body of work in clinical nursing research, including important nurse led interventions and the ability to attract large amounts of clinical research funding from national bodies, there are concerns that the emphasis on biomedical science is having detrimental effects on both the staff and students in modern schools of nursing and beyond.[13]

Partially in recognition of these problems, programs like the Mellon Foundation funding grant are explicitly intended to bring new perspectives to the health sciences through the humanities in an attempt to broaden the knowledge base of health professional education. These initiatives seek to expand the critical and creative thinking of a new generation of health leaders, and to draw new insights from history, art, film, music and literature about both the experience and significance of human health and illness. Rather than reflecting the biomedical rhetoric that lack of illness is a kind of personal morality, let alone responsibility, this approach recognises that illness is in fact an integral part of the human experience, and that there is no either/or dichotomy of health/illness. More accurately, these are both essential human conditions, which exist along a continuum, and people will move between them in the life-death cycle. The humanities are essential to understanding this critique of biomedicine: they give us the tools, the theory and the language with which to articulate that critique as well as to develop alternative approaches.

History in particular becomes an integral part of the humanities in health professional education because it sheds important critical light not just on the development of professions and practices, but on the social and cultural context of patients' lives.[14] If we are to take concepts such as patient-centred care and social determinants of health seriously, then we need history to understand the complexities and the realities of the real life circumstances in which people manage their health, and how social determinants are produced and reproduced when health care practitioners do not seek to challenge them. Ethical and reflective health practice relies on the ability to leave personal judgements at the door, and recognise the real burden that people with long term illness must face as they seek to rebuild or refashion their lives. There is no easy fix, no single solution, only a deeper understanding of the grey areas.

This grey area of uncertainty is where the humanities become so important in building ethical health practitioners. As Rita Charon so compellingly argues, ethical practice begins by listening and honouring the stories of illness with which we are presented.[14] These are stories that tell themselves in language, written and verbal, but also in art and literature. These are stories the point of which is in the telling, and the being heard. These are stories about ourselves as well. The hearing of our own narratives provides a means to put the self aside, letting go of the need to fix or heal or cure or be done with. It may mean putting aside the god-like hero complex so prevalent in the discourse of 'saving lives' and perhaps consider that sometimes, the point of health care is not to fix people but to go with them on their journey. This was the message Peplau tried to teach her nursing students when she talked about the 'privilege of thereness'[15], that the therapy, the medicine, is in the listening, in the hearing, in the seeing.

History is also a story. It is a jigsaw puzzle, the piecing together of disparate elements to paint an interpretation. It is not the facts "as they actually

happened"**, because who knows how they actually happened, and maybe it's not the happening that was important, but the way the happening was experienced. This is the strength of qualitative research in nursing as well, the history taking that nurses do when they meet a patient for the first time, the history they build as they walk with that person on their journey, wherever it may lead. This is life, as it is lived, in all its messy glory. This is what the humanities are for, to understand the human experience. Truly humanitarian and ethical health practice is not possible until health practitioners learn to look outside the clinic walls and understand the social, political and historical context of their practice.

Footnotes

* This process is the subject of a forthcoming monograph. The broader history of the struggle over ideas and philosophies in American psychiatry is well captured by Grob G. *From Asylum to Community: Mental Health Policy in Modern America*, Princeton NJ: Princeton University Press; 1991.

** This is known as the Rankean approach to history, wherein Leopold Von Ranke argued that history could and should be objective, merely relating the facts as they actually happened. This is a position usually considered untenable by modern historians – see Carr E, Evans R. *What is history?* London: Penguin; 1961 for an early dismantling of this approach to history.

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Kylie was awarded a Bachelor of Arts (Honors) in English and History and a PhD in History from the University of Wollongong in Australia. Before coming to Emory, Kylie worked in the School of Nursing at the University of Wollongong where she researched mental health nursing history and taught reflective practice. Kylie has also worked in multicultural HIV/AIDS health promotion in Sydney, Australia and studied scriptwriting at the Australian Film Television and Radio School.

Kylie's current research explores the development of psychiatric nursing in the US during and after World War II. This research has been supported by a fellowship at the University of Pennsylvania and grants from the Rockefeller Foundation and the American Association for the History of Nursing. Kylie is currently working on two monographs which trace the origins of nursing knowledge in psychiatry, and the relationship between nurses and race in asylums in the American south east.