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Psychiatric Nursing: Epistemological Contradictions

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Back to Top

Abstract

This theoretical analysis begins from the premise that the medical specialty of psychiatry is practically and ideologically dominant in relation to psychiatric nursing.To explicate some difficulties with psychiatric nursing from a therapeutic perspective, crucial 19th century European psychiatric epistemological developments are outlined. The article addresses the contemporary problematic of nursing agency in the face of mainstream psychiatry's focus on physical treatments. It is argued that there are intrinsic contradictions for present-day humanistic psychiatric nursing given the theoretical and practical power of the materialist medical model.

Key words: critique, epistemology, history, humanism, nursing, psychiatric nursing, psychiatry

There is a need for a closer examination of the philosophical foundations and epistemological bases of nursing knowledge. [1] This article explores the materialist epistemologies that mental health nursing has uncritically inherited from medical psychiatry and argues that the values of the latter are antithetical to humanist nursing theory and practice.

Back to Top

FALL OF HUMANISM AND RISE OF PSYCHIATRIC MATERIALISM

European early 19th century models of psychiatric etiology proposed by Pinel and Tuke were nonmaterialist. Their "moral" causes are similar in meaning to contemporary terms such as "emotional" or "psychological". [2] Proponents of "moral" treatment espoused humanist, or person-centered, principles. The treatments they advocated were nonmedical and involved compassionate attendants and pleasant surroundings. [3] Pinel was particularly opposed to venepuncture and cold showers (commonly used treatments deriving from the ancient humoral understanding of human sickness, sometimes termed the

Ayurvedic system) and to the punishment of inmates and reliance on medication. [4]

This mild-mannered approach to madness was taken over in the early decades of the 19th century by the materialist, or physical, orientation of the ascending medical profession. According to Johnstone, [2] this reduced the holistic philosophy of moral treatment to a collection of techniques that could be controlled, or performed, by medical doctors, who also laid claim to expertise regarding traditional humoral treatment as well as modern materialist etiologies.

During the final third of the 19th century, the repertoire of medically prescribed psychotropic substances also expanded [5] and exacerbated medicalization tendencies. Such chemical treatments, unlike cold showers, could be seen to require scientific knowledge and expertise.

The focus on drug treatments furthered late 19th century beliefs about physical internal causes of psychiatric disorders. A materialist epistemology and medication offer a complementary theory and practice that bolstered the legitimacy of the medical profession's claims to gain control of the treatment of insanity.

Other events relevant to the increasing esteem of materialist medicine and science in the second half of the 19th century include Pasteur's published accounts of his experiments in 1857, Lister's first use of antiseptics in 1865, Koch's discovery of micro-organisms in 1876, and the first use of X-rays in 1895. Germ theory, deriving from Pasteur and Koch's works, understands disease to be caused by pathological bodily changes resulting from infectious micro-organisms. Such discoveries intensified the psychiatric focus on the material body at the expense of the broader perspectives such as those espoused by Pinel and Tuke or the ancient humoral belief system.

In 1890 Korsakoff recognized the combined physical (multiple neuritis) and mental (confabulation, disorientation, and loss of memory) symptoms of chronic alcoholism to be one condition. Thus, a physical substance-alcohol-was shown to be the cause of "psychiatric" phenomena. Similarly, in 1894 Fournier discerned the connections between a history of syphilis and general paralysis of the insane. [3] The syphilis spyrochete was then proven to be the specific cause of syphilis. Some of the symptoms of the tertiary stage of general paralysis of the insane were seen to be similar to those displayed by people with "psychiatric" conditions.

These discoveries at the end of the 19th century provided a fillip for the medical belief that mental illness is a disease with physical origins. During this period scientists made great gains in understanding some physical and neurological disorders, and this created an optimistic climate for the future of materialist psychiatric etiologies and treatments.

The epistemology that facilitated these historical medical discoveries was that of the burgeoning natural sciences. The natural science epistemology emphasizes "objective" knowledge deriving from the scientific method and controlled empirical observations. According to these tenets, objectivity is achieved by the separation of the scientist (subject) from the object under study. This subject-object dualism is deemed to render the scientist neutral or unbiased for the purposes of rigorous experimentation and the uncovering of unequivocal facts.

Values associated with objectivity, observation, and linear rationality were absorbed into medical psychiatry's epistemological foundations as it crystallized in the last decades of the 19th century. At the same time, the discipline of psychiatry successfully extended its political and legal powers. [6]

Kraepelin (1856-1926) is considered by many to be the father of modern psychiatry. His famous Lehrbuch (textbook) was first published in 1883, and the final, eighth edition emerged volume by volume between 1909 and 1915. These texts were influential until at least the middle of this century. [4] His first textbook was published after chloral hydrate and paraldehyde were used by doctors (1869 and 1882, respectively), [5] after Pasteur and Koch's discoveries, after the demise of humanism (Pinel and Tuke), and after doctors had recognized connections between syphilis and general paralysis of the insane. Kraepelin proclaimed a materialist etiology whereby psychiatric disorders were inherited, had organic origins, and implicated central nervous system involvement. [7]

Freud (1856-1939) entered the psychiatric arena at about the same time as Kraepelin. He trained as a neurologist and was therefore initially steeped in the materialist medical epistemology of the era. In the development of psychoanalysis, Freud articulated ideas and frameworks to render notions of the "unconscious" aspects of human experience amenable to clinical and theoretical investigation. He considered that childhood sexuality, aggression, and emotional conflict were intrinsic to the etiology of "neuroses." (Kraepelin's primary psychiatric interests were in the domain of "psychoses.") Freud's humanist argument [8] contradicted mainstream medical beliefs of the time. His claims for a "science" of psychoanalysis, albeit with a foundational biology, emphasized psychic life and can be seen to be more social than material in focus.

Psychoanalysis had the potential to radically critique the turn of the century medical epistemology. [9] However, in the ensuing decades, medical psychiatry colonized and dismantled these challenges in the same way as it had taken over and diluted earlier "moral" approaches to psychiatric disorders. [2] Medical psychiatry thus reinforced its commitment to materialist etiologies and treatments.

Back to Top

PSYCHIATRIC LEGACY

Once people are primarily conceptualized as physical bodies, human concerns in the domains of emotions, ethics, or spirituality are marginalized or ignored. Psychiatry consolidated such an epistemology before entering the 20th century. As contemporary psychiatry is the dominant mental health discourse, from perspectives of political power and scientific credibility, this belief in materialist psychiatric etiologies permeates the associated health professions to some degree.

People who seek assistance from contemporary psychiatric services continue to experience the consequences of the significant theoretical and practice changes that emanated from the late 19th century. During those decades medical psychiatry became committed to physical etiologies, treatment by drugs, and diagnosing and naming or labeling. These remain the hallmarks of mainstream psychiatry in the 1990s. From a patient perspective, psychiatric practice is often focused on medical diagnosis and medication. [10]

As well as possible gains, concomitant losses are likely to accrue to consumers of psychiatric services, nonmedical practitioners, and society at large. Psychiatric nursing, more than other mental health professions, has been in the thrall of mainstream medical theory and practice. As the importance of objectivity, the mind-body split, and a material understanding of person increased, the values of caring, interactivity, holism, and self-expertise (of patients and nurses) diminished.

Mainstream medical epistemology considers that the psychiatric patient has a disordered mind arising from a damaged or diseased body. The etiological sites of such malfunctioning are understood to be genetic in origin and manifested as neurotransmitter imbalance.

Such an orientation ultimately mitigates against the agency of both the psychiatric nurse and the psychiatric service user. What is a consumer to do about his or her terrifying experiences if his or her body is faulty and only a medical prescription is offered? What is a nurse to do if mental illness is caused by neurotransmitter excess or depletion and the medication is meant to rectify the uptake at the receptor site?

Materialist psychiatric epistemology has profound consequences for psychiatric service users and nurses, beyond that of diagnosis and treatment by medication. A focus on the physical indicates a narrow view of patients and of oneself as a person and a nurse. The medical model seriously limits the patient's sense of competence, control, and responsibility. It also excludes or displaces the centrality of the nurse's interpersonal skills in supporting and improving patient resourcefulness and well-being.

Back to Top

CONSEQUENCES FOR PSYCHIATRIC NURSING

Psychiatric nursing emerged under the patronage of psychiatry [7] in a pre-existing organizational hierarchy in which the medical profession wielded ultimate power over patients' treatment. Thus, the materialist medical epistemology was absorbed uncritically and became assumed psychiatric nursing knowledge.

The consequences of this at the macro social level for nursing and patients includes ignoring or minimizing the relevance of structured class, ethnicity, and gender relations. Life realities such as class, poverty, and unemployment influence the experience, and course, of mental illness. Ethnicity and racism [7] also mediate patients' experiences of oppression and cultural contradictions. Gender-based difference and discrimination permeate many aspects of contemporary life. From women's perspectives, low income, underemployment, violence in the home, undue housework and child care responsibilities, [11] and other inequalities are relevant to mental illness vulnerabilities. Societal expectations of men in relation to narrow understandings of masculinity may also be relevant to some men's experience of mental illness.

At the micro social levels, the mainstream psychiatric epistemology and focus on diagnosis and physical treatments endorse the distancing of the nurse from the patient and discourage the acknowledgement of patient strengths, and as a result nursing care may be depersonalized and disempowering. Distance and separation are intrinsic to natural science epistemology for purposes of objectivity. In medical psychiatry gaining knowledge via subject-object separation is transformed into a clinical practice devolving on doctor-patient separation. Hall and Allan, [12] for example, explicated the negative consequences of interpersonal distance between nurse and patient, particularly in relation to supporting, caring, and healing.

When psychiatric nursing mirrors mainstream psychiatric practice, nurses can easily adopt utilitarian approaches to patients for the purpose of medical treatments such as medication administration, assistance with electroconvulsive treatment, observation for medication "side-effects," and checking on physically confined (secluded) patients. Outside the hospital, narrowly defined psychiatric nursing responsibilities often include giving depot medication and exercising powers of surveillance over persons deemed to be in need of psychiatric assessment or treatment.

These medically driven psychiatric nursing activities, by themselves, offer limited opportunities for unequivocal improvement in client well-being and are unlikely to elicit a realistic sense of therapeutic achievement. Such a possibility is supported by Fagin et al's [13] empirical evidence showing that hospital-based

psychiatric nurses experience a lower sense of personal accomplishment and lower intrinsic job satisfaction in comparison with community psychiatric nurses.

Back to Top

HUMANISTIC PSYCHIATRIC NURSING CARE

Humanistic nursing care goes back at least to Peplau. [14] In 1952 she defined health as the development of people toward creative and productive individual and community living. She outlined notions of unconditional acceptance of patients, client-centered nursing, a belief in the intrinsic human potential for growth in each person, and the shift of the balance of power from the nurse to the consumer as the latter responds to nursing care. Trust, empathy, and communicative interactivity are the keys to humanistic models of psychiatric nursing.

Rogers [15] is considered to be the father of client-centered (humanistic) counseling. Interestingly, in his own development as a therapist he came to realize that the more he accepted himself as a person, the more he accepted the client as a person and the less he felt compelled to be controlling. Such self-acceptance and confidence within the counselor facilitate the possibility of constructive changes from within the client. Rogerian therapy is based on the belief that the difficulties or issues are named by the consumer, the goals and ways to achieve them are within the client, and the therapist's primary role is to respectfully set up interactions and circumstances that increase the likelihood that the consumer will determine his or her own positive pathways.

Even though nurses earn their livelihood from this work, they draw on their skills primarily for the consumers' benefit. This means that personal and professional powers are used benevolently, rather than for personal gain. According to Horsfall, psychiatric nursing could begin by "respecting the person (client) as knowledgeable of self and acknowledging the source of the knowledge and [coming to realize that] working with the person is empowering for both the giver and receiver, for both gain even greater knowledge and insight than either had before." [16] (p318)

Humanistic and holistic nursing care devolve on the relationship between the nurse and the patient. Here the emphasis is on connection (as opposed to distance, when the nurse seeks utilitarian ends). Connection and interdependence are understood to be the basis of healing, [17] and the health of the nurse and the service user may then be seen to be interdependent as well. [12] Humanistic nursing care also highlights self-understanding, self-determination, and mutual responsibilities of the psychiatric nurse and the consumer. [18]

Empathy is an essential ingredient in humanistic client-centered psychiatric nursing. It involves the nurse acknowledging and processing his or her own emotions. [19] Empathic nursing care begins with the nurse's way of being with other people and extends to the human capacity to bear one's own pain and that of others. This is emotionally and intellectually challenging on one hand, but personally rewarding for the nurse and patient on the other. Humanistic care facilities the provision of positive feedback to service users [20] and the provision of positive feedback to nurses from clients who benefit from these interactions.

In psychiatric nursing texts with a humanistic orientation, empathy is essential for working with psychiatric service users. Empathy is not instrumental, even though it may be described as a technique. Stuart and Sundeen, [11] for example, consider empathy to be an integral aspect of the therapeutic nurse-patient relationship. Empathy in this instance is contiguous with genuineness, respect, and concreteness, all of which are interdependent facets of humanistic nursing and involve reflection on practice, experiential learning, and a commitment to personal growth.

Humanistic nursing stands outside the materialist medical model. Ultimately the therapeutic use of self is inconsistent with an epistemology that posits the dysfunctional body as the basic cause of psychiatric distress. According to humanistic principles, client change and improvement occur in response to interpersonal approaches and strategies. On the other hand, material medicine holds that malfunctioning neurotransmitters cause psychiatric conditions and that psychotropic medication is the most effective remedy.

However a positive, caring, and egalitarian orientation toward others is not likely to emerge easily when both parties who should benefit from such changes are comparatively powerless in the face of medical dominance within psychiatric services. As May [21] pointed out, patient difficulties and nurse responses are often mediated and impeded by health systems, hospital procedures, and ritualized professional interactions.

Back to Top

DISENFRANCHISED PSYCHIATRIC NURSES AND SERVICE USERS

People who experience psychiatric disturbances require trust, support, and care. None of these will be inevitably forthcoming if the nurse is rendered powerless by organizational practices and medical epistemologies and is therapeutically (along with the consumer) at the mercy of unpredictable medication. A cycle of impotence is perpetuated whereby the agency of both the client and the nurse is diminished, and the service user, as the more vulnerable and least powerful of the two, is likely to remain in a desperate state.

When service users' opinions are sought they commonly declare that they have not been listened to, that their concerns were discounted, and that professional language use was not conducive to developing trust or a sense of optimism. [22] As nurses spend more time with hospitalized patients, it is not surprising to find that psychiatric service users state that nurses do not always listen or empathize and sometimes behave in controlling ways. [23]

In recent years an action research evaluation program in a large Melbourne hospital in Australia has revealed a range of patient concerns. [23-25] Psychiatric service users' responses to the Victorian Mental Illness Awareness Council's consumer evaluation project [24] were mostly appreciative. However, some clients, as well as health care professionals, found the psychiatric environment personally unhelpful. One service user elaborated further:

You can't afford to delve deeper while you're there [in the hospital] because they can hurt you, and they always have that power to-I mean, I was held under the threat of never being able to leave-and it really is a child-parent sort of relationship. They kept on telling me it only took two signatures. [24] (p24)

Hedin [26] defined oppression as the prescription of a person's or group's behavior by others, the restriction of choice of one person or group by another individual or group, or the hindering of another person's capacity to act in his or her own interest. From this perspective it is evident that nurses and other psychiatric service providers are oppressing some service users-that is, they are using power against clients rather than with and for clients. Such oppression and misuse of power may not begin with nurses [21] but this is no excuse for anti-therapeutic nursing.

One psychiatric service user in the recent consumer evaluation research described the hospital power hierarchies in the following manner:

In my case you had [the professor] and then . . . the actual doctors on the ward, and then you had the students, and then you had the senior . . . charge nurse, and then you had the brand new nurses, and then you had the just-in nurses . . . There were just so many, and each level had less and less power. [25] (p69)

This situation indicates layered negative use of power and control on a grand scale.

Psychiatric nurses can replicate their own experiences of oppression in interactions with psychiatric service users. These negative uses of power work against the interests of patients and do not uncover the structured causes of impediments to therapeutic nursing agency. Such mechanisms prevent the possibility of recognizing that psychiatric nurses and patients have interests in common. These circumstances also prevent the development of viable practical and political alliances between nurses and service users.

The medical-psychiatric model of etiologies and treatments is implicated in this, along with the bureaucratization of services in hospitals and in the community. Psychiatric nursing cultures that have developed in response to these factors are also significant.

Back to Top

RECLAIMING HUMANISM IN PSYCHIATRIC NURSING

Given that the absorption of medical epistemology into psychiatric nursing reinforces forces distance from psychiatric service users, depersonalizes nursing care, and contributes to the disempowerment of patients, changes are imperative. It is essential that psychiatric nurses explore and critique hegemonic psychiatric beliefs and critically reflect on their own practice. Listening to and seeking feedback from service users is one way that nurses can begin these processes as individuals or in groups. [23]

One entry point for nurses is to engage with patients as whole people, in a social context, who are experiencing emotional pain and practical life difficulties. Being empathic, rather than assessing for symptomatology, may break down some barriers to effective nursing care that derive from the traditional psychiatric classification, diagnosis, and treatment model within nursing and medicine. Ultimately, neither narrow medical diagnoses nor vague nursing diagnoses assist in the development of a therapeutic relationship within which health-oriented goals can be mutually determined.

Personal experiences that commonly cross psychiatric diagnoses include feeling scared, being afraid of "going mad," believing themselves to be terrifyingly different, having difficulty expressing feelings, perceiving some problems as insoluble, and having communication difficulties. If a person experiences some of these feelings, they are often highly sensitive to the mood, demeanor, and subtle communications emanating from professionals. Service users frequently feel very vulnerable, and a basic need is to trust the psychiatric nurse and believe that he or she can offer some help. If they feel distant from and unsafe with the nurse, service users may use their remaining fragile internal resources to keep their fears to themselves. Desperate, self-salvaging reticence then creates another cycle of fragility and appropriate apprehension, which extend the distance between the nurse and patient. To prevent this, the nurse needs to develop a sensitive connection with the patient as a vulnerable person.

This negative cycle may have tragic consequences for consumers. Lindow, [27] who not only survived the psychiatric system but became well again, concluded that to save herself she had to stay away from psychiatry. Psychiatrically trained

personnel would not support her in her endeavors to assist herself by not taking drugs. In other words, the approaches of nurses and other health care professionals were disempowering because they would not acknowledge her self-expertise and support her decision, strengths, and preferences. A self-help group was more accepting and therefore provided a lifeline during the months she passed through psychotropic withdrawals, detoxification, and severe depression. Mainstream psychiatry is disempowering of consumers and mitigates against a humanistic psychiatric nursing practice.

A recent empirical study [28] of psychiatric service users' perceptions of nursing care highlights the relevance of humanistic nursing care. Beech and Norman [28] noted that an emphasis on medication was also perceived by patients as a diminished concern for the person. This illustrates the notion that a focus on somatic treatments increases the likelihood that the psychiatric service user will not be seen as a whole person, will not have his or her vulnerabilities understood, and will not be accepted as a person with ordinary human needs. Mainstream psychiatric practice simultaneously emphasizes the medical and depersonalizes the person.

To prevent a depersonalizing approach, psychiatric nurses need to decrease distance, increase connection, and work with consumers in egalitarian ways. In their research Beech and Norman [28] ascertained that communicating care, specific personal attributes of the nurse, and respect were key positive nursing quality indicators from patient's perspectives. Personal qualities such as showing a genuine interest in people, being friendly, caring, showing acceptance, and being patient [28] are all aspects of humanistic nursing care. Nurses need to be empathic and hopeful and to process and manage their own emotions as well as those of others to be able to provide the nursing care described and valued by psychiatric service users.

Humanistic nursing care cannot apply revolutionary leverage to an ossified system. But it can assist with changing nursing ideas, practices, and workplace cultures at the grassroots level for the benefit of psychiatric service users and nurses. Before humanistic nursing practice can be implemented, contradictory theoretical assumptions need to be uncovered.

Materialist psychiatry adheres to the belief that the causes of mental illness are within the physical body. This medical epistemology not only is implicated in rendering psychiatric service users powerless in the face of defective genes and malfunctioning neurotransmitters, but also raises serious questions about the therapeutic potential of much conventional psychiatric nursing practice. The specific consequences for psychiatric nursing practice deriving from mainstream psychiatry are insufficient attention to class, ethnicity, and gender constraints relevant to individual patients and practices that are distancing, depersonalizing, and ultimately disempowering.

In contrast, humanistic nursing emphasizes interpersonal relationship, is empathetic, values the patient as a person, and is more empowering for both psychiatric nurses and psychiatric service users. Such approaches decrease the attention on diagnoses, are consumer centered, and increase the focus on patient strengths and more egalitarian nursing practices.

Back to Top

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Previous Article | **Table of Contents** | **Next Article**