

Creating a space for recovery-focused psychiatric nursing care

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Accepted for publication 23 June 2008

WALSH J, STEVENSON C, CUTCLIFFE J and ZINCK K. *Nursing Inquiry* 2008; 15: 251–259

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Within contemporary mental health-care, power relationships are regularly played out between psychiatric nurses and service users. These power relationships are often imperceptible to the practicing nurse. For instance, in times of distress, service users often turn to or/and ‘construct’ discourses, beliefs and knowledge that are at odds with those which psychiatric nurses rely on to inform them of the mental status of the service user. The psychiatric nurse is in the position to impose knowledge onto service users, usually in concurrence with ‘traditional or bio-psychiatry’, without realizing or failing to acknowledge that the service user may have an alternative explanation of his/her mental health problems/experiences. In this paper, practice examples, based on the experiences of the four authors (from within and outside of services), are used to illustrate this ‘hidden’ power relationship. The authors use Foucault’s ideas about: (i) government; (ii) the knowledge/power nexus and resistance; (iii) and his analytic tool of genealogy to help unravel this paradox within psychiatric nursing practice. The authors also use the emerging discourse of recovery as an alternative (and challenge) to ‘traditional bio-psychiatry’ and consider the implications for psychiatric nursing practice.

Key words: Foucault, power, psychiatric nursing, recovery, traditional bio-psychiatry.

The prescriptive manner in which mental distress has been/is managed in what is best described as ‘bio-psychiatry’ (or to borrow Bracken and Thomas’ 2001 parlance, traditional psychiatry) has become unacceptable to a growing number of service users during recent years (Healthcare Commission 2007). Service users have been asking for greater control over and increased involvement in the drawing up of personal care and treatment programmes (Rose 2003) necessitating a change in the way mental health-care is delivered; from ‘doing unto’ to ‘doing with’. Responses to this request can be seen in some recent mental healthcare policy documents (e.g. Department of Health 2001, 2006; Scottish Executive 2006) wherein such papers espouse and emphasize the need for service users to be active partners in their care; and that 21st century formal mental health ought to be epitomized by ‘recovery’-based models.

Yet, many authors (for example Nolan 1993; Barker and Buchanan-Barker 2005; Morrall 2006) have commented that psychiatric nursing has ‘enjoyed’ a lengthy and well-formed alliance with traditional psychiatry. As a result, while the shift from traditional psychiatry to recovery can be achieved on paper with a few deft strokes of a pen, actualizing this shift in the reality of practice may well be a different matter. This is most especially the case because this radical alternation in direction requires a parallel re-thinking and reformation of the obscure (if not invisible) ‘government’¹ that accompanies traditional/bio-psychiatry.

Accordingly, in this paper we offer a brief overview of the central ideas and propositions that are embedded in the recovery model, and through problematizing existing psychiatry as a knowledge/power nexus — without commenting on its ‘truth’ value — the authors then try to create a space in which a recovery alternative can be articulated. Following this, the authors adopt a Foucauldian position and concern

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¹ That is government in the Foucauldian sense.

ourselves with the enactment of power and with challenging the (always artificial) boundaries that we refer and defer to in our everyday practices. In the paper, the authors intercollate their analysis with case and other examples from their collective experience of psychiatric services (from within and outside²) that seem to embody unequal power relations (invisible power, coercion and resistance). Thus, these examples both point to the discourses that have produced them and provide live examples of biopower (Foucault 1981). The authors also refer to alternative responses that would be formed by a recovery discourse.

THE RECOVERY MODEL AND CREATING A SPACE

The discourse of recovery may offer a viable alternative to traditional psychiatry³ (Bracken and Thomas 2001) and there is increasing evidence that recovery is an alternative which, reportedly, brings with it a greater sense of hope, self-determination, dignity and ultimately ownership of experiences (Deegan 1998). It is self-deterministic in that it promotes individual journeys of discovery, coping with, living with or/and eventually being void of symptoms. It is self-defined and so offers a challenge to traditional descriptions in which mental health problems (most often couched as mental illnesses) have been framed. The recovery paradigm opens up space for service users to articulate experiences of living with mental ill health on *their* own terms, without subservience to bio-psychiatry understandings, to oppose the paternalistic way in which mental health services are delivered. As an alternative, empowering, discourse, recovery invites the client into dialogue, provides clarification and encourages active participation (Virtanen, Leino-Kilpi and Salanterä 2007; see also the 'Hearing Voices Network', Romme and Escher 1994). The client is considered an expert on his needs, responses, desires, etc. There is a flattening of the hierarchy between clinician and patient; the process of treatment and change are co-created outcomes of their combined expertise.

Through its 'oppositional' ideas, recovery may be seen as discourse of resistance. It is embedded, however, in a less authorized knowledge — that of expertise by experience — than traditional psychiatry. Thus, the momentum of recovery-based approaches may be halted by the traditional

psychiatric care currently offered which gains 'taken-for-granted' authority from its connection with biosciences and, more latterly, the social sciences whose growth provided a more extensive knowledge base to draw upon (Foucault 1979b; Foucault 1982); having a body of legitimate knowledge means that serious speech acts are more readily available (Foucault 1972). Serious speech acts are statements that have their base in knowledge that is accepted by society, and, as Burr (1995, 64) notes: 'The power [*disciplinary power; our emphasis*] to act in particular ways, to claim resources, to control or be controlled depends on the "knowledges" currently prevailing in a society, and on who has access to that knowledge.' Existing attempts to 'turn the tide' of bio-psychiatry towards recovery have a poor track record of success. For example, 'Soteria' (Mosher and Hendrix 2004) was the provision of an alternative approach to recovery that placed personal choice in the foreground, tolerated 'different' behaviour, celebrated potential and was delivered via a non-professionalized system. The facility was evaluated using a randomized control trial (Mosher 1999) which demonstrated effectiveness and cost efficiency, illustrating its viability as an alternative via the same criteria that traditional psychiatry demands. Nevertheless, funding for 'Soteria' was not sustained and the project closed in 1983 (Mosher 1999) and Mosher resigned from the American Psychiatric Association, citing his dissatisfaction with the medical model dominance in psychiatry as a reason.

In the context of failed attempts at introducing alternatives to bio-psychiatry, a problematization of existing psychiatry as a knowledge/power nexus, although without commenting on its 'truth' value, may create a space in which a recovery alternative can be articulated and enacted, a recovery alternative that is synergistic with psychiatric nursing as interpersonal engagement. As Stevenson and Beech (1998, 795) argue:

There is no such thing as absolute power. If we can uncover the conditions which allowed a certain archaeology of knowledge to emerge, we can more easily reject knowledges as *necessary* accounts without rejecting them as *possible* accounts. Once knowledges are exposed as discourses, ways of talking about our lives, alternative discourses might more easily come into play.

Stevenson and Beech's argument appears to have credibility when one considers that Foucauldian ideas have been used to challenge existing practices across mental health disciplines (see Bracken and Thomas 2001; Holmes 2001; Holmes and Gastaldo 2002; Irving 2002; Ceci 2003; Thomas and Bracken 2004; Stevenson and Cutcliffe 2006).

In this paper, we take a genealogical stance wherein: 'The genealogist is a diagnostician who concentrates on the relations of power, knowledge and the body in modern society (Dreyfus and Rabinow 1982, 105).' In his genealogical

² The authors represent those who have used services, clinicians and academics in various personal combinations.

³ We use this interchangeably with bio-psychiatry which we take as a sub-form of bioscience.

approach, Foucault was concerned with the enactment of power and with challenging the establishment, and the practices of its members, by exploring the 'contemporary limits of the necessary' (Foucault 1984, 53). Or, put more simply, such analysis challenges the (always artificial) boundaries that we refer and defer to in our everyday practices. Accordingly, it is necessary for the authors to explain their understanding and subsequent application of Foucault and our approach to genealogy.

GOVERNMENT AND POWER/KNOWLEDGE/RESISTANCE

In this paper, we explicitly use a Foucauldian concept of power. Specifically we reject any version of sovereign power (Foucault 1979b) in which a ruler or the church wield power over individuals, and/or where only the sovereign or church has the right over life and death or how these are conducted, for example, the disposal of the physical body. We also reject psychological propositions that power is a 'thing', lodged within individuals and inherent within social systems and played out in power over another (see Rosinski 1965; Adler 1966; Berle 1969). Instead we use Foucault's ideas about government as a 'form of activity [*conduct—our addition*] aiming to shape, guide or affect the conduct of some person or persons' (Gordon 1991). Thus, it is the conduct of conduct. Therefore, government refers to the structuring of the possible sphere of action of others (Smart 1992). Government, from a Foucauldian stance, becomes necessary because of the new 'economy of power' (Foucault 1981). Foucault believed that certain cultural situations, for example, population growth, encouraged certain practices, like conduct of the public health towards increased productivity. In this respect, certain discourses of the person, as someone to be made/kept healthy, and as a site of possible disease (whether physical or moral), came into existence (Fox 1993), as did disciplinary power. The practices of government encourage the commodification of caring, taking it out of the domain of family/friends to the domains of professionals as something that is given and taken, bought and sold:

And government is dependent on expertise. Those who profess specialist knowledge and subjects, and in making up the relays that link programmes of government to the multitude of dispersed sites where conduct is to be judged, assessed, evaluated, understood and acted upon ... Government is all those strategies, forms of thought and action, that seek to conduct the conduct of others ... Truths, explanations, categorizations and taxonomies, vocabularies and diagnoses concerning human beings individually and en masse are conditions for the governability of conduct. (Rose 1996, 3)

GOVERNMENT STRATEGY: CLASSIFICATION/CATEGORIZATION

We present two strategies of government, of interest in the field of mental health-care, these are: classification/categorization and surveillance. Foucault notes that the change to disciplinary power was accompanied by a need to classify and categorize people and their behaviours:

This form of power applies itself to immediate everyday life that categorizes the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him which he must recognize and which others recognise in him. (Foucault 1982, 212)

Practice example 1

At the age of 17, Paul's family began to notice that he had begun to isolate himself. Over a 6-month period, he was less willing to work at weekends in the family's electrical appliances retail store and he was losing ground in his school work. He seemed unconcerned about the impact on his plans for university, telling his parents 'it's incontomand'. Instead of going out with friends, he was spending an increasing amount of time in his bedroom. A once amenable young man, he was now becoming uncommunicative and unkempt. This rapid change in behaviour prompted Paul's parents to become very concerned. When Paul refused to eat and refused to open the bedroom door, Paul's father felt he had no option but to contact Paul's general physician. After a brief assessment, the general physician noted that Paul had symptoms consistent with early psychosis and made a referral to a consultant psychiatrist. At no time was Paul asked about his wider life, and in particular his school experience where he was being systematically bullied. Paul met the diagnostic criteria for psychosis according to the *Diagnostic and statistical manual IV* (American Psychiatric Association 1994) and he was thereby embarked on a psychiatric career. Once categorized, it is extremely difficult to be *uncategorized*. The process produces a specific subjectivity, a source of further knowledge for the clinicians and a set of practices as the next example illustrates.

Practice example 2

John was admitted involuntarily to an acute inpatient unit following reports from neighbours that he was acting strangely. John was reported to be riding his motorbike up and down the path at the back of the row of houses where he lived; he was constantly shouting 'freedom'. John attempted to explain to the nursing staff that he was coming to an understanding that his experiences were spiritually significant

and this gave him strength and hope and a sense of freedom. John was described in the nursing notes as having 'relapsed' and as experiencing his 'third psychotic breakdown'. The care plan suggested that he should 'be monitored for further deterioration', and that 'medication compliance' should be ensured. At no point was there any reference to John's own understandings of his experiences or behaviour, or his hopes and dreams for the future.

As a result of his 'marginal behaviour', the psychiatric/mental health nurses viewed John as having little life potential. Biopower dictates that, with so-called severe and enduring mental illness, the best such individuals as John can hope for is to be well maintained through medication; such cruel compassion, as Szasz (1994) terms it, is used purportedly to prevent relapse. Relapse in the traditional psychiatry is a serious speech act in that it produces actions such as persuading, threatening, restraining and controlling (Holmes et al. 2004; Weitz 2004), and the statements regulated by this orthodoxy are well rehearsed, for example, the relationship between medication and relapse. Such speech acts are taken for granted, may not necessarily be accurate or based on a solid, robust empirical underpinning but are seen by many mental health practitioners (and society) as legitimate knowledge. In the epoch of modernism, alternative discourses about the efficacy of medical interventions in psychiatry (see Kirsch and Sapirstein 1998; Geddes et al. 2000; Leucht et al. 2003), side-effects including exacerbation of abnormal mental and behavioural conditions (see Breggin 1997, 2003/2004), discrepancies within pharmaceutical research (Cohen 2002; Healy 2005), and ethical concerns about the marketing power of pharmaceutical companies (Mongrieff, Hopker and Thomas 2005; Lacasse and Leo 2005; Thomas et al. 2005) are marginalized as efficiently and effectively as John's understandings of his experience with reference to spirituality.

A subtle and yet ubiquitous manifestation of power is in the very (privileged) words and language used in cases like John's. The use of language is a strategic act that often preserves relational asymmetry. Differential understanding is preserved in the use of professional jargon when speaking to or about the client, often in shorthand, for example, 'psychotic breakdown'. There is an unspoken message indicating, 'Everybody understands this talk, therefore you must understand, or be deficient'. As a result, the client is disempowered. As a strategic act, language also defines client health. If a client is to become 'better', in the bio-psychiatry discourse, 'better' is defined as a reduction in symptoms and an increase in compliance in terms of response, behaviour and medication. John offered some alternative knowledge and explanations for his experience. Yet in the bio-psychiatry system he is involved with, John cannot participate as an informant. He

is required to become a docile, psychiatric patient who can then become the source of further knowledge of psychiatry, for example, by comparing John's 'delusional' content to that of others deemed to be 'similarly psychotic'.

GOVERNMENT STRATEGY: SURVEILLANCE

For Foucault (1979a), the power of surveillance is demonstrated by the well-known example of the 'Panopticon', Bentham's 19th century architectural vision in which prison cells were built around a central observation tower. The cells were not open to the view of other cellmates.

All that is needed is to place a supervisor in a central tower, and to place in each cell a madman, a patient, a condemned man, a worker or a schoolboy ... they are like so many cages, so many small theatres, in which each actor is alone, perfectly individualised and constantly visible ... Full lighting and the eye of a supervisor capture better than darkness which ultimately protected. Visibility is a trap. (Foucault 1979a, 200)

The person in the cell has no means of knowing who is observing him/her or indeed if there is anyone observing. Foucault saw the Panopticon as a 'diagram of a mechanism of power reduced to its ideal form ... a pure architectural and optical system' (1979a, 205) and as Driver says 'Foucault's account of "Panopticism" is thus to be read as a model of a disciplinary programme' (1994, 120). Although surveillance in mental health systems does not necessarily take place in a physical space such as the Panopticon, as an optical system, its operation produces similar effects.

Within the world of mental health, community psychiatric nurses (CPN) are expected to report on the status of service users, using home visits to observe and assess the mental state of the individual with the 'illness'. Psychiatric nursing staff understand that they have a responsibility to inform others of any observed changes and record this on paper (written reports) or through technological means, for example, computers, and these reports are then subject to internal audit. Psychiatrists rely on community staff to provide accurate assessments of the service user's well-being. A brief appointment (usually lasting 5–10 minutes, every 2–3 months) is then all that is required for the psychiatrist to make a decision on the mental status of the patient and so to implement an intervention.

Practice example 3

Peter is a middle-aged single man living on his own in a deprived area. He is diagnosed with schizophrenia. Peter has long hair and always dresses tidily and is described by

others as a 'gentleman'. There are several young men who live close to him who are self-appointed 'vigilantes'. Peter is afraid of these individuals and rarely goes out at night in case he is confronted by them. This fear finally got the better of him. He shaved his hair, and got several tattoos, displaying them by wearing short-sleeved shirts. His appearance had changed from respectful to menacing. Staff at the day centre which he attended were concerned about this dramatic change in appearance and contacted his CPN. His CPN promptly called at Peter's home to assess him. He was struck by the change in Peter's demeanour and immediately called his psychiatrist for advice. Peter's psychiatrist told him to bring Peter for an appointment and prepare for an admission. After a brief psychiatric assessment, carried out by his consultant, Peter was admitted into the local acute psychiatric unit. For a long while, Peter had been expressing distress about living in a 'threatening environment' and that he believed that he would be able to recover if he lived somewhere where he felt safe and secure. There was nothing done to address his living circumstances.

In this example, interaction and conversation are kept to a minimum as reports from staff and clinical assessments (based on knowledge of symptoms and signs) are relied on to come to an objectified conclusion about Peter's behaviour which supports the conduct of conduct.

The conduct of conduct through classification, categorization and surveillance, is one approach to mental health distress and it stands in stark contrast to a discourse of recovery which forms mental health and illness as deeply personal (but not pathological); as dialogical (Seikkula and Olsen 2003), that is, relational to others; and hopeful. A recovery discourse steps aside from the idea of government through disciplinary power by looking to the person as having equal expertise. Peter's expertise had gone unnoticed by staff. He was aware of the negative effect that living in a threatening environment had on his mental health. The unrelenting persistence that some forms of human distress could be reduced to/or defined as an illness such as schizophrenia would indicate that bio-psychiatry continues to neglect the causal relationship between environment and emotional and psychological distress (Read, Mosher and Bentall 2004). From the perspective of bioscience, it would be irrational to believe that helping Peter move to a less 'toxic environment' would lead to recovery.

The concept of recovery has been challenged on grounds that it is obscure and vague and therefore meaningless (see for example, Whitwell 1999). Yet, it would have accorded Peter and opportunity for 'voice'. The language of recovery is owned by no one, but shared with everyone by way of personal narratives where resilience, self-determination and

personal triumph are demonstrated through word and deed. For example, Bassman (2007) writes of his personal journey in the hope that he might inspire and influence others who might be sceptical or find it hard to accept that recovery is possible. There are no speech acts within the discourse of recovery but speech actors. Language and behaviours are combined to convey autonomous acts of reclaiming stories of 'distress and, ultimately, their whole lives' (Buchanan-Barker and Barker 2008, 97)

Classification/categorization and surveillance are mechanisms of disciplinary power. For Foucault, power is productive of knowledge, subjects and practices. Any version of [knowledge or discourse about⁴] an event brings with it the potential for social practices, for acting in one way rather than another, and for marginalizing alternative ways of acting' (Burr 1995, 64).

Practice example 4

After 8 weeks as an inpatient in an acute psychiatry intensive care unit, Maureen was discharged with clear instructions given to her parents about the importance of her medications in maintaining her mental health. Maureen's brother and two sisters visited her regularly at home. She remained withdrawn, and her family noticed that her moods fluctuated from time to time. She would become agitated and excitable. Her family checked the medication packs and noticed that Maureen had not been taking her medication. They become more and more concerned as Maureen began to talk about angels and how she felt close to God. Her family contacted the psychiatric services and within days, her father brought her to see the consultant psychiatrists. Maureen took the opportunity to ask her consultant three questions: 'How long will I be a mental patient?', 'How long will I be on medication?' and 'Will I get better?' She received no response. After a period of silence, her psychiatrist began to ask about her daily activities; a few minutes later the appointment was over. Maureen left for home feeling disappointed. Her fears, namely that she would never be free from mental health services and that she would have to remain on medication for the rest of her life to control her illness, were not relieved by the silence that met her questions.

In the discourse of bio-psychiatry, the issue of exploring how Maureen came to be 'elated' requires no discussion. Maureen's references to angels and God were not seen as having any meaning outside being a symptom that is interpreted as a sign of illness/relapse. Furthermore, questions and comments are validated through the response

⁴ Our addition.

of the receiver. Maureen's questions were invalidated by the psychiatrist's veil of silence, as they were deemed irrelevant within a bio-psychiatry discourse, and perhaps even a sign of 'lack of insight' into her 'condition' or outright resistance (see below). The return to mundane conversation about daily activities served to communicate a clear message of exactly who would be deciding what is going to be addressed in these encounters. Maureen was to learn that it is unacceptable to speak to biopower.⁵ That she might participate in learning about her condition and making decisions about her needs and potential treatment alternatives was not explored or even considered. The psychiatrist's practices produced by biopower prevailed. The regime of truth prevents Maureen's queries, which imply a future without bio-psychiatry, being treated as a serious speech act.

Foucault did not see power as a form of repression or coercion, however. 'Power is tolerable only on condition that it mask a substantial part of itself. Its success is proportional to its ability to hide its own mechanisms' (Foucault 1976, 86). For example, government creates a specific style of subjectivity – governmentality (Foucault 1979b) – where 'docile bodies' practice self-discipline, signifying that power is successfully enacted. This is the nature of disciplinary power, in which people are disciplined and controlled by freely subjecting themselves to the scrutiny of others (especially 'experts') and to their own self-scrutiny and self-discipline. Such disciplinary power, Foucault believed, is a much more effective and efficient form of control (Burr 1995). The following example illustrates the possibility of power as visible (crude coercion) and invisible ('successful').

Practice example 5

Tom was told by staff on the inpatient unit that if he did not 'settle down' and take his medication, they would have to move him to the observation area. They emphasized the effect his behaviour was having on other patients. He continued to insist that he would not take his medication asserting that he could not see why he needed to take any. He was duly moved. Tom offered no overt resistance to being moved. He continued to refuse the medication, however, and after a few hours, staff decided to move him to the nearby intensive care unit. Again, there was no overt resistance from Tom when being moved. Tom was placed into a seclusion room on arrival at the intensive care unit. Three members of staff returned to administer medication to find that Tom had smeared his excrement over the walls

of the room. This time Tom fully complied and allowed the administration of medication to take place. Tom later confided to a fellow inpatient that the refusal to take medication and to smear was a form of protest.

Tom's case is an example of professional power failure in Foucault's terms. Increasing threats, and punishment (moving to ever more restrictive environments) are forms of crude coercion. These were met with the increasingly crude resistance from refusal of medication to smearing faeces. In Tom's case, however, an interesting question arises as to why he did eventually comply with staff wishes. This might be interpreted as him adopting self-surveillance; a governmentality of conducting his own conduct. On the other hand, it may be that Tom had worked out that his agreement to take the medication had become *his* decision, had an element of surprise in the context of the extreme behaviour of smearing, and so was a means to escape the cycle of action on action of power and resistance. If so, this would then become a clear example of the enactment of invisible power; Tom successfully hid the mechanisms of power (by not disclosing his reasons for taking the medication) while the staff simply described him as compliant.

Although Foucault has been criticized for not attending sufficiently to resistance to power (Fox 1993), he did point out that power and resistance are entwined: 'For Foucault, power and resistance are two sides of the same coin. The power implicit in one discourse is only apparent from the resistance implicit in another' (Burr 1995, 64). Given that there are always different discourses available in relation to a state of affairs, there is always the possibility of resistance to the prevailing discourse (or knowledge or 'common' sense), even one that is superficially benevolent.

Practice example 6

Joan had been an inpatient in acute psychiatry for 6 weeks, being described as 'elated' and 'having disinhibited promiscuous behaviour'. Several weeks after discharge, Joan had found a peer advocate worker. She revealed in discussion that she recognized that she had been 'elated' but remained unconvinced that her experiences were a product of an illness; she preferred to think of them as compensation for all the times she had felt miserable about her life. She revealed that the way she has been treated as ill had impacted on her life path; that she believed that she would never enjoy a sexual relationship, marriage or children. Joan understood her promiscuous behaviour as a last ditch attempt to gain physical and emotional closeness with someone of the opposite gender. As Joan never believed that her problems were illness related, she began to spend time

⁵ By 'biopower', we refer to the knowledge/power nexus that is sustained by its connection with science.

exploring and considering alternative views of 'mental illness' and recovery posted on websites and to read alternative texts that challenged orthodox western biomedical depictions of mental illness.

Joan described her struggle to have some normal life experiences, including an intimate relationship to a peer advocate. Alternatives concerned with helping her to explore less promiscuous and less challenging ways of interacting with the opposite gender were not considered in the acute psychiatry setting. Instead, Joan's awkward and arguably inexperienced attempts were seen as something that needed controlling (not modifying); as something that the mental health staff needed to govern, consistent with an economy of power where 'moral treatment' (Foucault 1961) is geared to create normalcy that is not threatening to individual or societal productivity (as promiscuity is perceived to be). Joan's story, as well as John's, illustrates also the strategy of omission — the failure to acknowledge there is anything meaningful outside the discourse of bio-psychiatry. It is likely that those working with Joan deemed it in her best interest to control her promiscuous behaviour. While omission may have been a way of acting in the best interest of the patient, it is ethically questionable. Here, omission retains the clinicians' power to shape Joan's behaviour and to maintain the definition of her experience within the parameters of the accepted discourse. Birch (1991) points out that such discourses produce self-sustaining disabling cycles: a cycle of disqualification, where 'sufferers' and families lose their sense of expertise and defer to the opinion of psychiatric experts; a cycle of victimhood, where 'sufferers' see little hope for a socially fulfilling life; a cycle of fatalism in which the 'sufferer' and her/his social network wait for the next relapse. Over time, Joan had come to realize that there are alternatives that she had not been fully informed of within her encounters with psychiatric staff. Joan had exercised resistance to the mental health system after discharge by seeking immersion in a discourse that has a basis in knowledge by experience and which is an alternative to the regime of truth of psychiatry. Joan's 'alternative' ways of thinking about her experiences can be read as a will or desire to 'other' (Deleuze and Guattari 1984, 1988) and as a form of resistance, but notably this occurred outside of 'regular' psychiatry.

Working within a recovery discourse, Joan and John might have been encouraged to give their personal narratives in relation to their experiences, fears, hopes for the future — where their best interests lay. Such a dialogical approach does not necessarily negate the importance of a bio-psychiatry perspective (and its associated interventions) and Foucault himself was not attempting to replace one regime of truth

with a successor. But, as Bracken and Thomas (2001) point out, a Foucauldian approach does refuse to privilege one explanatory framework at the expense of other (in this case, service-user held) alternative views.

CONCLUSION

Bio-psychiatry is the regime of truth under which much (but not necessarily all) psychiatric nursing practice shelters. It is a comfort for some in that it forms what can be 'legitimately' constructed, said and done. Irrespective of its truth value (which is questioned by service users), it marginalizes alternatives.

Within bio-psychiatry, the very idea that someone can recover from illusive illnesses such as schizophrenia (Boyle 1990; Bentall 2003; Read, Moshier and Bentall 2004) is met with suspicion: 'once the symptoms of schizophrenia occur (usually in young adulthood), they persist for the entire lifetime of the patient and are almost totally disabling' (Sawa and Solomon, 2002, 692). Bio-psychiatry is not the holder of hope but the preserve of pessimism. The continuation of 'symptoms' (regardless of the fact that people have demonstrated that they can thrive in the presence of such experiences) supports the negative hypothesis. The person is objectified (as a source of new knowledge) and subjectified in that s/he is constructed as deficient and in need and is conditioned to accept these definitions.

From a recovery perspective, words, deeds, descriptions and interpretations are to be shared through recovery processes, but bio-psychiatry shuns erstwhile accounts of 'problems with living' (Szasz 1984). One of the main constituents valued, particularly within non-medicalized mental health nursing practice is hope (Koehn and Cutcliffe 2007; Cutcliffe and Koehn 2007), and hope is also an important virtue found in recovery literature (see for example Jacobson and Greenley 2001; Andresen, Oades and Caputi 2003; Resnick, Rosenheck and Lehman 2004). One of the working principles of Soteria was that staff would have a high expectation for clients to recover. Moshier (2004, 351) describes the phenomenological context that lead to the setting up of Soteria: 'the atmosphere must be imbued with hope — that recovery from psychosis is to be expected'. As Foucault himself noted, power and resistance are co-existing. The reaction from bio-psychiatry, thus far, to the challenge of the recovery movement is to ignore the personal success stories, to record them as exceptions, a minor deficiency (i.e. misdiagnoses) in the medical and positivist search for 'truth'. In this paper, we have tried to explore and problematize the 'contemporary limits of the necessary' (Foucault 1984, 53) in respect of psychiatry and consequently, psychiatric nursing practices. We have exposed how biopower constructs certain

objects, subjectivities and practices. Using Foucault's ideas of government and the knowledge/power/resistance nexus with practice examples, we have tried to demonstrate that drawing on different knowledges produces different practices. In this respect, our paper might be read as a site of resistance to the regime of truth of bio-psychiatry and a creator of space for an alternative discourse.

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