

## **Abstract**

### ***The challenges and triumphs of psychiatric nursing education in Manitoba 1920-1995***

In Manitoba psychiatric nursing has evolved as a distinct profession with its own legislation, standards of practice and code of ethics. The emergence of psychiatric nursing as a separate legal entity officially began in March 1960 with the passage of Bill 86 through the Manitoba Legislature. However for forty years preceding that legislation there had been in place various kinds of training programs at the three provincial institutions, Selkirk, Portage and Brandon. An examination of the history of psychiatric nursing education in Manitoba highlights some of the unique features of this profession and creates the context for reconsidering the philosophical, epistemological, ontological and political underpinnings of the psychiatric nursing education curriculum.

Professional education must adhere to educational models and standards that ensure competent practitioners. Professions which serve the public, especially the vulnerable public, in very personal ways are particularly subject to the influence of mandated standards which must be part of the educational process. But other interests also influence the curriculum, disciplinary knowledge and political agendas have an impact on educational models and outcomes.

The purpose of this paper is to briefly examine the history of seventy five years of psychiatric nursing education in Manitoba and to offer a preliminary model for further development and exploration of the psychiatric nursing education curriculum.

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*The Challenges and Triumphs of Psychiatric Nursing Education in Manitoba 1920-*

If you asked any student wandering the halls of a Faculty of Education why they were there the most common answer would be that they want to be a teacher and generally they can further elaborate what kind of a teacher such as, an elementary, middle school or secondary teacher. Hardly ever will you find a student who tells you they want to teach engineering or nursing or English literature.

Teachers in tertiary education usually consider themselves as professionals first and teachers second and they are less likely to have engaged in education about teaching their discipline to others. There is certainly some evidence that this is changing, many Faculties of Education now have courses on teaching at the college level, but of course not everyone avails themselves of this opportunity and there are certainly many educators in colleges and universities ill prepared to teach their discipline. Others rely solely on their disciplinary knowledge and plan to impart it into empty vessels. Still others ignore the realities of the real world and provide excellent but unwieldy knowledge.

Professional education is a particular kind of tertiary education which I believe requires a particular framework that takes into account various influences on expected educational outcomes. Professional education does not really fit neatly into either a pedagogical or andragogical paradigm though it uses principles from both.

Professional education generally requires the passing on of very specific and often privileged knowledge, but it is also frequently required to adhere to standards imposed by

external agencies. Maintaining a balance between the disciplinary knowledge, the legal and political requirements of the approving or accrediting body, and one's academic freedom is a delicate balance.

What I want to address in this paper is the education of psychiatric nurses in Manitoba, as it was practiced in its first seventy five years from 1920 to 1995, by reviewing the historical and political influences on this particular profession. I also want to suggest a model for identifying the various discourses to which the psychiatric nursing curriculum is subject.

Registered Psychiatric Nursing in Manitoba is a unique profession with its own Act, Code of Ethics and Standards of Practice. Educating psychiatric nurses to practice within the legal framework of the profession in a safe and competent manner is at this time the responsibility of Brandon University. But the journey to the University has been a long and interesting one that has been strewn with many challenges.

Psychiatric nursing as a profession in Manitoba gained legal status in 1960, but for forty years before that mental nurses had been educated in the two provincial asylums, one at Brandon and the other at Selkirk and later at the Portage Home for Incurables. The names used to identify the institutions are those that were in use at the time though subsequent name changes reflected a more enlightened view. To understand the trajectory that mental nursing has taken in Manitoba it is necessary to look at asylum care between 1900 and 1910. This arbitrary time-frame is midway between the opening of the Brandon Asylum in 1891 and 1921 when some fairly sweeping reforms took place including the establishment of a training program at Brandon (Dooley, 1998; Hicks, 2002; Refvik, 1991; Tipliski, 2002).

The asylum in Brandon at the turn of the century was not unlike asylums anywhere in North America at that time. They were large imposing buildings isolated from the rest of the community and staffed by individuals who frequently could find no other employment. There were few treatments and those that were tried were often unpleasant and unproven. Little was expected from the staff except the maintenance of order and the prevention of fights, escapes and suicides. The attendants, as most of the staff were called, had little or no education and certainly no education concerning care of patients with mental illness. Occasionally a general nurse was employed, but this was to care for any patient who had a physical illness and there seemed to be no expectation that a nurse would in any way make a difference to the patient's mental condition. The asylums were generally self-sufficient in regards to housekeeping, laundry and maintenance and usually had farms and gardens which provided food for the inmates and keepers, and sometimes even made a profit for the institution. The farming and household maintenance also ostensibly provided a form of work therapy for certain inmates though it was generally only a thinly disguised form of cheap labor. In Brandon the farm fell under the supervision of the medical superintendent and annual reports never failed to mention the success or failure of crops and breeding programs. This practice was actually common to most asylums at the time and subsequent asylum reformers usually suggested, with varying degrees of sarcasm, that the business of the asylums should be patient care and not farming (Dooley, 1998; Hicks, 2002; Refvik, 1991; Rothman, 1980)!

In the 1960's a literature began amassing on the state of nineteenth century asylums, the social meaning of the care they provided, or didn't provide, the relationships formed within them and the role of the medical superintendents (Brown, 1994). This

literature reflects the similarities between asylums of Britain, North America and parts of Europe. It also highlights the rise to power of medical superintendents with ambitions in the new medical specialty of psychiatry. Much of this early literature was written by self-congratulatory reformers, who wanted to show the world how kind they were by rescuing the insane from life on the streets and providing for them a clean if somewhat neglectful environment. The dubious motives and the even more dubious care were soon however challenged.

Revisionist historians such as Foucault (1961/1965), Rothman (1971) and Scull (1979) suggested that the motivation for the establishment of asylums was social control and not kindness. Between these two extremes lie the works of the counter revisionists whose major thesis was, that regardless of the underlying social or political purpose of asylums there was a rich but unexamined life inside the asylum walls (Digby, 1985; Krasnick-Warsh, 1989; Shortt, 1986). These counter-revisionists insisted that the social and day to day life of the inmates and their keepers should be the real project of asylum literature. It is also in the asylum environment that the roots of psychiatric nursing lie and the growing body of asylum nursing literature highlights the impact of this context on the development and education of psychiatric nurses (Boschma, 1999; Church, 1987; Dooley, 1998; Hicks, 2002; Moran, 1995; Nolan, 1993; Tipliski, 2002).

In 1919 in Brandon three events came together that resulted in major changes to the asylum. A scathing report on the condition of the infrastructure and care of patients at the Brandon Insane Asylum, the return of many soldiers following World War 1 suffering from shell shock and a name change from lunatic asylum to hospital. The scathing report was the result of a survey of Canada's asylums carried out in 1918 by Clarence Hincks and

Dr Clarke, the Dean of Medicine at the University of Toronto, on behalf of the newly formed Canadian National Committee for Mental Hygiene. Across the country every asylum was condemned, not only for the appalling physical conditions but also for the moral bankruptcy which extended to staff and even to government supervisors. The Brandon Asylum however was singled out by name as one of the worst in the country. To add to this the First World War highlighted the mental unfitness of many young recruits, and the returning soldiers suffering from shell shock needed immediate and urgent care. The Canadian Military added their scathing assessment of the Brandon facility and insisted that all returning soldiers be housed at Selkirk. An embarrassed Norris Government sprang into action and one of their first acts was to rename the institution *The Brandon Hospital for Mental Diseases*. The title hospital brings with it certain expectations and one of the first effects of this action was the appointment of a new medical superintendent. In 1919 Dr. Baragar was appointed to Brandon and he acquired approximately 800 patients, a couple of hundred ill prepared, mostly male staff, about the same number of pigs, cows and hens and a structurally decaying building (Dooley, 1998; MacLennan, 1987; Refvik, 1991).

The events in Brandon coincided with a movement on both sides of the Atlantic towards the medicalization of care of the insane. Medical superintendents wanted to be recognized as legitimate medical practitioners and Dr. Baragar, was no less ambitious. One of the ways, perceived by the superintendents, to improve both the appearance and the prestige of asylums was to recruit and train young women into the role of nurses, who would have the appearance of nurses in general hospitals and who would perform similar tasks. Young female nurses in the early part of the 20<sup>th</sup> century epitomized the heritage of

Florence Nightingale in regards to demeanor and skills. Their demeanor was characterized by gentility and obedience to the physicians and their skills frequently meant the performance of ritualized techniques such as cleaning instruments, making beds and giving bedpans, none of which had much use in an asylum (McPherson, 1996). Despite the uneasy fit this was the vision of Dr. Baragar and his colleagues. This drive to model psychiatric nursing on general nursing seems to have had more to do with the medicalization desires of the superintendents than with common sense (Dooley, 1998; Hicks, 2002; Tipliski, 2002).

But could asylums be turned into hospitals and inmates into patients? Consider the differences between asylums and general hospitals. The physician in the general hospital may have had perhaps twelve or even twenty patients to care for. He would have issued orders for poultices or bandaging, which were common procedures of the day and a female nurse would apply the ordered procedure to a willing patient who was generally lying in bed. By contrast, the asylum was characterized by patients crowded into locked wards and little but custodial care. Patients were expected to be up and dressed and to the best of their ability were expected to participate in the day to day life of the asylum such as working in the laundry, kitchen or farm. As well as preventing escapes, fights and suicides the attendants also supervised the inmates in their work. There were few treatments like those administered to patients in general hospitals, after all where do you apply the poultice?

Despite the contextual and philosophical challenges Dr. Baragar did succeed in establishing a training program of sorts in 1920 at the Brandon Hospital and a year later another was commenced at Selkirk. To say this was a political move is an understatement.

It was not only Baragar's dream but it also satisfied the political masters who had their own reasons for wanting to improve asylum conditions.

This medical-political influence on psychiatric nurses training continued from 1920 to 1960. The Medical Superintendents controlled what the student nurses learned in the classroom and an examination of documents suggests that the kind of knowledge they wanted the nurses to have was based as much on what they wanted them to do for the doctors as for the patients. There were no consistent standards and education was usually subverted to service requirements of the institution. Never the less during that forty years a number of adaptations, modifications and events occurred that culminated in the legislation of 1960 which officially incorporated the Registered Psychiatric Nurses of Manitoba (Dooley, 1998; Hicks, 2002; Tipliski, 2002). This legislation also established a committee, comprised mainly of medical superintendents and nursing administrators, to control the curriculum. This medical hegemony continued till 1980 when it was legally changed by an act of the Manitoba legislature. There is still a mandated body which gives approval to the curriculum, though the composition now includes psychiatric nurses. But the standards of practice and legal requirements of the profession continue to impact the nature of the curriculum, as it no doubt does in many professional disciplines, but it also begs the question "What is the disciplinary knowledge of this profession"? Disciplinary knowledge is identified as the second influence on the curriculum in the proposed model.

### **Disciplinary knowledge:**

What was, should or could be the nature and role of disciplinary knowledge in psychiatric nursing? Unique knowledge is considered one of the hallmarks of a profession (Barber, 1965; Etzioni, 1969). “What was the unique knowledge of psychiatric nursing when it was strongly influenced by the medical superintendents”? Curriculum documents suggest that the medical superintendents designed a curriculum based on a combination of psychiatric medical knowledge and general nursing. Much emphasis was given to disease states and the medical model. There was also borrowed knowledge from general nursing on the performance of a variety of scientifically based tasks, such as sterile dressings, which had little place in the asylum setting. The psychiatric nurses, rather than performing the physical and ritualized tasks of the general nurses, spent a large part of their day engaged in interpersonal relationships with people whose very ability to engage in relationships was often severely impaired by their illness and their unique world view (Various documents located in the McKee Archives at Brandon University and unsorted material located at the College of Registered Psychiatric Nurses of Manitoba). “What disciplinary concepts would be most appropriate in this context”?

The importance of curricula being based on sound disciplinary knowledge and models was a key issue in educational circles in the 1960’s (Bruner, 1960; Phenix, 1964; Schwab, 1964). Phenix (1964) devised a schema for classifying knowledge in his work *Realms of Meaning*. He identified six realms of meaning based on the logical structure of knowledge. Further he created a link between the logical patterns of knowledge and the varieties of meaning ascribed to man’s experience of being. Surely the experience of being labelled mentally ill requires a very special pattern of knowledge.

Phenix's first two realms, symbolics and empirics are the traditionally recognized subjects of reading, writing arithmetic and the natural and social sciences. The third realm is classical, art, literature, music and drama. The fifth realm Phenix identified as the moral or ethical and the sixth as the synoptic which includes the integrating subjects of history philosophy and religion.

But it is his fourth realm, synnoetics, that is of most interest here. Synnoetics is not a frequently used or well developed realm, but it is one that is underexplored as the possible basis of disciplinary knowledge for psychiatric nursing. Synnoetics is described as meaning in which one person has direct insight into others or oneself. Phenix suggests that in the first three realms, symbolics, sciences and aesthetics, knowledge depends on a subject object relationship, in synnoetics it is a subject to subject relationship. The concept of relationships is central in psychiatric nursing.

The disciplinary knowledge of psychiatric nursing in the days of the superintendents was a curious mix of medical knowledge, housekeeping and etiquette. And while disciplinary concepts such as those of Phenix were beginning to emerge, there is no evidence that they touched the psychiatric nurses, or their instructors, in Brandon. What ever disciplinary knowledge underpinned their curriculum it no doubt suited the needs and goals of the time. But as psychiatric nursing matures into an academic discipline the essence of the discipline needs to be more clearly articulated. Synnoetics, may be a realm of meaning worth exploring.

All disciplines, according to Dressel & Marcus (1982) have five components or structures. The first of the five is "What are the concepts of interest and what are the types of problems with which this discipline is concerned"? (as cited in Stark and Lattuca 1997,

p.145). And while relationships or synnoetics may be the disciplinary framework for psychiatric nursing the central question is how to form healthy and helpful relationships with a person experiencing what has been termed mental illness. This is third influence of the curriculum framework. “Which concepts of mental illness are best suited to the practice of psychiatric nursing”?

### **Concepts of mental illness:**

Concepts of mental illness have evolved through centuries of understanding, misunderstanding and political expediency. No other illness in history has experienced the same degree of interpretation and reinterpretation and had so many different meanings as mental illness, even to the point of denying its existence (Sedgwick, 1982; Szasz, 1970). Because of the number of ways to view to mental illness it is impossible to do justice to the huge literature the topic has spawned. A statement by Thomas Szasz (1970) perhaps summarizes the situation,

...they (mental illness) had formerly been known by other names, heresy, buggery, sin, possession ...or accepted as customary and natural and were not designated by special names. In the eighteenth and nineteenth centuries a host of such phenomena were reclassified as illnesses (Szasz, 1970, p.137).

Szasz, is of course referring primarily to witches, masturbators and homosexuals as examples of how perceived social and political deviants, who had once been burned at the stake or castrated, were subsequently redesignated as ill rather than evil and confined to mental asylums. He also alludes to the “invention” of mental illness stating that some behaviors previously unclassified suddenly became illnesses. Even today in the “bible” of

designations, *The Diagnostic and Statistical Manual of The American Psychiatric Association*, which has evolved through four editions in fifty years, diseases come and go. Sedgwick, (1982) draws parallels with the practice of “labelling” in some socialist (and probably capitalist as well) societies where free thinking dissidents were declared insane and hospitalized. The distinction between hospitalization and incarceration is not always clear and in some of the cases cited by Sedgwick they serve the same purpose, the silencing of protesting voices. The literature on the meaning of mental illness reached a peak in the 1960’s with the works of Foucault, (1961/1965) Goffman, (1961) Laing, (1961), Szasz, (1970) Scheff, (1967). The debate continues and the mentally ill are still with us.

There are many turning points in history in which one concept comes to gain dominance over another. The 1800’s are considered the rise of medical psychiatry with a combination of social reforms, greater understanding of the nervous system and the hypothetical structure of the human mind (Ellenberger, 1970). Superstition and religion, both of which had previously provided the explanatory frameworks of mental illness, were replaced with science.

The medical model, with its emphasis on diagnosis and treatment, certainly dominated in the early part of the twentieth century and coincided with the efforts already discussed to improve the status of asylums. This spawned a number of “scientific” treatments which in turn gave rise to the “nursing techniques” which characterized psychiatric nursing in the first half of the century.

Other models of mental illness and frameworks of treatment flourished in the second half of the twentieth century and also influenced psychiatric nursing, as they

become part of or were popularized by the medical establishment. Medication in the ninety fifties became the treatment of choice as well as a means of chemical restraint. Behaviorism, reality therapy, group therapy cognitive therapy and a number of other “isms” emerged as ways to treat and manage not only mental illness but the mentally ill as well. Community care became the goal of the seventies and brought a new set of challenges. Psychiatric nurses became concerned not only with caring for the patients but also with the environment in which they lived. Assisting clients with basic living skills, adapting to community living and helping families adjust became new responsibilities of psychiatric nurses. Not all communities were welcoming and the role of advocacy became added to the psychiatric nurses repertoire of skills. The medical model was no longer the predominant model of care.

Models of illness and care have evolved and changed over the years, psychiatric nurses have adapted to those changes but the focus of the psychiatric nurse must be on the persons experience of their illness and the impact on their lives, not the illness itself. A psychiatric nursing model of mental illness needs to accommodate human experience elements not just disease elements.

### **Curriculum frameworks:**

Finally, in what way should the curriculum be designed and delivered to remain congruent with the goal of educating psychiatric nurses to engage with people whose world view is often unique, the course of whose illness is often unpredictable and whose life context is often complex. The educational goal is also however, to graduate the kind of psychiatric nurse demanded by the politicians, the legislators, the profession and most of

all the clients. These are conflicting demands and educators have to juggle these requirements, which at times seem to be at odds with sound pedagogical principles and academic freedom.

There are a number of curriculum models based on various configurations of teacher, learner and subject matter but there is one model in the tertiary education literature which may reflect the reality of professional curricula. Gay, (1980) after identifying the traditional conceptions of curriculum, which are well known to educators, the technical, rational and experiential added a fourth provocative model. The pragmatic model, identified as being "...neither systematic or rational. It is a dynamic political and social interaction model, reacting to events and stakeholders who wield power in determining both purpose and process of curriculum...the negotiated curriculum" (cited in Stark and Lattuca, 1997, p. 32). While this statement to a large degree reflects the tensions inherent in professional education programs there are also other tensions between various curriculum models.

Eisner and Vallance (1974) identified five conflicting models of curriculum. The technical, which is highly structured and focuses on the development of technical skills, the academic-rational with its emphasis on "what is worth knowing". The learner centred, development of cognitive processes and self actualization and finally the social reconstruction model. Habermas (1970) identified three types of knowledge and their uses in society. Curriculum theorists have suggested the types of learning environments in which each would be fostered. The technical model, focuses on the development of technical knowledge and skills which are generally achieved through Tylerian objectives. The practical model focuses on the acquisition of knowledge to shape actions in the real

world and often employs experiential learning. Finally emancipatory knowledge challenges the existing political structures, why some discourses have dominance over others and how social relations are distorted by power. This model is not as much about the achievement of particular knowledge but rather how particular knowledge comes to be privileged over other knowledge. Critical questioning is the underlying framework.

The curriculum of the fifties and sixties in psychiatric nursing was clearly technical. Educational objectives were designed to achieve particular psychiatric nursing goals. There seems to have been little room at that time for understanding the experience of the patient. There was a gradual transition towards inclusion of more complex knowledge but the curriculum goals still stated “This is the knowledge most worth knowing”.

As psychiatric nursing becomes more complex the need for a unique educational framework becomes urgent. “Covering the content” and perfecting the skills is not enough. Today’s psychiatric nurse engages in complex relationships in complex environments but there is also a need to challenge the political and medical structures which underpin the complexities. Psychiatric nursing is not just about knowing and doing but also about feeling and this too must be accommodated within the educational model.

Each of the curriculum models has some value in psychiatric nursing education. Knowledge skills and attitudes can be fostered through the models of Eisner and Vallance, but there is also a need for emancipatory knowledge, so that the very assumptions upon which psychiatric nursing rests can be brought into focus.

**Conclusion**

Professional education is a particular kind of tertiary education which is subject to a number of competing influences. Psychiatric nursing is an example of such a profession which has mandated responsibilities to serve the vulnerable public and to adhere to precise ethical and practice guidelines standards while at the same time engaging with people who have unique world views and who often thrive in ambiguous situations. Psychiatric nurses require attitudes and skills that range from existentialism to political savvy. Obviously their unique knowledge skills and attitudes must be fostered through a unique educational process.

This framework suggests that the curriculum must be sensitive to political, disciplinary and conceptual factors as well as educational practices.

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