Rebels with a Cause:
The Experiences of 'Rebel' Nurses Resisting Against Psychiatry

Simon Adam, RN
Brenda Ridley, RN
Cheryl Van Daalen-Smith, RN

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Three Canadian Registered Nurses provided a panel wherein they shared their experiences with psychiatry in their respective roles as RNs. The following is a recollection of those narratives, with the sporadic addition of some scholarly sourcing should this be helpful for readers. There is no way to have shared the real synergy and passionate dialogue between the panelists and the audience, but what we do know is that it was an important moment of voice for each of us and for many who came to hear our reflections. For maybe ... just maybe ... other Canadian nurses will tap their inner strength to 'see', name and question ... **publicly**.

Reflections on Resistance

Simon Adam , RN

Here is an emergency department. It is a particular one, though it could be almost any one, for they are all very similar: A regional trauma unit humming with the activity of patients, their families and friends, and hospital staff. To the casual onlooker, the setting, a seemingly politically benign clinical enterprise that depicts patients as passive and satisfied recipients of medical and nursing care, to me, became an environment laden with institutional processes, categories, and priorities. Hundreds of people each week would become the means by which the institution exercises its ruling power and control over the patient, and specifically, over the elderly and the psychiatrized.

In a slow, steady, and rather sobering awakening, I came to realize that the "care" for which elderly patients and patients with "mental health complaints" accessed the institution, they did not receive, and was marginal at best, and at times, outright needlessly traumatic. The department, whose administrative priorities lie in the meeting of Ministry targets, attending to extralocal political objectives often incongruent with those of the patient, and, ironically, aggressively marketing an image of "health care excellence" and "innovation in health care" to the public, is the backdrop against which my resistance efforts to psychiatry is set.

Having entered the antipsychiatry movement as an academic, I became more politically and socially aware of the problems that faced my patients, the problems that the institution created and perpetuated for them—problems that are almost always seen by the practitioner as help rather than harm. Why is it, I would ask, that the bedside practitioner needs to be rigorously politically sharp (most novice nurses are not) in order to see that the care is problematic? How difficult it is for this struggle to prevail, for nurses to come to such an awareness, to change harmful practices, and to transform the system as it is! Where acute care nursing is largely populated with novice nurses with what I call a "politically naïve understanding of the institutional regimes of ruling that subjugate them and their patients", I also came to experience my resistance efforts being met with resistance. It was not only the resistance of my nursing colleagues, but my own as well, as I grappled with the antipsychiatry movement myself as I came closer and closer to understanding just how radical it is and what it proposes to accomplish. I often found myself asking, how does one do away with a system that, albeit harming many, is also helping some? What will replace the help that the severely anxious young woman, for example, receives in a form of a sublingual relaxant? What about the person accessing the psychiatric emergency service for feelings of danger and fear? I learned to step away from these questions and look at the institution as a symptom of larger problems, and one of which is biomedical psychiatry, where I stopped accepting a regime that marginally serves the very few and harms all others subjugated by it.

Reflections on Resistance

The following is a letter written to a colleague two days after an incident that occurred in the emergency department (of note, the name “Janet” is a pseudonym and not the real name of the individual addressed below):

Dear Janet,
I am writing to you in light of a situation that I experienced with you in looking after a patient in room 28 on Sunday. Recall I asked you to come in and help me pull him up in bed, as he was climbing out of the stretcher? I apologize for not speaking to you in person, but it is for two reasons: the emergency environment does not allow for privacy, and second, I was quite taken back by your response [to the patient’s call] that I wanted to wait and think about what I had to say. I had been in room 28 for about 10 minutes talking to the man and assessing him in an effort to de-escalate him and subdue his anxiety, and thus his behavior. I want to bring to your attention the patient needs that were deferred and as a result caused him to be anxious, discontent and climbing. He was hungry, he was cold, and he had a diaper placed on him though he was not incontinent, thus needing to go to the bathroom. Institutional problems that are beyond you and I render us nurses powerless to quickly and efficiently tend to the needs of the elderly, as they take time and they take us away from other more urgent acute needs of other patients. For this reason, I understand that deferring the patient's needs were not necessarily any one person's fault, though my concern is mainly in your reaction to his behavior: walking into the room and ridiculing the situation ..."this is ridiculous..." in front of the patient and scolding him, stating that "this is the third time we had to put you back..." suggesting restraints. Janet, what I saw in your behavior demonstrated insensitivity to the patient's needs and a poor understanding of the fact that if needs are not addressed, they cause behavioral changes in patients, especially the elderly. Rest assured, this is between you and I and I hope we can professionally dialogue about this whenever possible. In an institution that values and privileges acute care over geriatric care, it is important to be attuned to such sensitivities as simple patient needs, although arguably, his needs are not so simple to him. I am confident that you understand my perspective.

What happens when an institution preoccupies itself with “patient flow” and the meeting of Ministry targets? What happens when the institution deliberately and carefully deploys resources to disproportionately address acuity and not chronicity? What happens when most of the support is injected into the “trauma program,” and the “critical care program” in an institution that obviously does not only serve trauma and critical care patients?

The scenario above is much too common. The nurses and other staff are so preoccupied with making care ends meet at high-speed with all their patients that the needs of the elderly, often activities of daily living such as feeding, toileting, and ambulating them, often are “forgotten.” Research demonstrates that if such needs are not promptly addressed, they can lead to delirium in the elderly patient (Inouye et al., 2006; Palmisano-Mills, 2007). When there is this acute confusion, coupled with persistent calls for needs that are not addressed, when the patient is delirious and cannot communicate coherently, the restraints come out. Here, we have an elderly man asking for toileting that was met with a diaper, a blanket and a sandwich that he was never given; becoming more and more anxious; and becoming more and more of a candidate to be restrained. The more anxious and delirious he was becoming, the more he fit the institutional category of the so-called “least restraint policy” where the “assess[ed] risk for injury to self or others which may occur in situations such as: falls, agitation, aggression, wandering, and alteration of consciousness” calls for restraining his limbs. Basic needs are de-prioritized in the emergency department. They are unimportant as they relate to acute and emergency patient care, and the idea is that they should not be expected anyway in a department whose mission is to be “saving lives.” Pushing aside such basic needs directly

leads to the very “problems” that Janet and I encountered with the man above and with most elderly patients, and are remedied with ridicule, behavior-labeling, and restraints: psychiatrization.

A second clinical case from my experience follows, and this occurred several weeks ago during a late evening shift in the emergency department:

I am the triage nurse: A 16 year-old girl enters my booth with her mother, where the mother was asking for her daughter to be seen by a psychiatrist for what she (the mother) deemed as behavioral problems. When I asked the patient what the problem was, it was the mother who responded and subsequently responded to most of my questions despite my questions having been directed at the girl. The mother stated that her daughter was intending to harm herself and had muttered that she wanted to end her life. The daughter, hearing this, quickly interjected and stated that this is not so and that all she had said in a heated argument with mom at home was: "you make me want to kill myself," and nothing of the sort of implying that she really wanted to commit suicide or cause any harm to herself for that matter. It was simply a figure of speech.

There was a short back-and-forth between the girl and her mother, where the mother was insisting that the girl had behavioral problems and that this was the problem that brought them in, and the daughter negating that there was any problem at all. The mother continued along the vein that she was very concerned for her daughter’s safety and the daughter contested any intention to harm herself. The daughter, adamantly stating to her mother and me that she "did not need to be here," then addressing the mother: "you didn't need to bring me here...there is nothing wrong with me." At one point, the mother said that until her behavior changes, she still needed psychiatric help.

I communicated my observations of the mother and the girl to the emergency physician and to the psychiatric emergency nurse, who after assessing the mother and daughter, agreed that the daughter was not ill at all and that it was merely an argument between the two that had prompted the mother to bring her daughter in for a psychiatric evaluation. The behavior of the daughter had no basis in illness or pathology. The patient was discharged very shortly thereafter.

I included this case for two reasons: to demonstrate that psychiatry has the power to colonize the minds of people, in this case, the mother, as to label her child as mentally ill and use psychiatric intervention as punishment; and, to make a case for the need for continued resistance and better patient advocacy.

Psychiatric terminology has become so mainstream, being used in everyday language, in exchanges with friends, family, and colleagues. We frequently and easily use phrases such as *you’re crazy! You need help. You’re nuts; you need to be locked up!* Psychiatry and the language of psychiatry has colonized the thinking of so many people that the instant we observe behavior in others that is different from ours or behavior that does not conform to the observer’s understanding of normal reality, that behavior is pathologized: psychiatrized. This is what I experienced in the mother’s case above, that she had decided her daughter must have a mental “illness” based on the mother’s observation of the daughter’s “inappropriate behavior.” When we look at the fight against psychiatry, we, as professionals and activists must understand the power that psychiatry has exerted on the minds of people to take it in as a dominant tool to understand human behavior, thus diagnosing otherwise poorly understood behavior as mental “illness.” In this case, my resistance against psychiatry was not directly against psychiatry *per se*, but rather against the mother’s thinking that had become subjugated by psychiatry.

In an effort to advocate on the behalf of this girl, rendered powerless by the institution (of psychiatry) and her mother, I, as an advocate practitioner, had to understand that the mother's thinking was flawed and that I not only needed to assess the girl, but also the relationship between her and her mother that was unfolding before my eyes. Triage nurses sit at a pivotal point in every patient's care in the emergency department. The above situation could have unfolded very differently had I been uncritical of the mother's understanding of her daughter's behavior. The institution makes it very easy to categorize patients into preset diagnoses or "complaints" and classify them according to "presentation" or the findings based on the objective assessment of the nurse. I could have very easily selected the institutional category of "Mental Health Assessment" and as part of my assessment, narrated, for example, "patient aggressive, not cooperating at home, high risk for harm to self, may attempt suicide, and requires psychiatric intervention." This would have taken the girl into a different direction within the institution, and this is precisely what many other nurses, lacking the political sharpness I discussed above, may very quickly do.

Cheryl van Daalen-Smith, RN
Preamble: The journey into my own resistance against psychiatry was an organic one: it evolved as experiences within my career accumulated to the point at which I could not ignore the messages unfolding before my nursing eyes. A general discomfort was always there, and I allowed it to come out and see the light of day. Below you will find a near verbatim transcript of my oral presentation at PsychOUT --no references, not neatly woven together, but ripe with the passion that fuels all that I do surrounding the rights of folks labelled 'mentally ill', 'treated' or hospitalized.

We originally called this session "Rebels with a Cause". We know that a rebel is someone who refuses to conform. And in our phone calls to nurses involved in all kinds of movements, social justice movements, anti-poverty movements, who are doing incredible work, the label 'rebel' was problematic for some. "I'm not a rebel" is what we heard. So I was going to talk a bit about the gendered expectations that are still found in nursing, to be a good girl, to fit, to be a good person, but we're now thinking about looking into this a bit more, perhaps in a paper. We want to look at resistance happening in nursing.

So that's that...

I am very worried about nursing's complicity in psychiatry and also about nurses' complicity in psychiatry. In other words, by not speaking up and speaking out, it can be argued that we are, in fact, sanctioning what is happening. So I am going to tell you about some of my efforts and some of my experiences in resisting. I won't share all of them, and I won't go too far back, but we're hoping that this conversation today is going to open a lot more dialogue.

All this could have started when I was told that I was going to have to go and watch electroshock as a student at my nursing school. I didn't like the word 'go and watch'. It felt exploitative and felt wrong. And fainting after seeing it and being told that I might not have what it took to be a nurse. I mean, it could've started there, but I didn't have the language yet, and I don't know when it came. Or maybe it started when there was a measles outbreak, and I was a public health nurse based in schools. So they pulled us all out of those duties, and we then were to immunize all the kids. So rather than my work that involved sitting beside boys and young men and girls and young women, listening to them talk about their lives from their vantage point, my job was immunization for several months. This is typical for those who work

in public health, for the primary role of public health is disease prevention. I remember that one of the questions was “Are you on any medication?” And while this is not statistically analyzed, close to 70% of the girls and young women who sat with me at my little table for six or so months in gymnasiums in southern Ontario had been prescribed some sort of an anti-depressant or were on one. So how can you bear witness to that startling finding as a registered nurse whose code of ethics says that you are to be accountable, that you are to ensure that there is no harm is coming to people, that people have dignity, and that you are supposed to be an advocate for social justice? Nursing understands the link between health and social justice. I remember speaking about this to senior nurses, and it didn’t go anywhere. One supervisor completely shut me down.

And this experience of being shut down is not unusual for nurses who speak up. I can’t tell you how many times I was shut down. Just assume it unless I tell you otherwise.

Another experience was when I was working at a hospital, doing admissions of kids diagnosed with blood cancers, and in these admissions, you of course find out their address. I found out that so many were coming from one given town. You have to be a pattern recognizer when you are a nurse, and here was a pattern! I brought it forward in team meetings, saying there is something happening here, pointing out the close proximity of a nuclear power plant to this town, and I was again shut down and was told by the physician in charge of that unit, via the head nurse, not to tell the parents about this finding. We didn’t want to be alarmist.

So many boys in the schools where I was working were being prescribed Ritalin, and I noticed this trend increasing and increasing. It was almost as if this was a rite of passage! I spoke up about that and was told I wasn’t being a team player. I was asked. “Why do you have to be like that?” “What? Are you a feminist?”. Like that was going to scare me or silence me.

Another time was when I took a job on a child adolescent psychiatric unit, and part of the required training was ‘non-violent crisis intervention’. I asked to see the agenda so I could see what it was about and was told, “No, no, just go. It’s paid. Just go. It’s two days.” So I went, and it was in the basement of the hospital where there was carpeting and padding and mats everywhere. They were teaching us how to grab kids and how to hold them in a certain way. I said, “I’m not doing it. I’m just not doing it. This is hurting children, and I am a **nurse!**” There was the argument. They said: “you have to learn how to protect yourself if something happens.” I responded, “Why don’t we prevent it in the first place?” I don’t think that is what a nurse is supposed to do. I didn’t go to school to learn breaks and holds and this kind of thing. So things didn’t start off very well right there. A non-conformist during orientation? Not good.

Then at another institution, I was getting the Compendium (*Compendium of Pharmaceutical Specialties*) out when a patient I was caring for was getting a new drug.
I would write down information about the drug including the side effects and was sharing that with families. I would say: “Your son is being prescribed this medication. Do you have any questions?” Would explain the medication, its indications and its side effects. It is in our standards of practice, and it is in our code of ethics to do this, because we are the ones who hand the medication or administer the medication to the individual. We need to ensure informed consent. If you administer this medication, you have to ensure informed consent. So naive me, explained meds, discussed side effects, offered to have the pharmacist speak with families, and brought back their questions to report. What happened next? “Reprimanded” isn’t even the right word. I was shut down and told that is the physician’s responsibility. I explained that I understood the trio of responsibility when it comes to medications, i.e. prescriber, dispenser and person administering the medication. All three of us, I explained, are responsible for informed

consent. I also pointed out in my beginning advocate's voice that most families did not have a medication explained to them, but rather were told "your child needs this" or "I'm prescribing x or y" and that was it. This is not in disrespect to physicians. I believe that the general public must take it upon themselves to ask more questions rather than to expect being told what to do.

So that happened. I still maintained my employment.

My biggest experience was with my entry into the antipsychiatry movement. I was working at an institution, and an eleven-year-old boy came in. He was wheeled in and, he wasn't walking or talking or toileting or anything. He was shut down. He had for all intents and purposes shut himself down, which is a safety mechanism. It's a language. Something is going on in his emotional surrounding. Something else is going on. Within 24 hours, that young boy who wasn't walking, talking, toileting, eating, and was wearing sunglasses and a baseball hat was guerneyed to an adult hospital for shock. And it wasn't recorded in the chart. He was sent several times.

I spoke up. Why can't we give him some time? Why can't we let him settle in and get used to us. Why can't we work to build trust, and slowly, let him guide us to the true cause? I knew that I was on shaky grounds and quite alone in my emergent critique, but you know, I can still see his face now. Well sure enough, after a few sessions—and no I don't call it therapy, I call it shock—he started to walk, and talk, and toilet and took his sunglasses off and his hat off, and he ate, and eureka ! "Look, he's better."

So I ask: Can we not provide a safe haven? Can we not facilitate him to follow his own path of readiness and respect when he's ready to share? If he's ready to share, what's going on? Something's going on. And there were so many flags stemming from the behaviour of his family that I grew more and more uncomfortable. My nursing gut and all of the signals of my nursing instincts were telling me that there was so much more than his presenting 'language', if you will, language of being totally unavailable and as invisible as he could humanly make himself...

They sent him home!

So that was my entry....

What do I know about psychiatry? I've not been hospitalized, as many of you have. But who knows how your life might turn out? I decided for *him* that I had to try and do something. So for now, I've been doing some work around trying to prevent boys and young men... girls and young women from being rapidly prescribed psychotropic medications in the first place - from being pathologized and medicalized.... "This pill for every ill" mentality is now targeting children and youth, and I'm so gravely concerned. I've been doing work around de-pathologizing girls' and women's anger, because I feel that girls and young women get anesthetized by societal and gender-based expectations to never be angry, when we know that anger is a message and a safety mechanism, and must never be dismissed.

The last thing I want to say, at least for now, is that you wait for a forum like this as a nurse to speak up and speak out because your colleagues sometimes think *you've* got a problem. They ask, "What's your problem? Why are you a radical all the time?" Radical? "Radical" means that there is a norm and a non-norm. So scrap that...

Brenda Ridley, RN
At the beginning of my part of our panel, I struggled with my emotions as I felt very moved by what Simon and Cheryl had presented. I also felt guilt about my own role as a health care professional, as a perpetrator of treatments like pharmacological or physical restraints. There was also a connection to the audience who were so engaged in listening to the information we had been sharing.

As a nurse, I am bound by my professional responsibilities to provide care without judgment to patients as people. As a human being, applying my personal moral code, I should be judgment-free and feel empathy towards anyone who has been incarcerated and traumatized by mental illness and psychiatric treatment. What is concerning is so many of my colleagues in health care do not follow this professional practice.

Ross and Goldner's review of stigma, discrimination and negative attitudes in nursing summarizes what needs to occur:

> Honest reflection and assertive action must be taken by the nursing profession to minimize stigma and discrimination of people with mental illness, including stigma directed towards patients seeking care and stigma towards nurses who experience mental health problems. (Ross & Goldner, 2009, 556).

Visions of Inpatient Hospital Care

To enter, you must be admitted via a psychiatric health care team. Your stay will be as long as deemed necessary to treat you and release you back into the community. You are given an identifying armband for your vital statistics--name, identification number and a second armband indicating your level of independence. The colour denotes status (i.e. blue on ward privileges, purple off-ward privileges and red locked observation area only).

For others to enter the area, there must be a checkpoint via a locked entryway. After you show identification, you wait to be admitted. As you enter the area, you observe people in supervised areas moving about. Each person that you encounter is wearing a different colour identification band. Some of the people walk about freely, while others are restricted behind a locked area with windows to the corridor. The analogy that comes to mind is visiting the zoo. Each creature is housed in a locked environment with an identification plate and ID tag to inform others of who and what they are.

The 'Psychiatric' Patient and Acute Illness

You have experienced pain in your abdomen and lower chest that you have never felt before. You know you need to get to the hospital to be looked at. You call for a cab and arrive at the Emergency department after about 20 minutes.

The triage nurse who is the gatekeeper for prioritizing access to the health care team asks about current medications and past medical history. You mention your history of schizophrenia and the current medications you are taking. You are placed in a chair, waiting to be seen. The pain increases, and you start to feel dizzy. You call out for help and fall to the floor. You are told to "stop acting out" for attention and sit back in your chair as you are disturbing others.

Another 15 minutes goes by. You are feeling even worse and afraid. You are now nauseated, dizzy and sweating with the pain. A transportation staff person notices you look unwell and mentions this to the triage nurse. After two hours you are taken into a room for observation. An electrocardiogram reveals you are having a heart attack. Suddenly, the team swings into action and you are transferred to the acute resuscitation room.

The doctor asks why you didn't come to the hospital sooner with your pain. The nurse mentions to him that you were difficult to assess because you were "acting funny". You have successful treatment for your heart attack, but you are told that you may have permanent heart damage.

At shift change in the ICU you overhear the team refer to you as "the schizophrenic with the heart attack". You will be back, they say, because you won't keep taking medications--you are crazy after all. I walk through the ICU where I work and see you crying. You share your story, and I am speechless as to how to respond to the indignities you have suffered at the hands of the health care team.

As a nurse practicing for over 25 years, I will admit two things to start off with. The first is that I have made mistakes in treating people with dignity and respect that everyone deserves. The second is that I can't imagine what it is like to deal with the health care system and the diagnosis of "mental illness". I cannot imagine what it is like to have everything you do in life judged by anyone who has had contact with you because you have been labelled as a "psychiatric client" or "patient". It is like what Lawrence Stevens from the antipsychiatry movements speaks of in terms of the far-reaching consequences of therapy. The presumption of unreliability, untrustworthiness and emotional instability haunts those who have sought out psychiatric or psychological "therapy". It is a stigma you carry for the rest of your life. It may preclude success in academic pursuits, job opportunities and access to health care and insurance benefits (Stevens, 1997, 2).

The thing that I do know is that there has to be a better way to support people. Our efforts as nurses and rebels need to be to help to provide better care for all.

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