



Commentaries

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Nursing and extrapyramidal symptoms: a critical commentary

The recent paper by Gray & Gournay (Gray & Gournay 2000) commenced with a 'fanfarish' declaration that, according to the National Service Framework (1999), 'psychotropic drugs lie at the heart of modern psychiatric care'. This sentence, alone, demolished a mass of writing produced by nurses over the last 20 years on the nature of care. Had they plumped for the word 'treatment' rather than 'care' then their assertion might have some standing. But to say that drugs lie at the heart of *care* signifies either a slapdash approach to the usage of language (probable) or a wholehearted acceptance of the centrality of pharmacology in psychiatric nursing (possible).

This ill-considered approach was evident in their emphasis on nurse prescribing. Nurses' prescribing only becomes meaningful if you name the drugs in question. I see no evidence that nurses are acquiring prescriptive control over antipsychotic drugs: if that is indeed what they mean. Not that I would want them to. However, my point is that it is premature to advocate nurse prescribing without specifying *what* will be prescribed.

Inasmuch as nurses are often the 'companions' of patients then invariably they attain an influence in the 'prescriptive process' in the sense of how patients manage their medication. This perspective, however, shifts the ground away from prescriptive empire building towards the kinds of problems involved in *having* to take drugs. After all, no one – apart from addicts – takes drugs as such: most of us *have* to take them. In psychiatry, many take them under legal duress.

Gray & Gournay (2000) cannot be unaware that other psychiatric nurses would identify 'prescriptive power' as a problem, that their response to the question: 'What can we do about acute extrapyramidal symptoms?' – the title of their paper – might

be to say 'Do not give them' or, at least, do not give them so much or so often: or inform people about what is being given to them: maybe *they* could choose! Oh, I forgot! Whilst the acceptance of these drugs is unworthy of much comment, their rejection is said to constitute 'noncompliance'. These authors ask if side-effects affect compliance: yes, but only insofar as I would link the concept of compliance to 'self preservation'.

Near the end of their paper they declare that as nurses 'move ever closer to prescriptive power' they will 'make a positive contribution to the use of effective treatment for what is such a debilitating illness'. It is hard to know what to make of this. As stated, I doubt that nurses *will* assume prescriptive power over psychiatric medication. If they do, can we expect that they will change their title from nurse to doctor? If not, this will complicate the provisions of the medical licence because this is what licences do: legitimate prescriptive power.

This paper lacked prescience about the complications which might attend these questions. A great deal was said about iatrogenics in a clinical way but there was little about the subjective worlds of patients, the wavering control which they have over their lives or – the unthinkable option – actually reducing medication or stopping it. It is something of an overstatement for them to define extrapyramidal symptoms as an illness as if this was something that happened to patients instead of being induced by medication. All therapeutic medicines carry unwanted effects and the issue is to balance these against the desired effects. Cancer treatments are an obvious example where life and death issues have to be weighted. Of course in this instance patients are provided with frameworks within which choices can be made. In psychiatric practice, patients may not have a legal entitlement to choice and if nothing else this ought to introduce an element of rigour in respect of administering drugs which cause ill effects. This is especially true where the gap between desired and undesired effects can

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be narrower than in other areas of medicine. This becomes startlingly obvious in Gray & Gournay's (2000) own descriptions of side-effects:

'Akathisia (literately "can't sit still") is characterised by a subjective sense of inner restlessness, mental unease, unrest and dysphoria.

This is commonly accompanied by a characteristic pattern of restless movements including rocking from foot to foot, walking on the spot, and shuffling and tramping of the legs. In severe cases patients pace rapidly and are unable to sit or lie down for more than a few minutes.' (p. 206)

Is this really preferable to hearing voices?

A discussion of these kinds of problems would have been more appropriate to a nursing discourse (and to a nursing journal!). And no, I am not suggesting that nurses not look for side-effects nor educate patients about them. What I am suggesting is that the human experience of taking medication, the right to have a say, even the right to refuse, are the central concerns of nurses. Had the paper declared its intention to examine extrapyramidal effects as *an aspect* of the overall care of patients then these reservations would hardly apply. However, it clearly prioritized the *management* of patients and their side-effects in such a way that individual responses, other than involuntary 'side-effects', were barely mentioned. I counted less than half a dozen uses of the word *nurse* throughout.

I don't want to question the humanity of the writers concerned, but would it have been so difficult for them to concede some of the personal issues involved? Or that nurses may (even occasionally) desire to represent a patient's refusal to take prescribed drugs? Why demonstrate a medicalization which exceeds that of many psychiatrists? And why the extraordinary emphasis on biochemistry? Commenting on the biochemical research linking brain pathology to dementia TomKitwood (1988) stated: 'These papers are not read by many doctors, let alone those involved in the day to day business of geriatric care; indeed, it is likely that they have been scrutinised closely by only a very few persons.' (p. 124)

How much more true is this for adult psychiatry. It is not that such information is not relevant. It is the degree of its relevance in a nursing context which is the question.

For Gray & Gournay, it is as if '*Psychiatry in Dissent*' (Clare 1976) had never happened. It is as

if the social psychiatry patiently (if erratically) built up since the Enlightenment is now to be set aside. And these writers are *nurses*. It would appear that they have, at least on paper, adopted a psychiatric stance which spectacularly minimises subjective experience. My view is that in a nursing context this is problematic.

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Write! Now!

Writings: stillborn children one sends oneself in order to stop hearing about them – precisely because children are first of all what one wishes to hear speak by themselves. Jacques Derrida, *The Post Card*.

The art of the writer consists in little by little making words interest themselves in his books. Edmond Jabès, *Je Bâti ma Demeure*.

When I recently agreed to assist Professor Barker with the *Commentary* section of this journal, I wrote to ask him what he wanted me to do. 'Just try and find some b***** to write for us', he replied. I have to confess to being a little surprised that no one is writing for *Commentary*, since I have written several pieces and have found it great fun. It also offers the opportunity to write in a more relaxed style on more contentious issues, as well as contributing to ongoing debate triggered by previous papers.

All academic journals rely on contributions from their readers; indeed, the distinction between readers and writers is (or should be) illusory, since all readers are potential writers. I have a number of theories why readers might be reluctant to make their own contributions to the journals which they read.

The authority of the text

Firstly, there is the problem of what we might call 'the authority of the text', the perception that publication for a wider audience in a national or international journal gives a certain credibility to the paper; that it somehow makes it 'special', particularly if the journal operates a peer review system. This perception has two consequences. Not only does it reinforce the distinction between readers and writers (I am merely a reader of other people's papers; I could never be good enough to publish myself), but it also inhibits critique (the paper has been published, therefore it must be good/true/beyond reproach, so who am I to criticize it?). Unfortunately, the more academic and learned the journal, the more authority is given to the papers which it publishes, and so the less likely those papers are to be perceived as open to critique.

This authority is, in my opinion, a fiction invented by journal editors and writers. It is, perhaps, a necessary fiction which encourages authors to submit papers in the hope of being perceived as an expert in their field, and which also encourages sales of the publication by giving the impression that it is making an important contribution to the discipline. However, it is a notion that has come under sustained criticism in recent years, particularly by the poststructuralists such as Barthes and Derrida, for whom the authority (the authorship, if you like) of the text lies with the reader rather than with the writer. As Wittgenstein (1953) pointed out, we cannot assume that the meaning placed in the text by the writer will be the same as the meaning extracted by its many readers, each of whom reads their own interpretation into it. Barthes (1995) referred to such texts as 'writerly', since each reading entails a rewriting by the reader, and each rewriting carries at least as much (or little) authority as the original text. Derrida (1976) spoke of such rewritings as 'a chain of supplements', and pointed out that they are potentially infinite in number, since each supplement to the original text inspires further supplements, and so on.

So, where are all of these supplements? The best we have managed in the *Journal of Psychiatric and Mental Health Nursing* was a run of papers initiated by Kevin Gournay back in 1997–8 (and which has recently been revitalized by Burnard and Hannigan). The problem, as Derrida pointed out, is that the term 'writing' implies more than simply the inscription of words on a page. I am sure that we have all 'rewritten' many of the papers we read, but that we have done so in our heads or in discussions with colleagues rather than on paper. If we cannot completely shake off the idea that publication imposes an authority on a text, then let us at least use it to our advantage and publish our supplements so that they are accorded the same authority as the original.

The threat of critique

The second problem is that many writers appear to be afraid of receiving critique, which is perceived as a sign of a weak paper. In some cases this might completely inhibit potential contributors from writing at all; in others it leads writers to protect their papers from what they see as hostile criticism by 'writing out' anything controversial or which lies outside of mainstream thought. This, in turn, results in 'safe' papers, which back up every statement with numerous references and arrive at only the most tentative and uncontroversial conclusions. In addition, the (in my opinion, mistaken) belief that academic papers should offer balance and fairness to all sides of an argument has resulted in an over-use of the well-tested rhetorical form of 'thesis-antithesis-synthesis', which has made many papers almost impregnable to traditional academic critique. Thus, not only are many writers shying away from writing the kind of 'cutting edge' papers that the *Commentary* section seeks to publish, but they are also, perhaps, finding it difficult to offer critique on previously published work.

It is unfortunate that the word critique ('a critical essay or review', according to the Oxford Paperback Dictionary) shares the same roots as the word criticism ('finding fault; a remark pointing out a fault'), and that the concept of a 'critical community' of writers has been tainted with the flavour of destructive fault-finding. As I suggested earlier, the concept of critique is the lifeblood not only of academic journals, but of the discipline itself, and is in serious need of rehabilitation.

The restrictions of form and content

The third problem, which follows directly from the second, is that the perceived aims and functions of writing are becoming increasingly narrowed, such that many academics now see their only writing duties as to record and to report. This situation has been fuelled in recent years both by the evidence-based practice (EBP) movement and by the pressures placed on writers by the demands of the Research Assessment Exercise (RAE), both of which are (rightly or wrongly) stimulating an increase in reports of empirical research at the expense of theoretical and speculative papers.

I would wish to challenge the notion that the main functions of writing are to record and disseminate existing knowledge, whether it be in the form of research findings or grand theory. There are at least three other ways that writing can make a significant contribution to the published output of a discipline. Firstly, there is polemic, which challenges the notion that academic writing should be fair, balanced and impartial, and that it has an obligation to arrive at the truth, usually through a synthesis of existing knowledge and theory. Polemic is positioned, one-sided, and usually provocative. It can also be stimulating, passionate, and can initiate debate. Secondly, there is 'blue skies' writing, in which new knowledge is created through the act of writing itself, such that 'not until we had written this down did we quite know what we knew' (van Manen 1990). Thirdly, there is experimental writing, in which the usual conventions of form and/or content are deliberately transgressed in order to stimulate the reader to develop (and hopefully to publish) her own thoughts.

Each of these genres challenges the idea that we should only write when we have something concrete to report, such as research findings or a well-rehearsed theory. They also question the generally held assumption that we should always write clearly and concisely, and that the author always has a specific message that can be transmitted unambiguously to the reader.

The conventions of critique

In addition to pushing at the boundaries of the conventions of academic writing such as objectivity, balance, clarity and dispassionate enquiry, I should also like to challenge the conventions of critique.

For example, it is usually accepted that it is permissible to comment on the method(ology) of research but not on the findings, on the assumption that if the research is well designed and well conducted, then the findings are *de facto* valid and true. There is, of course, a compelling logic underpinning this position, but it is a logic which stems from viewing research as a mechanical procedure rather than as a 'messy' practice (cf. Schön 1987). Furthermore, this convention is arguably a consequence of power rather than rational argument, since the hierarchy of research evidence is constructed in such a way that the authority of scientific method always overrides the authority of experience. Can you imagine an academic journal publishing the following critique: 'The study was well designed and well conducted, but I cannot accept the findings because they do not accord with my experience'? Why not?

Time's arrow

Finally, there is the general view that it is not worth responding to journal papers because it is often over a year before the replies are published, by which time the issue is no longer current and the debate has moved on. That perception might be accurate for some journals, but if you write something today for *Commentary* it could appear in the next issue. So write! Now!

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Developing abilities: the future of clinical supervision?

Over the last 15 years there has been a considerable amount of writing about clinical supervision in nursing. While much of this discussion has been well informed and thoughtful, it is also clear that writers have approached their task with already formed opinions. These of course have influenced the stand they have taken and the conclusions they have reached. Some of these conclusions have been based on literature search (Yegdich & Cushing 1998) and on practical research where respondents have been asked either what they want or what they do (Butterworth *et al.* 1998). The problem here is that answers are limited by experience and knowledge. Some writing seems to be based on somewhat limited experience of actually delivering clinical supervision (Bodley 1991).

Over the last 15 years I have delivered clinical supervision to a large number of nurses, mostly on a regular basis. During that time I have also developed a process for the delivery of supervision and taught the basics of this to significant numbers of psychiatric nurses. In both the teaching and the delivery of supervision I have taken the position that if practitioners keep returning to the seminars and supervision sessions then they are gaining something. It may not be this simple but it is as good an indicator as any.

In the mid-1980s supervision in nursing was largely conducted by line managers. Indeed the structure of organizations made this almost inevitable. Those of us who had an inkling that there was more to nursing than keeping the patient physically safe, teaching them what we thought they should learn and administering medication, were left to seek out some form of external supervision, that is, external to the organization, and pay for it ourselves. Through this process we began to realize the extent of the countertransference responses that were elicited in our day-to-day activities with patients and how these responses perpetuated the dysfunctional behaviour, feelings and thinking of our clients.

The problem with supervision which was provided in this way was that those who had the motivation to get out and get it often received it from psychotherapists and subsequently left the nursing profession to study psychotherapy which was of course much more satisfying to them. Thus the

nursing profession was for a time bled dry of its most therapeutically oriented talent.

When the opportunity arose to begin what psychotherapists called clinical supervision in nursing, the first rule we made was that it must be entirely outside the line management system. At this time the numbers involved were so small that this was never seriously challenged. We used an experienced psychotherapist as a trainer and began to train ourselves as clinical supervisors. Nurses who wanted to discuss their work and reflect on it could apply to a designated senior nursing person. There was no obligation.

What should be supervised?

In the absence of any clear indication as to what should be addressed in this relatively new activity in nursing, we looked to psychotherapy, to social work and to clinical psychology for direction, while at the same time insisting that supervision in nursing was in fact addressing something different. We knew that psychotherapy in particular had some insights that were useful for nursing practice, particularly psychiatric nursing practice, but it seems that we did not quite know how to integrate this new thinking.

The issue of the purpose and goals of supervision in nursing practice was further complicated by the use of the word 'supervision'. The word in our language means 'vision over' or 'over sight'. We wanted it to mean something different, more in line with the general thinking of psychotherapy and the way it was used in that profession. This was and is confusing. In psychotherapy it seems that the meaning of the word has been extended rather than changed. The practice of supervision was introduced in Europe by the early psychotherapists in order to pass on their knowledge and also to make sure that newer practitioners were safe to practice. Hence, there were two principal functions, development and accountability.

It seemed to us that in nursing, the only function of supervision up until that time was accountability. The true developmental function had vanished and we wanted it re-installed. Because of the structures within which nurses and nursing operated, accountability was inevitable. A hierarchical line management structure, of its nature, has accountability as a primary function. However, there is no necessary imperative toward the development of

those individual personal abilities that contribute substantially to that rare being we call a good nurse. 'Supervision', so-called, must address the developmental function. And, if this were to happen it could not for obvious reasons be carried out in a line management structure.

So we have made a clear distinction here between line management functions and clinical supervision functions. Although many will take issue with this idea, basically for purposes of this discussion, line management is concerned with accountability and safe practice. It is the task of the clinical line manager to see that standards of practice are maintained. Clinical supervision is concerned more with the professional development of the practitioner. In psychiatric nursing this might mean a focus on the development of the self as a therapeutic agent. Further, it is increasingly clear that unless there is a good system of line management in place it will be difficult for practitioners to obtain good clinical supervision.

So, having decided that good supervision with a developmental function should primarily be conducted outside of line management, the question of the focus of supervision begins to emerge. Initially, in floundering around borrowing from various other professions, we decided that the focus of supervision should be the nurse-patient relationship. Supervision sessions would focus on what actually happened in interactions between nurse and patient. These situations could be examined in some detail, complexities brought into sharp focus, different aspects clarified, transferences and countertransferences revealed. The fact is, however, that often the supervisees are not ready for this. They simply cannot and do not imagine that there is any difficulty in the patient relationship that is worth reflecting upon. It's like many other things in life, you can tell people that it will be good for them and they will try really hard to do it but it really has little impact on them.

Furthermore, having revealed a countertransference response, what do you do with it? Certainly it is good to be conscious and the development of consciousness impacts on our way of viewing the patient, but as nurses we have no mandate to work through the transference. We are not psychotherapists. We are however, mandated to relate to the patient in a manner which is therapeutic and understanding the transference systems enacted by the client certainly enables us to view them differ-

ently. The question then becomes, 'Do we want to view them differently?'

Although the evidence is for the most part anecdotal, based as it is on 15 years of conducting supervision sessions and discussing supervision with colleagues, there is good reason to think that many psychiatric nurses are not ready to examine the patient's life and their own responses to it. It is too difficult to manage the strong feelings and there is too much of what Yegdich (1996) calls 'sheer mental effort' involved. They will come to supervision sessions again and again with either nothing to discuss this week, no problems or 'I simply haven't had time to think about anything just yet'. If they have got something it will generally be related to career choices, promotion, their dissatisfaction with their job or the system, other staff or perhaps even some trauma they have been caught up in. These experiences of supervision are supported by the work of Wolsey & Leach (1997) and Butterworth (1997).

Now I'm not intending to suggest that these things are not important. They are. However, the fact remains that some staff, for long periods of time, will discuss almost anything related to their work except their relationships with the clients or patients. My response to this for some years has been that these things have to be discussed sometimes. That the fact that we work in an organization, in teams, etc., makes nursing a little different. That if we cannot sort out the difficulties in our teams and with each other we will deliver poor care. That there needs to be a trusting relationship within which the traumatic experiences that are so much a part of nursing the mentally ill can be processed. But, the real business of supervision is to focus on the client relationship.

The sum total of my experiences over 15 years has now led me to consider another possibility. Perhaps it is that until and unless people are able to process these other matters adequately and appropriately, they are unable to begin the profoundly disturbing process of examining relationships with their clients in any depth at all. They must perhaps first learn to process experiences that are less demanding before they are capable of examining their responses and their involvement in the pain and distress of the patient who has a mental disorder and whose life is in disarray. This is developmental. Examination of the patient relationship is not possible in any authentic way until examina-

tion of other matters (e.g. authority) and ones relationship with them has to some extent been mastered.

What does clinical supervision in nursing aim for?

It seems to me that the time has come to define and describe what it is that is supervised in nursing. Those who have used supervision for some time in order to process their experience have no doubts of its value. But what is its territory? When we sit down with a colleague in a supervision session, what are we supervising, and what is its purpose? I am suggesting that nursing should claim its own territory. Everything about nursing is different from other disciplines in the Health service. The numbers are different, the personality types are different, the training is different, the hours worked are different, the responsibility is different, the relationships with patients are different and the position of nursing in the health hierarchy is different. Everything substantial about nursing is different from other disciplines within the Health Services. It follows therefore that the system of supervision should be different and not borrowed or begged from other disciplines. It is time to articulate our own need for not only a line management system, but also, and separately, a developmental process which is based substantially in our own experience of working with the mentally distressed.

There is always a difficulty when building an argument in deciding where to start. What are the assumptions on which this argument will be built? I take as my starting point the notion that development proceeds by building on that which is already present and well integrated. Development occurs when we build on and extend that which is already well developed. The child learns to feed itself only when it has some degree of mastery over certain muscles. The child cannot feed itself until it is ready. To attempt to teach the child something before it is ready is to court failure and frustration.

So it is with certain personal and interpersonal skills. Until the person is ready to learn them, until the prior learning has occurred and is integrated, some interpersonal skills cannot be learned. (Some of these aspects might be referred to by psychotherapists as developmental blocks). This whole notion is further complicated by two further diffi-

culties. Firstly, much of what is to be learned interpersonally may be quite unconscious in the person who needs to learn it before they can move on. Secondly, we are all born with different abilities. Therefore there are some things that some people will never learn. They simply do not have that ability.

When we apply this thinking to the development of psychiatric nursing we are led, I think, to the conclusion that there are a wide range of people involved who are all developing different things at any particular time. Some, for one reason or another, may be psychologically quite primitive in their functioning; others, much more sophisticated. All are developing or capable of developing some aspects. If we are serious about providing for their development, if we believe that it is proper for nurses in order to maintain their practising certificate to be involved in their own ongoing development, then we must make it possible developmentally for them to do so.

Description of supervision

We could perhaps consider a description of supervision that enables people to develop by encouraging them to process appropriately the experience(s) they are struggling with in their professional practice, rather than forcing them to struggle with what we think is important for them. Perhaps supervision should be defined as 'a relationship within which nurses reflect on all aspects of their professional practice with a view to processing their experiences so that blocks are removed, real abilities are developed and spontaneity (creativity) is maintained in the patient relationship.'

Experience suggests that it is time to define our own boundaries for supervision in nursing. That is, to provide supervision that is focused on the real developmental learning need of the practitioner. Prescriptive formulas that are narrower than this are surely doomed.

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