Nurse Education in Practice 38 (2019) 138–144

Contents lists available at ScienceDirect

Nurse Education in Practice

journal homepage: www.elsevier.com/locate/nepr

Original research

Toward critical thinking as a virtue: The case of mental health nursing education

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ABSTRACT

Critical thinking in nursing is largely theorized as a clinically-based idea. In the context of mental health education, this presents a problem, given documented evidence of a shift to demedicalize mental illness. Using institutional ethnography, this article examines the critical thinking of nursing faculty in a baccalaureate nursing program in a Canadian university by way of focus group interviews, observation periods, and the analysis of a number of institutional and legislative texts. The findings suggest that the critical thinking of nursing faculty is caught within a constrained institutional-textual order. Drawing on critical theory and Foucauldian philosophy, recommendations for nursing education are made in order to diversify and extend critical thinking in mental health nursing.

1. Introduction

Much work has been done in an effort to define, operationalize, and evaluate critical thinking in nursing. The concept has been prepared for practice-ready application (Jarvis, 2014; Potter et al., 2014), including specific concept analyses (von Colln-Appling and Giuliano, 2016), comprehensive reviews (Chan, 2013), and deployed in specialty-specific case-study resources (Harding and Snyder, 2015).

1.1. Background

While recent work has identified a promising range of conceptualizations of critical thinking among humanities educators (Moore, 2013), the nursing literature on critical thinking, specifically that which examines the educator's perspective, appears to be limitedly located within the discourse of the clinic (Hobus, 2008), understood as a cognitive process that involves logical reasoning and problem-solving (Rowles et al., 2013). Analyses of critical thinking in nursing education seem to be oriented towards clinical contexts and outcomes, with the critical thinker having to employ a set of cognitive skills to tackle and prevent clinical problems and other patient complications (Benner et al., 2008; Jarvis, 2014; Mundy and Denham, 2008; Raymond and Profetto-McGrath, 2005).

In the context of mental health nursing, educators have linked critical thinking to ethics education, lamenting the demise of a comprehensive ethics education due to a privileging of technically-oriented skills (Pachkowski, 2018). Nursing pedagogues have grappled with critical thinking in mental health, advancing that reflective journaling (Waldo and Hermanns, 2009) and the introduction of non-traditional community-based clinical practicum placements, such as homeless shelters, into nursing curriculum, facilitate critical and holistic thinking (Nardi et al., 1997).

Literature in support of a critical mental health analysis in the context of nursing education was largely absent. The existing literature, while taking issue with various dimensions of nursing education–-whether in clinical learning or ethical decision-making–adopts an overwhelmingly biomedical standpoint. It is literature that has taken up biomedicine as its legitimating discourse, thus necessarily framing mental health as a medical phenomenon. This position has been identified as what Foucault (2002) calls the "self-evident," and elaborated on by Roberts (2018) in the context of mental health as "any therapeutic practice–and the theoretical perspective that informs that practice–[which] can implicitly or explicitly be positioned as obvious, natural or universal" (p. 2). The 'universality' of biomedicine in mental health discourse has been demonstrated elsewhere, where it was found that nursing education is linguistically and institutionally colonized by psychiatry (Adam, 2017a,b).

2. Aim

This article reports on findings from a study that examined the institutional and discursive reproduction of biomedical psychiatry by undergraduate nursing education in Canada (Adam, 2017b). It specifically reports on the concept of critical thinking as a factor in this reproduction. More pointedly, it addresses the following two questions: 1) How do nursing educators understand the concept of critical thinking in mental health? 2) What are the institutional and discursive processes that govern this understanding and practice?

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https://doi.org/10.1016/j.nepr.2019.06.006
Received 21 July 2018; Received in revised form 9 April 2019; Accepted 10 June 2019

3. Method

3.1. Methodology and approach

The method of inquiry used is institutional ethnography (Smith, 2001, 2005, 2006a, & 2006b). This methodology is a sociological approach that examines how everyday social relations structure people's experiences by such social institutions as schools, hospitals, the family, and so on. While institutional ethnography is effective in elucidating power relations and their governing institutional processes, what is often not made visible by this methodology is a way to proceed to begin reversing those very power relations. In that respect, a critical theory framework from a Foucauldian perspective (Butler, 2002; Foucault, 1983, 1995; 2007) is drawn upon in order to extend the ethnographic analysis in that direction. A Foucauldian perspective on the nature of truth (ontology) and knowledge (epistemology) offers the theoretical underpinnings for questioning accepted norms and practices and can help elicit information about the variety of rationalities and strategies available to nurse educators for informing mental health nursing practice (Guba and Lincoln, 1994).

The uniqueness of critical theory in comparison with other philosophical paradigms in nursing is that it is attuned to individual perceptions, the sociopolitical context, and the rules that govern both (Mill et al., 2001). In this study, Foucault's (1980) description of the complex interrelationship between ontology and epistemology, and view of the relationship between knowledge and power, provide the foundation for this conceptualization. According to Foucault, "'[t]ruth' is linked in a circular relation with systems of power that produce and sustain it, and to effects of power that induce and extend it" (1980, p. 133). Ontology and epistemology are blurred in this reality. The 'realm of the possible' in an institution is shaped, enforced, and normalized over time by those with the power to define it. In the absence of insight, those on the margins of power are subject to a reality that exists outside of them, yet "govern his or her own inner experiences and significant values" (Holmes et al., 2006, p. 183). Intensive explication and consciousness raising are the emancipatory tools available to individuals to break free from the constraints of "the panoptic kind of 'expert seeing'" that determines in advance what will appear as reality and as options or choices in that system (Holmes et al., 2006, p. 183). In this way, critical theory can be viewed as a context-specific approach based on a theory of beliefs about how institutions work. Combining a Foucauldian analysis of the discourses circulating as truth with an institutional ethnographic analysis of policies and practices helps explicate the assumptions and the processes related to nurses' decisions and can explain why certain approaches in nursing education may be more supported than other approaches.

In this study, competing discourses in nursing education were examined along with the processes linked to institutional governance to identify the prevailing meaning of critical thinking in nursing education. The processes that have enabled one definition to become normalized, or understood as reality, in relation to alternative definitions of critical thinking, including critique, in mental health nursing practice are also closely examined.

3.2. Data collection

Data were collected from two educational institutions that offer a baccalaureate nursing program and share an identical curriculum in a collaborative partnership in Ontario, Canada. Guided by the principal investigator, ethnographic interviews (Smith, 2005) were conducted with eight faculty members who teach in the program at both educational institutions and ran between 60 and 90 min. The interviews served as an entry point into the research, by which a perspective was gained on how faculty understand and operationalize the concept of critical thinking in the context of mental health. With mental health as the contextual backdrop, faculty members were asked to articulate how they conceptualize the idea of critical thinking and how they determined that a student is engaging in critical thought. The interviews were audio recorded and transcribed verbatim. The principal investigator also participated in observation periods of nursing lectures on mental health given by four faculty members (one of whom was an interview participant), amounting to about 10 h of such observation. During the observation periods, field notes were generated, documenting the faculty member's engagement with the various texts, concepts, and theories related to mental health. The institutional texts that emerged from both the interviews and the observation periods, as well as those identified by the principal investigator as relevant ethnographic texts also came to serve as data for this study.

3.3. Data analysis

Data analysis followed the standards of institutional ethnography (Smith, 2001, 2005; 2006a, 2006b). The interview transcripts were interrogated in pursuit of the work knowledges of the participants. To understand their everyday experience, the interviews helped construct their day-to-day interactions with the idea of critical thinking in the context of mental health. Using elements from the methods of Emerson et al. (1995), field notes were taken, compiled, and interrogated for evidence of what Smith (2006a) calls 'act-text-act sequences.' These are instances when social actors interact with institutional texts, effectively participating in the institution's governing processes and the governance of their very own practice. Those texts (emerging in the interview transcripts and in the observation field notes) which appeared to mediate the work of the participants were identified and mapped.

3.4. Ethical considerations

All participants received written information (including consent forms) about the study two weeks prior to and immediately preceding the interviews and observation periods. Study approval was obtained from the Research Ethics Review Boards of both educational institutions wherefrom the data were collected.

4. Findings

4.1. Nursing educators' understanding of critical thinking in mental health

Faculty members articulated a number of views in response to the question: What is critical thinking? Consider the following two responses:

> *I think critical thinking is basically common sense. Part of our challenge is for us to get students to think outside the box and to ensure they follow this process and collect all their data and analyze information to make the best judgment.*

> *A critical thinker is someone who dares to be different and goes outside the box and really, really tries to figure out why.*

While the first participant directly suggested that critical thinking ought to be understood as "common sense," the second participant quite markedly diverged from this conceptualization, advancing that it is a rather daring act, one that compels the critical thinker to go beyond everyday common-sense ways of thinking and doing. This sort of contradiction was likewise evident in other responses, such as the following, offered by a seasoned faculty member and a prominent nursing scholar:

> *Critical thinking to me is about asking the question "why?" It is about asking who, what where, when, and how, and keeping those questions on the table. It is also not necessarily being satisfied with what you think is the answer, because today's answer may be tomorrow's foolishness … I do understand, however, that there needs to be very reductionistic ways of narrowing things down to begin to understand them.*

The promising critical view she offers here appears to be undermined by a reliance on reductionism. While faculty members took on the concept of critical thinking in ways that appeared to free it from the "scientific," the "logical," and skills-based framing, they also came to apply it in rather concrete and mechanical ways. Correspondingly, they appeared to straddle two opposing worlds: That which temporarily allowed them to rupture out of rigid and mechanical understandings of the concept and one that also found them bound by reductionistic institutional categories.

Faculty members were further asked to articulate the concept in the context of mental health. Specifically, they were invited to discuss how they inspired critical thinking in their students in order to extend beyond biomedical understandings of mental health and mental illness. That is, they were invited to comment on mental health in the broadest sense, while considering social, environmental, and political dimensions of health. To that effect, they offered some dynamic and informative responses. The following faculty member highlights the importance of lived experience:

> *The "critical" part of critical thinking is being able to take parts from lived experience. Reflection is part of that, and I have to know where my biases are, where my cultural beliefs are, and still take that into account as I look at data, read an article, and be able to apply the totality of who I am as I analyze and dissect something and synthesize it.*

Below, two other faculty members emphasize the importance of structuring their students' pedagogical experiences into such instructional strategies as case studies or role play:

> *I think that students have the capacity to think critically about mental health issues if they had the opportunity to apply them from a case-study perspective.*

> *We examine feelings: How do students feel about me playing the role of someone with schizophrenia or someone who is delusional or suicidal?*

While articulating challenges in engaging their students in critical thinking, faculty members invoked interventionist-type arguments, citing the importance of identifying that "something is wrong," in order to formulate treatment interventions. Consider the following two faculty responses in that respect:

> *The problem with students is that they have no common knowledge of the mental health issues in front of them. If they can communicate with patients and identify that something is wrong, it will make the situation a lot better.*

> *I have taught second, third, and fourth year students, and I can't say that I had a student in mental health who has come up with a new or different strategy or intervention.*

Still, all faculty members articulated in one way or another, a logic-based approach to critical thinking, locating the concept as a technical, skills-based idea. They drew on such skills as data collection, data analysis and application, diagnostics, and on 'evidence-based' discourses and processes. Following are comments from two faculty members representing this finding:

> *The problem is getting them to use problem-solving skills and to put their knowledge to practice. There is no integration. We need a science-based approach, and they're not able to understand that yet.*

> *As educators, we emphasize to students to analyze the data they are seeing. We ask: What do you need to think when you see the order? Does your patient need this? Is it applicable? Is it out of range?*

How is it that faculty, while articulating rather promising and highly critical conceptualizations of critical thinking, fell back on an essentialist understanding of it? Why is their thinking about the concept primarily understood from within a clinically-based technical discourse? How is it that faculty members did not articulate a political conceptualization of the concept? The answers in part lie in making visible the powerful institutional processes that came to govern their actions and their thinking. Correspondingly, in the following section, faculty perspectives on critical thought are further examined, though understood in the context of this larger institutional complex, beginning with its governing texts.

4.2. The institutional processes governing critical thinking in mental health nursing: where critical thinking theory appears

The concept of critical thinking is adopted in three foundational nursing textbooks, the first of which is a first-year text on the comprehensive assessment of the healthy body (Jarvis and Browne, 2009; Jarvis, 2014) whose two most recent editions are used in the program under study. The other two texts–one of which is a fundamentals text (Potter et al., 2014), the other, a medical-surgical manual (Lewis, Heitkemper, Dirksen, O'Brien and Bucher, 2014)–are used to various degrees in a number of courses across all four years of the nursing program.

Two major theories on critical thinking emerged in these three sources. The first is drawn from a framework that inextricably ties critical thought to clinical reasoning (Lewis et al., 2014). This framework links problem solving, clinical care, and critical thought together. Jarvis (2014) further elaborates on this framework, suggesting that critical thinking comprises a set of learnable skills, 17 such skills, to be exact (for a complete list of these skills, refer to Jarvis, 2014, pp. 4–6). Of these 17 skills, one of them appears to promisingly rupture out of clinically-based logic and invite the critical thinker into the creative realm. This skill, identified as *evaluating and revising thinking*, appears to minimally demand some thinking *about* thinking while possibly encouraging self-critique. This skill is defined as *the observation of the actual outcomes (of medical interventions) while comparing them to the expected outcomes*. It involves the analysis of whether or not the interventions were successful and includes thinking about what could have been done differently (Jarvis, 2014). While this appears to encourage the critical thinker towards a big-picture analysis, the issue remains, however, that what appears to be the only non-clinical skill seems to also be understood solely in the context of the clinic, given that it becomes folded into an intervention-based context. As such, it is only clinical thinking that is evaluated and revised. In other words, according to this theory, for example, the student is said to be critically thinking if they simply reconsidered and changed how they administered a certain oral medication to a patient in response to the patient's inability to swallow it. It would therefore seem that this framework is entirely clinical, by which critical thinking is *only* to be understood in a clinical context.

The second major theory of critical thinking outlines a model to guide the nurse's clinical decisions about patient care (Potter et al., 2014). This model involves three levels (basic, complex, and commitment) and five components (standards, attitudes, competencies, experience, and a specific knowledge base). It posits that the clinician's ability to critically think is said to grow with experience, hence the three 'levels.' The assumption here is that the longer the clinician is immersed in clinical work, the more progress that clinician makes towards becoming a skilled critical thinker. Critical thought, according to this theory, hinges on "safe, effective nursing care" (p. 143) that is ultimately achieved by the application of its five components. This theory assumes that 'care' is absolutely necessary and ostensibly helpful, and like the one discussed above, is entirely clinic-based. It also raises concerns for those who reject the medicalization of human behaviour and human emotions (Adam, 2017a; Breggin, 2017; Hagen, 2007; Hagen and Nixon, 2011) and the professionalization of mental health services (Burstow, 2015).

The importance of these critical thinking theories cannot be understated. Maintaining control of and refining clinical knowledge in

order to ensure safe, effective, and ethical nursing care are foundational to professional nursing practice. In the case of mental health, and in considering the shift to demedicalize mental illness (Breggin, 2017; Burstow, 2015; Hagen, 2007; Minkowitz, 2014; van Daalen-Smith, 2011) the critical thinker must be charged with the task of stepping outside of clinical discourse and ask, for example, whether the clinic is an altogether appropriate place for those suffering from disruptions in their mental health. In such a case, it would appear necessary that the clinician exercise critical thinking not in so much a clinically-based way, but rather by using a politically-informed, method, to question the very foundations of the discourse in which the clinician is operating.

How then, is the critical thinker to rupture out of the discourse of the clinic and level a critique *at* instead of *within* it? In order to begin so much as to sketch an answer to this question, the institutional complex and the relations within it that structure critical thought must first be made visible. What follows is a discussion of these relations, with an emphasis on the textual processes that substruct them.

4.3. The textual relations of critical thinking in mental health

Using mental health discourse as the clinical backdrop, faculty members' perspectives on critical thinking were examined. Specifically, they were asked to articulate in very broad terms, the ideas of mental health and mental illness. Correspondingly, they dialogued extensively about these two ideas in an effort to deconstruct much of what is currently known as mental illness. The following two respondents offer some of their insight:

> *I would like to believe that 50 to 100 years from now, our understanding will be much better. The DSM is not a perfect picture, but it's an important part. To say that there is no such thing as depression, which is in the DSM, that's silly. I know that there are cultures that say it does not exist. Some cultures would say "just buck up! Get on with life and deal with it!"*

> *There is excellent stuff in those textbooks, but how it is brought to life is dependent on the values, beliefs, and the lens of the person doing the teaching.*

The following two faculty members offered a rather broad understanding of mental health, pointing to a critical engagement with the subject. Noting, however, that while they pushed the discursive boundaries of biomedicine and psychiatry, they also appeared to be caught in a certain textual bind: The "NCLEX." That is, they articulated a close ascription to the National Council Licensure Examination–the licensure exam for nurses in Canada–an exam that is known to be biomedically and clinically heavy (Adam, 2017a,b).

> *In class, everything we talk about is mental health promotion, not about treatment. My course is more about how we can create a caring community. There wasn't a lot of mental health content in the course. I added a lot, especially now, because of the NCLEX.*

> *I can do a makeover using the structure of the NCLEX to talk about patient safety because mental health safety was not there. I make students understand that there is a net of factors working together. Most of the time, there is no label and no diagnosis, even though patients are at risk.*

A rather troubling finding of "making a diagnosis," despite the fact that "it may not be needed" appeared. This practice of being textually mandated to diagnose patients emerged as a disconcerting 'prerequisite' for care. Consider the following faculty member's response that outlines how diagnosis can be an exclusively textual process:

> *From a practical perspective, you kind of have to make a diagnosis [of mental illness] even when you know it may not be needed. But for practicality, you do. I would say that it is a problem in our society and our medical community: You have to write something out in order for something to happen and to take care of the patient.*

In fleshing out their ideas on critical thinking in health assessment, Jarvis et al. (2009) outline the concept of diagnostic reasoning, understood as the "process of analyzing health data and drawing conclusions to identify diagnoses" (p. 2), positing that diagnostic reasoning "is based on the scientific method" (p. 2). They describe this concept in substantial depth while stressing the importance of its being a vital dimension of the critically thinking nurse. This idea of diagnostic reasoning, however, seems to fall by the wayside, as the above faculty member describes. It appears that in an effort to be "practical," the mental health practitioner must ascribe to an institutional-textual practice of having to "write something out," effectively keeping in line with interests dissonant with those of the patient and the critically thinking practitioner.

Faculty members drew on various institutional concepts, some noting that a number of salient texts guided–or at the very least, intercepted–their everyday teaching work. They explicitly drew on such concepts as "common sense," "thinking outside the box," "lived experience," "data analysis," and "problem solving and integration." They also drew on such texts as the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2013), the NCLEX, and regulatory practice standards, in order to justify their understanding of critical thinking and make sense of their own critical thought process in the context of mental health.

One other consequential text that frequently emerged and came to bear on faculty members' teaching work is the program's policy on grading student assignments. This policy functioned as an intermediary text that linked the extralocal institutional texts to the everyday teaching and learning work. Taken together, these texts can be plotted on a map as an institutional intertextual hierarchy, depicted in Fig. 1:

In order to understand how these faculty members' teaching work became hooked into certain institutional relations, it is important to outline the textual processes that come to organize it. As discussed

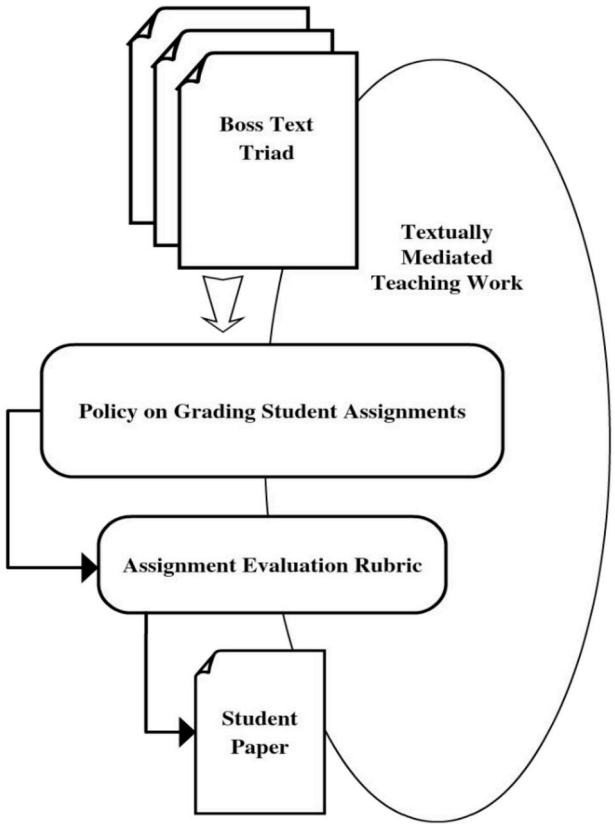

Fig. 1. The intertextual hierarchy of teaching work: Eclipsing critical thought.

above, the dominant theories on critical thinking emerge out of three foundational nursing textbooks in the program under study. These, as it were, can be conceived of as a boss-text (Smith, 2005) triad (Fig. 1). Residing at the top as an influencing force on critical thinking theory, to a certain degree, they dictate content found in the lower level text. This lower level text (policy on grading student assignments) is discursively linked to the boss-text triad, while at the same time authorizing what is to be inserted by the faculty member into the assignment evaluation rubric. For example, in this policy, explicitly outlined are the criteria for an A/A+ paper, some of which are: *Excellent/exceptional capacity for critical thinking*, *excellent/exceptional capacity for creativity, ability to organize ideas logically*, and *ability to analyze, synthesize, and express ideas logically*. Highly evident here is the linguistic dominance of "science" and "logic." The technical rationality of critical thought in this policy is marked by such verbs as *analyze* and *synthesize*, and such adverbs as *logically*. The policy's telling language appears to steer the faculty in the direction of the "logical" and the "mechanical," rather than the artistic, the creative, and the political. This appears to relegate critical thinking to an automatic and predictable discursive-institutional process, rather than an emancipated and courageous endeavour. By way of the faculty-constructed rubric, the clinically-based understanding of critical thinking is transported into the student paper (and practice) as the faculty member authorizes an institutional-textual rendering of the concept in the student's thinking, theorizing, and scholarly writing.

5. Discussion

The nursing academy employs highly developed critical thinking theories, predominantly for purposes of refining and keeping safe and ethical clinical practice. These theories are central to the nursing student's daily navigation of clinical learning and the understanding of the many complex tasks that students are expected to perform in their practicum placements. Moreover, nursing faculty teach critical thinking in various ways, having developed creative interpretations of the concept, some of which are rooted in established theory while others are informed by their own experiences. In the present study, in demonstrating their own critical thought process in the context of mental health, faculty members offered dynamic interpretations and critiques of mental health and illness, psychiatric discourse, and mental health nursing pedagogy.

Overwhelmingly, however, they theorized mental health and the critique of psychiatric discourse from within a clinical framework. Deploying powerful and important criticisms of current nursing and medical practice in mental health, they brought to the fore such issues as the 'textually based diagnosis' and the importance of therapeutic communication and lived experience. In their deconstruction of the concept of critical thinking, nursing faculty drew on such ideas as common sense, health promotion, phenomenology, and experiential learning. While leveling an important critique at current mental health education and practice, they likewise remained at the level of the clinic. That is, in their critical thought process, they rarely stepped outside of clinical discourse. Nearly absent was an extralocal, political analysis of discourse and practice, which appeared to be eclipsed by a sort of clinical-based thinking. This clinical-based thinking would find its roots moored by a number of institutional texts and policies which in turn came to organize how nursing educators critically thought. This missing political analysis has been lamented by other nursing scholars, who suggest that nurses' activist practice in both clinical and academic spheres has been constrained, in "favour [of] a technical rational approach to nursing education" (Buck-McFadyen and MacDonnell, 2017, p. 1).

The sort of rational approach of which Buck-McFadyen and MacDonnell speak is not unlike that examined by Foucault in his development of his theory on critique and critical thought (Butler, 2002; Foucault, 2007), whereby he advances the idea of critique as a practice of transforming one's relationship to oneself into a form of art. This is contrasted with the scientific and rational approaches to contemporary modes of critical thought, of which the dominant theories on critical thinking in nursing discussed here, are an example.

Both the textually-authorized and the experientially-articulated faculty perspectives appeared to be subsumed by this discourse of technicality/rationality, subjugating nursing educators' critical thinking and relegating political critique to a clinical interventionist mode of thinking. This is to be expected, however, given how this textually-authorized institutional process hooks teaching work and the critical thought process of the faculty member into its discursive order (Fig. 1). But what of the moments of resistance and those moments during which faculty members demonstrated a promising possibility of talking back to this technical rationalization? What of the highly critical disposition to having to make a diagnosis and the advocacy for "creating a caring community for each other?" How can the educator emancipate critical thinking in mental health and much like the important critical works discussed above, lodge a critical attitude (Foucault, 2007) *at* psychiatric discourse? These questions are addressed in the next section in a discussion on recommendations.

6. Recommendations and conclusions

Foucault describes critique as a sort of ethical self-transformation–a virtue. He contrasts obedience to virtue whereby in obedience, the social actor is bound to a set of prescribed institutional and discursive categories, whereas virtue allows the self to rupture through the constraints of any given 'epistemological horizons' of an instituted practice, discourse, or institution. Foucault (2007) outlines the idea of critical thought as an emergent endeavour where the critical thinker must possess a disposition (a critique) to not "be governed like that, by that, in the name of those principles, with such and such an objective in mind" (p. 44).

It is this critique that lends itself to the possibility to question truth claims and transform power relations, the sort of critique that resists hegemony in governance, recognizes the non-universalism of institutional and discursive law, and positions the thinker to be able to open up a plurality of epistemological possibilities. While recognizing that governance is not inherently a negative force, Foucault (1983) advances critique as a form of vigilance over taken-for-granted practices, noting that these practices are not always "bad, but that everything is dangerous" (p. 231). Their danger lies in their risk of reproducing problematic understandings of people and societies, much like the reproduction of the medicalized view of mental health examined in this study and elsewhere (Adam, 2017a,b).

Considering the findings in the present study and given the critical mental health movement and the shift to demedicalize mental illness, nursing appears rather distant from this emancipatory conceptualization of critique. What is demonstrated here is that at best, nursing educators largely engage with critical thinking as a concept to be applied and evaluated (in linear and mechanical ways) rather than a tool to be used to open up a variety of ontological and epistemological possibilities.

The findings provide an opportunity for nursing to become aware of how the academy hooks critical thinking into an instituted set of textually-based practices, subsumed by a sort of technical rationalization. Foucauldian theory, in turn, can offer nursing a critical attitude, that which allows the critical thinker to step outside of clinical discourse. Nursing faculty might then arrive at counter-narratives in order to partake in exposing a "fundamental illegitimacy" (Foucault, 2007, p. 46) in psychiatric discourse that has long been examined by critics (Adam, 2017a; Breggin, 1991; Burstow, 2015; Hagen, 2007; Hagen and Nixon, 2011; Holmes and Murray, 2011; van Daalen-Smith, 2011), some of whom are indeed nursing scholars.

Drawing primarily on Foucault's work in the context of sexuality (Foucault, 1990), an *'ethics' of existence* is not understood as a practice of a set of principles of morality or in terms of conventional morality

theory, but rather as the transformation of the relationship of oneself into a work of art. This work, according to Foucault, involves the cultivation of a disposition to engage in continuous struggle to recreate the self. This is a practice by which the social actor possesses a freedom (albeit limited) to transcend seemingly impermeable institutional and discursive boundaries and 'break up' crystalized truths and practices. While Foucault does not (and likely cannot) provide a precise definition of what the final product of the self might look like, he offers the following insight on what it means to act within a framework of an ethics of existence:

> Of course, all moral action involves a relationship with the reality in which it is carried out, and a relationship with the self. The latter is not simply "self-awareness" but self-formation as an "ethical subject," a process in which the individual delimits that part of himself [sic] that will form the object of his moral practice, defines his position relative to the precept he will follow, and decides on a certain mode of being that will serve as his moral goal. (Foucault, 1990, p. 28, p. 28)

In order to extend critical thought, nursing may be offered the sort of ethics that compels the critical thinker to take the risk of unraveling the stable subjectivity, shrouded by constraining and rationalizing conceptions of what is currently known as critical thinking. It is an ethics that could permit the thinker to jeopardize a crystallized, clinical orientation of critical thought in mental health discourse, which appears to have dominated nursing consciousness. It is a sort of practice that dares to risk to re-imagine a world in which labelling, psychiatric diagnoses, and likewise pathologizing discourses do not exist. In their efforts to radicalize critical thought, nursing educators must confront another level of risk and prepare for the possibility of the "denunciations of those who naturalize and render hegemonic the very moral terms put into question by critique" (Butler, 2002, p. 220). This critique invites the uncomfortable possibility of epistemological chaos and the instability of one's very own formation as a subject–one's very identity within their professional discourse. Nursing educators might also prepare for and respond to censure by the status quo, much of which is substructed by discourses of technical rationality.

Given the documented biomedical dominance in mental health discourse in Canada (Adam, 2017a), by way of critique, one way that nursing can partake in working toward discursive plurality is by drawing on the works and on the narratives of psychiatric survivors, alternative critics, radical therapists, and activists. Nursing regulators and professional agencies are able to support nurses and nursing scholars in this endeavor by redesigning their biomedically-heavy legislation, regulatory documents, and licensure processes. These can be diversified by the voices of those speaking the counter-narrative, including survivors, radical therapists, and critical social scientists.

As scholars concerned with emancipatory knowledge, another important question that nursing educators may find themselves asking is: "What is the relation of knowledge to power such that our epistemological certainties turn out to support a way of structuring the world that forecloses alternative possibilities of ordering?" (Butler, 2002, p. 214). The answer in part lies in the potentialities offered by the counter-narrative in the critique of psychiatric discourse. These counter-narratives give rise to alternative ways of ordering and structuring the discourse of mental health–one that is counter-hegemonic and more human-centric. Additionally, nursing faculty must also respond to and promote their own moments of resistance. Indeed, a number of such moments surfaced in the interviews. As an example of this, a faculty member, in her grappling with the scientific validity of mental illness, offered how her experience in influencing the curriculum toward less of a biomedical framing was met with the moral obligation to prepare her students for the biomedically-heavy nursing exam. Below, she shares a brief statement about this experience:

> *The argument is that it isn't an illness, that there isn't enough medical model content in order to have it in class, but because nobody else was covering it, we felt a moral obligation to at least introduce the concepts of severe, persistent types of illness, so that if they write their exam, at least they'd have a clue.*

Lastly and more generally, nursing scholars are invited to consider diversifying their critical thinking in mental health by drawing on such areas as the social sciences and humanities (McKie and Naysmith, 2014), and such movements as feminism, critical disability, neurodiversity, and mad studies. An important next step is for nursing educators, researchers, scholars, legislators, and other leaders to consider working together and redeploy critical thinking in mental health in a political and pluralistic way. It is by way of this rupturing notion of critique that nursing can transcend the confining and clinically-based understandings of critical thought and re-imagine a world in which critique in nursing education is emancipated from the confines of the technical rationalities that currently frame it.

7. Limitations and implications for future work

Like any other ethnography, this study is time-bound. While the institutional and discursive processes analyzed here are currently at play in undergraduate nursing education in Canada, they are subject to shift and change at any given time. However, the study's findings and implications are not necessarily geographically limited. The textual complex that came to govern teaching and learning work is applicable beyond the local program-specific level, given its governing texts are nationally and globally consequential (e.g. the DSM). Implications for future research include the possibility of a pilot nursing program that takes up some of the recommendations made here, specifically, the balancing of mental health with the voices and scholarship of psychiatric survivors, mad communities, and radical therapists, and works from the social sciences and critical social movements. Another is an inter/transdisciplinary (psychology, social work, medicine) examination of critical thinking in the context of mental health.

Funding

This research did not receive any funding from public, private, or not-for-profit agencies.

Acknowledgments

I wish to thank Dr. Bonnie Burstow for her valuable support during the early development of this article.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.nepr.2019.06.006.

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