

Therapeutic interventions

Christine Palmer

KEY POINTS

- Mental health nurses use a range of therapeutic interventions when they work with people who have mental health problems and/or serious mental illnesses.
- You will be more therapeutic in a mental health context if you understand yourself.
- Being able to identify the stressors in your life will enable you to help others with their stress.
- Relaxation skills and assertiveness skills can be learned and are useful for all nurses.
- Risk assessment and crisis intervention strategies are used in a range of environments or settings.
- Psychotherapies include individual psychotherapy, planned short-term psychotherapy, motivational interviewing, cognitive behavioural therapy and dialectical behaviour therapy.
- Behaviour is learned, and so it can be unlearned through behaviour therapy.
- Group therapy is a cost-effective and therapeutic way to treat larger numbers of people at the same time.
- Family therapy is an intervention that works to effect change in the family system.
- Psychoeducation is a family-oriented intervention designed to empower and engage families in the care of the mentally ill.
- Client-centred ideas of recovery indicate that people will not engage with rehabilitation programs unless they have hope for a better life.
- Social skills training helps people to learn or re-learn social skills.
- Case management is a client-centred approach to working with people in the community in which the key worker assists the client to live in the community as independently as possible.
- Electroconvulsive therapy is an intervention with attendant nursing responsibilities.

KEY TERMS

- activity groups
- assertiveness skills
- behaviour therapy
- case management
- cognitive behavioural therapy
- crisis intervention
- dialectical behaviour therapy
- electroconvulsive therapy
- family therapy
- group therapy
- individual psychotherapy
- instilling of hope
- interviewing
- motivational interviewing
- planned short-term psychotherapy
- psychoeducation
- psychosocial rehabilitation
- psychotherapy
- relaxation skills
- risk assessment
- social skills training
- stress management
- telephone counselling

LEARNING OUTCOMES

The material in this chapter will assist you to:

- identify stressors and learn strategies for managing stress
- understand the implications of accurate risk assessment and crisis intervention
- differentiate between aggressive, passive and assertive response styles
- recognise fundamental concepts related to a range of psychotherapeutic intervention strategies such as individual psychotherapy, planned short-term psychotherapy, motivational interviewing, cognitive behavioural therapy and dialectical behaviour therapy
- describe how behaviour is learned, maintained and extinguished
- recognise the therapeutic factors as they occur within therapy and activity groups
- understand family-centred approaches to treatment
- realise how psychosocial rehabilitation contributes to recovery from mental illness
- consider how nurses can influence the recovery of people with enduring mental health problems
- understand how working alongside or with the client contributes to better outcomes for the client
- consider the ethical issues related to electroconvulsive therapy.



ELSEVIER

Introduction

This chapter provides an overview of a range of therapeutic interventions used by mental health nurses working with people with mental health problems and/or serious mental illnesses. Some of the content here will require you to review material in other chapters to help your understanding. Working through this chapter will not give you the skills to be expert in any of these techniques, but it will enable you to understand some fundamental concepts. You may even begin to understand yourself better. When you are working with people with mental health problems, a deeper understanding of yourself will help you to be more therapeutic. One aspect of self-understanding and the understanding of others involves culture—throughout this chapter, it is important to consider the specific cultural perspective and needs of the person.

We all experience stress and the outcomes of living stressful lives. Being able to identify the stressors in your life will enable you to better manage your own stress before you can begin to help others with their stress. There are many stress-management strategies from which to choose. This chapter considers relaxation skills and assertiveness skills. Relaxation is a simple physical skill that can be learned with practice, and assertiveness skills are particularly useful for nurses in any area of clinical specialty.

Mental health nursing requires accurate assessment of risk to ensure good outcomes, because a person may represent a risk not only to themselves, but also to others in the community. Crisis intervention also requires specific skills that aim to ensure risk minimisation. Crisis intervention can occur in a range of environments or settings, and telephone counselling is just one of these.

Many therapies or therapeutic endeavours have been developed to help people with their psychological problems. Among those discussed briefly here are the psychotherapies, such as individual psychotherapy, planned short-term psychotherapy, motivational interviewing, cognitive behavioural therapy and dialectical behaviour therapy. In addition, behaviour therapy, group therapy (including activity groups) and family therapy (including psychoeducation) are briefly reviewed.

Psychosocial rehabilitation is the term used to describe the kind of rehabilitation that is provided particularly for those with enduring mental health problems. According to client-centred ideas of recovery from mental illness, people will not engage with rehabilitation programs unless they have hope for a better life. While people can arrive at a sense of hope without the input of nurses, we are also able to contribute to a person's sense of hope so that a more desired life can be achieved. Social skills training is also an aspect of psychosocial rehabilitation that will help people relearn the skills they need in order to engage more actively in the communities in which they live.

Finally, this chapter considers the roles of interviewing, case management and electroconvulsive therapy in contemporary mental health nursing. Taking a more collaborative approach to interviewing supports the orientation towards client-centred care. Case management is also a client-centred approach to working with people in the community. Case management approaches of the past focused on management of the client's needs, but today the emphasis is on the key worker supporting the client to develop the skills to live well in the community as independently as possible. Although electroconvulsive therapy remains a contentious intervention, it is a valid treatment strategy with attendant nursing responsibilities. While providing information on all these topics, this chapter also asks you to reflect on who you are, and what you believe and value.

Stress management

Before considering how to manage stress, it is important to understand how stress manifests and affects the body. Among the effects of stress are increased blood flow to skeletal muscles, decreased blood flow to other organs, increased heart rate, raised blood pressure, rapid breathing and increased arousal so that vision and hearing are more acute. This is the body's way of preparing for fight or flight. That is, the body prepares to fight and defend against, or flee, the stress-causing situation. For example, say when walking back to your car after finishing work late at night, you hear footsteps behind you. In order to prepare you for fight or flight, all of the responses described above occur. They are all essential and automatic physical responses designed to keep you alive.

These responses occur in part because adrenaline is released into the bloodstream. Stress is a normal part of life today but if we have too much stress or if it is prolonged or too intense, we experience a range of unpleasant symptoms. These include a dry mouth, tremor, palpitations, sleep disturbance, shoulder and neck pain, irritability, indigestion, uncertainty and confusion. Having high levels of adrenaline and other hormones circulating through the body much of the time is bound to affect our functioning, as we should only be in a state of hypervigilance or hyper-alertness for a brief period of time.

It is also important to consider what causes stress. It is not usually a particular event or situation that causes stress, but your perception of and reaction to the event. For example, two people coming across a dog in the street might experience the situation quite differently. One person might view the dog as 'man's best friend' and experience pleasure in seeing the animal. The other person might view the dog as a potential threat, perhaps because of a dog attack during childhood, and subsequently experience fear and anxiety, resulting in stress. Also, although we all experience stress, not all stressful situations have a detrimental effect on us. This

is because of a range of internal and external factors that help to mediate the impact of stress. Internal factors might include effective coping skills and a relaxed personal style. External factors might include strong social support and a comfortable living environment. Nevertheless, the inability to manage stress ultimately leads to difficulties in living and, for some, mental health problems.

Escot et al (2001, p 273) examined the stress levels of nursing staff working in an oncology setting and found that 'stress is primarily related to inadequate training, lack of time to deal with the psychological component of caregiving, especially terminal care, and relationships with other medical staff'. Edwards et al (2002, p 213) found that 'mental health workers are likely to experience stress as a result of working closely with patients over an extended period of time'. Other workplace difficulties causing stress that these authors identified included increased workload, increased administration, lack of resources and problems with management.

It is important to remember that the stresses we experience in one part of our lives, such as at work, will overlap into others, such as relationships, and vice versa. There are many opportunities for us to experience stress at work. Simply working a variety of shifts during the week can be stressful. The responsibilities that nurses are expected to take on, often without the necessary experience, also contribute to stress. Personal relationships provide their own challenges and we all experience these at some time. Before you can focus on managing stress, you need to identify what causes stress for you (see the first exercise at the end of this chapter).

Once you are aware of the major stressors in your life, you can begin to think about how to manage them or, more correctly, manage the *effects* of the stress you are experiencing. Remember, it's not the stress itself that is the problem; it's how you react to the stress that is crucial. According to Battison (1997, p 24) there are four main techniques people use to manage stress. You can:

- change the situation
- increase your ability to deal with the situation
- change your perception of the situation
- change your behaviour.

Notice that there is a definite call for change in your life. However, many of us find change stressful. If you have a perception or belief that change will be difficult, you are much more likely to find it stressful. If you believe that change presents opportunity, you are less likely to find it stressful. Nevertheless, if we do not change the behaviour that results in stress, stress will remain a part of our lives and we will ultimately suffer ill health—mental, physical or both.

Skills such as time management, being assertive, relaxation, yoga, visualisation, managing change, meditation and correct breathing can all be learned relatively easily, and some of these skills are addressed in this chapter. Changes to your lifestyle such as healthy eating, reducing alcohol, drug and tobacco consumption, and exer-

cising, require considerable commitment. It is important to find out what works well for you in addition to lifestyle changes so that you can use these strategies whenever you feel the effects of stress.

Relaxation training

Relaxing is an excellent way to manage your body's responses to stress. It works because you can't be both tense and relaxed at the same time. When you experience tension, relaxation is a certain way to alleviate it. It is also important to use relaxation to prevent the adverse effects of stress, not just manage these symptoms. Relaxation can involve simply setting aside some time to sit back and listen to soothing music, read a good book or take a stroll around the park (Battison 1997). Listening to music and reading might also be done from the comfort of a hot bath combined with aromatherapy. Learning to breathe more effectively will also lead to relaxation.

Progressive muscle relaxation (PMR, also known as deep muscle relaxation) can be carried out reasonably quickly and with great effect. It can be done independently or by following the instructions on an audiotape (available in a range of outlets including music stores). Because PMR is a skill, it will take practice. You won't develop the skill overnight. Progressive muscle relaxation involves the progressive relaxation of the major muscles of the body while making a conscious effort to distinguish muscle tension from muscle relaxation. It has been found that PMR also relaxes the mind and internal organs (Romas & Sharma 1995). Ultimately, you will be able to relax groups of muscles at will, which can be done anywhere. Progressive muscle relaxation has been shown to be effective in treating a range of physical and psychological conditions such as headaches and anxiety disorders and in preventing the effects of stress (Ayers et al 2007; Romas & Sharma 1995; Rausch, Gramling & Auerbach 2006).

To begin to learn how to use PMR, you will need to set aside some time every day to practise. You can do this sitting in a comfortable chair, or preferably lying down. Find a quiet place where you won't be interrupted. Avoid PMR immediately after food as relaxation of the stomach may occur, resulting in delayed digestion (Patel 1991). If lying flat on the floor or bed, be sure that you let your feet flop loosely and, if in a chair, let your arms hang loosely. Above all, be sure that you are comfortable or you will find it difficult to relax. You can either follow written instructions until you have memorised them or you could record the instructions on an audiotape and play it through each day. This way you can devote your attention to relaxation.

Before beginning muscle relaxation, it is important to take a few slow, deep breaths to prepare yourself. Progressive muscle relaxation involves working the major muscle groups, starting with the lower limbs and working through to the head (although some authors don't follow this directional flow). Begin by flexing the feet, holding the flexion for a few seconds, then

releasing the tension. Focus on the difference between the tension resulting from flexion and the relaxation resulting from releasing the muscles. Repeat this action for each muscle group and take a short break between each action. Alternatively, tense and relax the calves, thighs, buttocks, back, chest, shoulders, hands, arms, neck, jaw, eyes (face) and forehead (Battison 1997). Finishing the session should involve acknowledging freedom from tension, resting quietly for a few minutes and counting backwards from ten. Then take a deep breath and get up quietly. To effectively help others develop relaxation skills you need to be able to do this well for yourself. This will also lead to a belief in the benefits of relaxation.

Assertiveness training

Assertion is about being able to communicate clearly to others and avoiding misunderstandings that might contribute to stress. Assertiveness, therefore, is a communication skill that will enhance your interpersonal effectiveness and make social situations more comfortable (Gambril 1995). As our personalities develop, we tend to learn a pattern of responding that is aggressive, passive or assertive (see Table 24.1). The passive person's rights are often violated by others. Being taken advantage of inevitably leads to frustration, anxiety and unhappiness. At the other end of the continuum, the aggressive person violates the rights of others and takes advantage of them. The aggressive person is generally defensive and humiliating, perhaps resulting in social isolation. The assertive person, however, protects the rights of each party and achieves goals without hurting others. This results in self-confidence and the ability to express oneself appropriately in emotional and social situations.

Central to these ways of responding is the consideration of basic human rights. We all have the basic right to be treated with respect, for example, and the right to say no without feeling guilty. Making your situation understood by others in a non-aggressive way enables you to feel comfortable without violating the rights of the other person. It is important that your verbal and non-verbal behaviours match. Appropriate non-verbal behaviour to support your verbal message includes good eye contact, a firm voice (don't apologise or shout), and open body posture to show sincerity (Patel 1991). So, what is your communication style?

CRITICAL THINKING CHALLENGE 24.1

You've had a number of stressful situations within your family recently, and so you have been unable to complete your essay on time. You approach your lecturer to ask for an extension on your essay return date.

Decide which of the following responses would best describe your pattern of responding.

You would say:

- If it's okay with you . . . If it's not too much trouble . . . um, would it be okay . . . this essay that's due . . . I'm sorry . . .
- I've had a number of stressful situations lately and I'm going to need an extension on the essay. Would it be all right if I have another week to return it to you?
- Look, I can't get that essay done on time. You haven't given us enough time. You should schedule these things better.

The first response is non-assertive or passive and the last response is aggressive. As you can see from the assertive response, the message is honest, direct and clear. The problem is clearly addressed and the desired outcome openly negotiated.

Being assertive is a skill that anyone can develop with practice. Learning to be assertive means that you will have a choice about how you respond to others. It is important to be aware that you are under no obligation to be assertive all the time. When you have assertion skills, you have the choice to be assertive or to say nothing at all. Many of us have never learned to be assertive and may find it difficult to change patterns of responding that are passive or aggressive. For example, women in some cultural and religious groups learn to defer their thoughts and feelings to those of others, particularly men. These early and strong patterns of responding might be difficult to alter in the short term. However, it is important to determine what your pattern of responding is so that you can acknowledge it and work on changing specific aspects of your behaviour.

There are many types of assertion skills that can help you to handle situations you will encounter either personally or professionally. Some difficult situations can include making or refusing requests, accepting and giving compliments, expressing opinions, giving negative feedback or being confrontational, initiating conversations, sharing intimate feelings and experiences with others, and expressing affection. Examples include conveying a nursing assessment to other members of the

Table 24.1 Comparing passive, assertive and aggressive styles

<i>Passive</i>	<i>Assertive</i>	<i>Aggressive</i>
Communicates indirectly; can have human rights violated	Communicates directly and clearly; protects own rights and the rights of others	Communicates critically and explosively; violates the rights of others
Does not achieve goals	Achieves goals without hurting others	Achieves goals at the expense of others
Allows others to make choices or decisions	Chooses for self	Intrudes on others' choices
Doesn't manage problems	Addresses problems and negotiates	Unwilling to listen to others and acts on problems too quickly

(Source: adapted from Davis 1989.)

multidisciplinary team, and refusing a request to care for a client with complex needs when you are a novice nurse. Indeed, nurses' concerns about advocating on behalf of clients have been found to be a factor that supports the use of assertiveness skills in the workplace (Timmins & McCabe 2005). Many of us find it hard to refuse unwanted requests and this can make life difficult. Just as often, a person might be unable to accept a compliment without countering it by minimising it. For example, when someone says, 'You look nice today', it is important to say 'Thank you'. It's quite a different response to say, 'Thanks, but this old dress/suit belongs in a clothing bin'.

Teaching assertiveness skills to others is usually done in groups involving people who need to develop assertion skills. There are a number of workbooks available that can be used to work through and learn how to develop assertiveness skills. A simple and easy text by Davis, Robbins Eshelman & McKay (2000) can help you to assess your interpersonal style and your difficulties before guiding you through some strategies for changing your behaviour if you see the need to do so. Once you learn some of these skills, you'll be able to support others to recognise their non-assertiveness or aggressiveness and help them to learn new ways of behaving.

Risk assessment

Risk assessment involves determining whether a person has the potential for self-harm, either actively or passively, or is considered to pose a risk for hurting someone else. Whenever a person with a mental health problem seriously hurts or kills another person, this usually elicits a strong reaction from the media and the public. When the result is an official enquiry into organisations and individual mental health practitioners, the outcome is usually a tightening of risk assessment and risk management strategies as well as considerable anxiety among staff. Where the client involved in violent behaviour has been treated in a secure environment such as a forensic psychiatric unit, the need for accurate risk assessment skills is heightened (Kelly, Simmons & Gregory 2002). Risk assessment is designed to *prevent* rather than predict self- or other-directed violence. It is a continuous and dynamic process that is affected by the person's changing mental state and the environment at the time. Therefore, risk assessment is a critical clinical skill in practising as a competent beginning mental health nurse.

CRITICAL THINKING CHALLENGE 24.2

When a client is at risk due to self-neglect, we refer to this as passive self-harm. How might you assess the risk for passive harm?

Risk assessment is not straightforward and it is inevitable that mistakes will be made. According to Doyle & Dolan (2002, p 651), 'clinical risk predictions are

only slightly above chance and the competence varies greatly between clinicians'. This means that risk assessment depends on the skills of individuals rather than on the outcome of focused education. A recent review of clinical risk management practices in New Zealand found that only 25% of mental health service providers had good practices in place (Mental Health Commission 1998)—there is a tendency to assume that risk assessment practices are 'natural', when in fact they need to be made explicit in policy documents for all to understand and follow. Because nurses spend more time with clients than do other health professionals, we are able to gather important information that will inform the multidisciplinary team regarding a person's risk. So, if during your interactions with a client you feel concerned about the person's potential risk, acknowledge your role and responsibility to report this to the team and write about it in the client's file.

Risk for violence

Some risk factors for violence identified by Doyle & Dolan (2002) include a history of violence, recent verbal threats, a lifestyle that is violent (such as belonging to a gang or trafficking illicit drugs), and being a victim of childhood physical and sexual abuse. The presence of alcohol or other substance-use problems and/or personality traits that are antisocial, explosive or impulsive also increases the risk for violence. Although many believe that marijuana is a safe drug, a belief assisted by its description as a 'recreational drug', it has been found to contribute significantly to violence (Mullen 2002). Fear, hallucinations, agitation, anger and suspiciousness revealed through a mental status examination will also alert you to an increased potential for violence. There has been considerable research into specific diagnostic groupings (Axis I disorders) considered to have a greater or lesser potential for violence, with significant variation among the results (Monahan et al 2001). However, an Axis II diagnosis of antisocial personality disorder is predictive of future violence (see Ch 17 for more information about personality disorders). A tool might be useful in helping to predict the risk for violence, depending on your level of expertise. Abderhalden, Needham & Miserez (2004) offer a tool for use in the acute inpatient setting, while Murphy (2004) points out that community mental health nurses tend to rely more on their experience than on the use of an assessment tool.

Self-harm and suicide

Some people carry out acts of deliberate self-harm without aiming to commit suicide. Some attempt suicide unsuccessfully and may therefore fall into the category of self-harm. Risk factors for self-harm or suicide include: the presence of suicidal ideas, feelings of hopelessness, having a plan for committing suicide and having the means to carry out that plan. Demographic factors such as age (younger than 25 or older than 65), being male, being single and having no social support increase

CASE STUDY: AN AVOIDABLE DEATH?

A report on the care provided by a public mental health service in New Zealand was released in October 2002. This followed the case of a client who was discharged from inpatient treatment without a thorough risk assessment and ultimately without a risk management plan, resulting in tragedy. The client was a young man with schizophrenia who also abused alcohol and marijuana. He had made threats to kill his younger brother and his mother based on his (incorrect) belief that they had sexually abused him. He also believed (incorrectly) that the family had taken large amounts of his money. The family's concerns reportedly had not been listened to and, therefore, not acted upon. Evidence of episodes of aggression, drug use and paranoid thoughts towards his family recurred throughout his inpatient clinical notes. Nevertheless, he was permitted to leave hospital to live independently. Following one week's leave and after three home

visits by the social worker, which revealed substantial alcohol use, and two visits by the client to the mental health service, he was officially discharged from hospital. That same evening, he drank bourbon and beer and drove to his parents' house, taking with him a knife, a plastic container of petrol and a change of clothing. He confronted his mother at around 3 am and 'stabbed her some 56 times, resulting in her death' (Health & Disability Commissioner 2002, p 39). He then used the petrol to set fire to the house and his mother's body.

The report by the Health and Disability Commissioner points to evidence that signs of risk, concerns expressed by the family, and opportunities for more accurate nursing assessment had not been responded to, and that therefore this death might have been avoided.

the risk for suicide. Young people have their own set of risk factors, largely related to what is going on in their home, school and social environments (Murray & Wright 2006). Diagnoses of depression or borderline personality disorder carry with them an increased risk for self-harm and suicide. In addition, 10% of people with schizophrenia will commit suicide and 15% of people with alcohol- or substance-dependence problems will also kill themselves, although alcohol is implicated in up to 65% of successful suicides (Varcarolis 1998). Ultimately, being mentally ill increases the risk for suicide (see Chs 10, 11 and 23). Using a tool to guide your suicide risk assessment is suggested, particularly for novice nurses (Cutcliffe & Barker 2004).

Factors that protect against violence or self-injury include a safe environment, strong social support, a good relationship with staff and an acceptance of the current treatment approach (Doyle & Dolan 2002). Clearly, nurses have a role in preventing violence or self-harm. Given that nurses are in the best position to assess and manage risk, we need to be sharpening our risk assessment skills. But these are skills that tend to be taken for granted and learned 'on the job' rather than formally. Understanding risk factors and protective factors will help you to better assess risk. However, more accurate risk assessment comes from deeper knowledge and extensive experience.

Crisis intervention

What represents a crisis for one person might not have the same impact on another person, but no one is immune to crisis (see Ch 10). Situational life crises such as unwanted pregnancy, death of a loved one, serious physical illness and assault are frequently the cause of emotional disequilibrium or imbalance requiring crisis intervention. Being able to intervene effectively during a crisis is a critical clinical skill required by the mental health nurse.

Crisis intervention has developed as a specialty area in mental health nursing that largely involves responding

to people in the community who are overwhelmed by problems or difficulties with life. Often people are referred by a primary healthcare provider (such as a general practitioner or nurse practitioner) or by a family member. Some individuals will make direct contact, often because they have no one else to turn to for help. However, crisis work is not limited to the community setting. Nurses might be required to work with someone in crisis in any number of settings, including a range of mental health and physical healthcare settings as well as the local community or even at home.

We invariably respond to crisis with our usual ways of coping. However, because of the magnitude of the problem or a distorted perception of the problem, our usual coping behaviours might fail to resolve it. As a result, we might try other means of coping (such as alcohol or other drug abuse, eating excessively or not eating at all) and these are usually even less effective. Crisis intervention involves interrupting a maladaptive or ineffective pattern of responding and supporting the person to return to the pre-crisis level of functioning (Greenstone & Leviton 2002). Therefore, the focus is on current difficulties and the time frame is brief.

Crisis intervention is quick, short term and based in the here and now. 'Management of the crisis, not resolution, is the goal of crisis intervention' (Greenstone & Leviton 2002). Crisis intervention helps the person in crisis to locate or develop the resources from within or externally in order to return to the pre-crisis level of functioning (Myer 2001). At times, following resolution of a crisis, an individual may actually develop new coping skills that will help him or her deal more effectively with future crises. Conversely, lack of resolution of a crisis may result in more disabling psychological problems and subsequent crises will not be well managed.

In order to work effectively in crisis intervention, it is important to have a model to direct your actions. The model will ensure that no relevant information is missed, so the best possible outcome is achieved for the client. There are many available models (for example,

CASE STUDY: SUE

Sue is a 29-year-old woman who is distressed about her relationship breakdown. She had been married for two years before her husband began seeing another woman. He informed her two days ago that he is leaving her for the other woman. While talking with you about her feelings of betrayal and helplessness, she mentions that her father sexually abused her as

a child. She realises that the same feelings have been generated through this experience. One of the aims of crisis intervention in Sue's case would be to stay focused on the current issue that has precipitated the crisis, in this case the relationship breakdown. The sexual abuse issue can be dealt with at a later time and potentially over a longer time frame.

see the work of Slaikou (1990) and the model offered by Greenstone & Leviton (2002)) but they all reflect the need to act quickly and to base interventions on an accurate assessment of the situation and of risk. Aguilera (1994) offers a simple model for assessing and managing crises. She asserts that there are three factors that, when present, defend against the development of crisis. These are the presence of social support, intrinsic coping skills (such as the ability to solve problems), and a realistic perception of the event, resulting in the belief that you can manage. Consequently, if your assessment reveals a lack in any of these areas, you would direct your interventions to meet the area of need.

Well-practised communication skills, particularly listening and helping the person to tell their story, are fundamental to crisis intervention. Without being clear about what the problem is, it is unlikely that you will be able to intervene effectively in a crisis. Crisis intervention is one time when you, as the helper, take some control and provide direction because the person in crisis is usually unable to do so for him or herself. Myer (2001) suggests that we take control and determine the direction of the therapy without causing dependence. 'The more severe the reaction to the crisis situation, the more active the crisis worker must be' (Myer 2001, p 6). The focus is on ensuring both physical and psychological safety.

Telephone counselling

Counselling by telephone is designed to support people in crisis, so it usually involves a single session. It often occurs after-hours and at no cost to the recipient. In addition, telephone counselling affords anonymity to the caller at a time when the person is experiencing vulnerability. As with any counselling session, the telephone counsellor helps the person cope with the crisis by working through feelings and by problem solving. Outcomes include resolution of the problem, referral for further treatment or, if the counselling is unsuccessful, lack of engagement. Interestingly, it has been found that most calls to crisis centre call lines are from people seeking social support rather than crisis intervention (Watson, McDonald & Pearce 2006), which may require an adjustment to the way that telephone services are offered. However, telephone counselling might also be set up for the convenience of the client—for example, for people with physical disabilities who might otherwise have difficulty accessing an office. In addition, some counsellors might augment face-to-face

counselling sessions with telephone sessions (Sanders 1996).

Nurses working with community crisis teams are frequently required to counsel people by telephone. Their goal is to make an accurate assessment and to ensure safety for the caller and others. Others at risk might include spouses or children in cases where the caller is expressing anger against them. Nurses working in psychiatric inpatient units and hospital emergency departments also do telephone counselling, often by accident rather than design. Often people in crisis will contact these services for help when they are at a loss to know what else to do. Nevertheless, whenever you are called upon to counsel someone by telephone, you will require a recipe or process to help you work through the situation.

There are many models for crisis intervention by telephone (Egan 1998; Lester 2002; Slaikou 1990) but they all follow a similar problem-solving plan. There needs to be initial engagement or the development of rapport through a caring, honest and open approach before the problem can be explored and analysed. The same counselling skills used for face-to-face counselling are used, but with greater emphasis on listening. Following engagement, it is important to determine the person's safety before moving on to explore their needs. Once the person's needs have been thoroughly explored, a plan of action would be developed that includes a follow-up appointment.

CRITICAL THINKING CHALLENGE 24.3

How do you make psychological contact when you don't have eye contact? Role play a counselling session by telephone. In pairs, sit back-to-back or side-by-side and begin to work through a mock crisis situation. Begin by introducing yourself. Continue for 5–10 minutes.

Report back to the larger group:

- What specifically helped with engagement?
- How did you overcome the barrier of no eye contact?
- How did you know how comfortable the client felt?
- How did the client know that the counsellor was interested?

When working on the telephone, more frequent verbal responses are necessary. It is important to let the client know that they are being heard and that you are there, listening to the story. Typical verbal encouragers include: *uh-huh, yes, sure, go on, mmmm, right, okay, I see, Do you want to say more about that?* and *Please*

tell me more about that. These verbal encouragers let the client know that they are being listened to, and this enables further elaboration of the story about the current crisis.

Listening carefully is also very important. When telephone counselling, there are no visual cues to attend to so you must focus your listening skills more acutely. This enables a more accurate assessment of what the client is thinking and feeling, which enables you to reflect that understanding to the client in a truly empathic way. The telephone counsellor needs to listen for voice tone, pitch and volume, and breathing noises that might indicate anxiety, grief or anger. It is important to listen for crying and other noises like snorting, groaning, grunting, sighing, laughter, sarcasm and silences (Sanders 1996). These will need to be interpreted in the context of what is being said.

Psychotherapy

Once extremely popular, psychotherapy now has to compete in a world where the biomedical approach to diagnosis and treatment prevails. The biological model focuses on chemical treatment and limits the consideration of a person's historical trauma. Psychotherapy, on the other hand, is concerned with 'the complex messy nature of the human experience. This includes the problematic domains of the aesthetic, the ethical, and the spiritual' (Petchkovsky, Morris & Rushton 2002, p 330). The term *psychotherapy* is used to describe a number of interpersonal models, each with its own individual philosophy and set of techniques. Examples of psychotherapeutic models include individual psychotherapy, planned short-term psychotherapy, cognitive behavioural therapy, motivational interviewing, and dialectical behaviour therapy. To be able to practise any of these psychotherapies, you would need to undertake a specialised program of study that might include supervised practice, but nurses can and do conduct psychotherapy.

Individual psychotherapy

The early work of Sigmund Freud (1938/1965) revealed that much of what motivates us and influences our behaviour occurs at an unconscious level. Despite some of his work being challenged over the years, this tenet still holds true and it is this understanding that underpins psychotherapy. Although psychotherapy can occur in groups, it most commonly occurs individually. The goal of psychotherapy is to effect change in the person's character, as difficulties of living are viewed as linked to childhood development of the psyche. 'Psychodynamic theory is rooted in the belief that we develop a sense of self during childhood' (Gallop & O'Brien 2003, p 216) (see also Ch 8 for information on psychotherapy).

Psychotherapy occurs between client and therapist, usually over a lengthy period of time (time-unlimited). It provides the client with opportunities to examine the historical experiences that have shaped who they

are and influenced their life decisions. This happens when the client brings those past experiences into the present relationship with the therapist and re-enacts them (transference). Transference is an unconscious process, that is, the person is unaware that he/she is doing it. According to Evans (2007, p191), 'transference is about one's fundamental ways of relating to those one loves, fundamental ways that repeat throughout one's life, although new experiences do provide the possibility for change in this pattern'. The person may begin to relate to you as the nurse in one of these patterned ways, for example, as someone who can be trusted, loved and respected. From this place, the client might be able to talk more deeply about the things that concern them. Alternatively, the client might respond to you as someone who is unlikeable and untrustworthy, reflecting that person's earlier experiences. This negative transference is quite common and needs to be immediately recognised as such rather than taken personally.

The therapist is also responsible for recognising what he or she brings to the therapeutic relationship and the counter-transferences that support the client's re-enactment of earlier relationships. For example, it is important to recognise that reciprocal love or dislike for the client is counter-transference and that expressing this would be counter-therapeutic and potentially destructive. Counter-transference can be viewed as a natural and expected response in some instances (for example, responding as the caring and nurturing mother), but it is important to recognise this response as counter-transference, as it has the potential to be damaging to the client. For example, an adult who struggled as a child to get confirmation of love from a parent might re-enact that struggle in the client-therapist relationship (transference). The therapist who doesn't recognise the transference and allows the client to continue to seek affirmation (without challenging it), is demonstrating counter-transference. So, the therapist is responding to a situation that is rooted in the client's past and causing the situation to be repeated in the present. The appropriate response on the part of the therapist would be to explore the client's need for love and to help the client gain insight into how this is related to experiences from an earlier time in his or her life. Counter-transference can be viewed as a natural and expected response in some instances (for example, responding as the caring and nurturing mother), but it is important to recognise our response as counter-transference, as it has the potential to be damaging to the client (see Ch 23 for more information on these terms).

Gallop & O'Brien (2003) argue that nurses need to deepen their understanding of psychodynamic theory, not just at the cognitive level, but at the affective level—the level of emotions. We need to be aware that our own developmental experiences determine who we are and that we re-enact our personal histories in everyday relationships, professional or personal. Much of this occurs unconsciously and puts us at risk of behaving inappropriately. 'Our history that creates the self is replayed in

every interaction and decision throughout our lives. So that when we respond to our clients and they respond to us, we in the present bring with us our past' (Gallop & O'Brien 2003, p 219). This is particularly important to acknowledge when we are working with people who are already distressed by mental health problems and are vulnerable.

Planned short-term psychotherapy

Initially known as brief psychotherapy, this group of psychotherapies is now more commonly referred to as planned short-term psychotherapy. This title differentiates it from short-term therapies that are not planned. The brief therapies began in the 1960s when efforts were made to make the psychotherapeutic model of counselling available to greater numbers of people. Access to psychotherapy was limited due to the time-unlimited nature of early psychotherapy. However, the brief therapies expanded as it became clear that they could be very effective (Bloom 1997). Brief psychotherapies include interpersonal psychotherapy, cognitive behaviour therapy and motivational interviewing. Effectiveness, efficiency and economy have therefore led to an explosion in planned short-term psychotherapies.

The goal of planned short-term psychotherapy is to manage problems in the here and now (the present). The duration of the short-term therapies ranges from a single session through to around 20 interviews, as compared with individual psychotherapy, which occurs regularly over at least a two-year period. Short-term therapists believe that the person's presenting complaint is symptomatic of deeper psychopathology, so that ultimately, in managing current difficulties, significant psychological change also occurs (Bloom 1997). This, of course, matches the goal of the original, time-unlimited psychotherapy. Given today's fiscal environment in healthcare services across Australia and New Zealand, improved access to less expensive forms of treatment is welcomed. Furthermore, 'planned short-term psychotherapies are, in general, as effective and long lasting as time-unlimited psychotherapy' (Bloom 1997, p 7).

Motivational interviewing

Motivational interviewing (MI) is a relatively modern psychotherapeutic model, having been conceptualised in 1982 by Bill Miller and Steve Rollnick. It is an intervention that was initially developed for work with people with substance abuse and dependence problems. Indeed, Miller (1998) defines addiction as fundamentally a problem of motivation. You may be aware that many people with these problems tend to use the defence mechanism of denial—that is, they initially refuse to acknowledge that a problem exists. Once the person begins to acknowledge that there may be a problem, they may still be reluctant to engage in treatment. This indecision is known as *ambivalence* and MI essentially aims to change the substance-use problem by helping people to explore and resolve this ambivalence (Rollnick & Miller 1995).

Motivational interviewing is described as a directive form of counselling. It is not directive in terms of the therapist telling the client what to do and how to behave, because it is also defined as a client-centred counselling strategy. It is directive in that it is goal directed and the therapist provides guidance in an attempt to resolve ambivalence. When the client begins to see that there is a problem with substance use, resistance is expressed or experienced. This is normal and expected, and is accepted as part of the MI approach. The therapeutic relationship is more like a partnership where two people work together, rather than a professional relationship where the therapist is acknowledged as the expert. It is thought that the nature of this type of relationship is also empowering. This gives the client a sense of self-control and personal power, which contributes to the recovery process.

Rollnick & Miller (1995) differentiate what they call the spirit of MI from the techniques they recommend to support it. Central to MI is the need for the therapist to resist persuading the client to make changes in behaviour. Motivation to change is determined to come from the client. Readiness to change, however, is a result of interpersonal interaction rather than being a personality attribute of the client (trait). Any attempts to persuade or coerce the client will only lead to increased resistance. The counselling style is described as quiet and involves guiding the client towards considering the options and their consequences. It is not confrontational. The therapist would never tell the client what he or she should be doing. According to Rollnick & Miller (1995):

It is inappropriate to think of motivational interviewing as a technique or set of techniques that are . . . 'used on' people . . . rather it is an interpersonal style. It is a subtle balance of directive and client-centred components, shaped by a guiding philosophy and understanding of what triggers change. If it becomes a trick or a manipulative technique, its essence has been lost (Rollnick & Miller 1995, p 326).

The wheel of change or transtheoretical model developed by Prochaska & DiClemente (1983) is used to support the philosophy of MI. The model outlines five stages related to the readiness to change behaviour—in this case, abstaining from addictive substances like alcohol:

- *Precontemplation*—the individual does not intend to change. The person is often not aware that there is a problem, and is not actively looking for an alternative life.
- *Contemplation*—there is acknowledgement that a problem exists, and so the person begins to think about change. There is a developing awareness of the advantages of change, but the disadvantages are also recognised (Prochaska 2001).
- *Preparation*—the person begins to learn new skills and gather information as the readiness to change

develops. At this stage the plans are for change to take place within the next month (Finnell 2003).

- **Action**—significant behaviour change occurs as the person begins to engage in new behaviours.
- **Maintenance**—permanent changes in behaviour are now sought. The person works towards establishing the change, by adjusting their lifestyle and actively avoiding returning to old patterns of behaviour.

According to the philosophy of MI, the therapist guides the client through these stages at a pace determined by the client. Changing destructive patterns of substance abuse and dependence does not happen all at once. Motivated by relevant and meaningful goals, the change occurs progressively (Finnell 2003). As relapse is viewed as part of the process of change, a return to earlier stages in the process is considered normal.

In addition to the spirit of MI, five principles underpin the model, as outlined by Miller et al (1992).

- **Avoid argumentation**—there should not be any confrontation or arguing with the client. This will only result in the client returning with argumentation and withdrawing from the therapy. If the client were to deny having a problem with alcohol, despite the overwhelming evidence, the therapist would not argue about the evidence with the client.
- **Express empathy**—this is considered critical to the approach. Expression of empathy gives clients the message that they are heard and understood. This is important because it is unlikely to have occurred within the family or the community. This leads to clients being more open to therapy and to sharing their stories. Clients are also more likely to be open to the gentle challenges from the therapist about their beliefs about substance use. Change occurs because clients are more comfortable in working with their ambivalence.
- **Support self-efficacy**—supporting a person's sense of self-efficacy contributes to the client's belief that change is possible. Self-efficacy is supported through acknowledging the person's past ability to change and by supporting the person to choose his or her own plan for change. Observing others who have made changes in their lives is also a powerful motivator for change.
- **Roll with resistance**—resistance from the client is considered normal and not to be contested. The counsellor rolls with the resistance by encouraging the client to find his or her own solutions to problems. Because there is no differentiation between the therapist and client, there is nothing for the client to fight against. The counsellor might offer new perspectives, but these are not imposed on the client.
- **Develop discrepancy**—this involves helping clients to see the discrepancies between what they hope to achieve (their goals) and how they are currently

behaving. Recognising that their actions are leading them away from rather than towards the achievement of their important goals provides the motivation for change.

Motivational interviewing has been found to be very effective, particularly where a person's suffering from the effects of the addiction has increased, as it does over time. People have changed their patterns of substance dependence after as little as one to two hours of MI. And a single session of MI prior to embarking on a rehabilitation program has been found to double the chances of a person's abstinence continuing three months later (Miller 1998). And this is possible because someone has actively listened to the client's problems, helped the client to acknowledge and resolve ambivalence and supported them in achieving their goal of a changed life. But problems with motivation and behaviour change are not limited to the addictions field and not to mental health problems alone. MI has been found to be effective in working with people with eating disorders (Carels et al 2007; Treasure et al 2007), with sexual health concerns (Byrne et al 2006), with criminal offenders (Clark et al 2006) and in improving general health (Butterworth et al 2006; Knight et al 2006).

Cognitive behavioural therapy

Cognitive behavioural therapy (CBT) grew out of behavioural therapy but is considered a planned short-term psychotherapeutic technique. Originally designed as a treatment approach for people with depression, CBT is now used for a range of disorders, and has been found to be a cost-effective approach (Myhr & Payne 2006; Vos et al 2005). It is usually conducted over around 16–20 sessions. Its premise is that there is an interrelationship between thoughts, feelings, behaviour, biology and the environment. That is, each factor influences the others. This has been understood for centuries. The Roman emperor Marcus Aurelius wrote:

If some external object distresses you, it is not the object itself but your judgement of it which causes pain. It is up to you to change your judgement. If it is your behaviour which troubles you, who stops you from changing it? (Blackburn & Davidson 1990, p 16)

In the cognitive model, our thoughts are classified into three layers: the outer layer holds our automatic thoughts, the middle layer contains our intermediate beliefs or underlying assumptions, and the inner layer stores our core beliefs. The core beliefs develop during childhood as a result of experience and the influence of significant others. Cognitive behavioural therapy aims to cause change at each of these levels. The goal of treatment is to bring into conscious awareness the client's negative automatic thoughts, which are specific to certain situations, and the person's underlying assumptions, and to challenge them.

We all have negative automatic thoughts that are present when we are awake. They are responsible for many of our behaviours. An example of a negative automatic thought is: 'I can't cope'. This leads to the person behaving in a helpless way. The underlying assumption might be: 'If I can't work this out, then I'm no good'. The core belief for this person might be: 'I'm a failure'. The negative automatic thoughts are the most superficial and are more likely to be acknowledged. Once challenged, the client learns to develop new or revised beliefs. These are considered during therapy and practised in vivo (in real life).

Assessment for suitability to engage with the CBT model is carried out initially. This assessment will determine whether the client has the motivation to change and whether he or she has the ability to engage and to problem-solve. The model is prescriptive—that is, there is a distinct process for engaging in therapy with the client. Regardless of the person's difficulties, the same specific techniques and strategies central to the model are used. These include Socratic questioning (Calvert & Palmer 2003) and homework, such as charting behaviours and mood using a visual analogue scale, and keeping automatic thought records. Keeping an automatic thought record alerts the client to the negative automatic thoughts that continue to affect their feelings and behaviour, ultimately maintaining mental health problems. Homework is set after each session to ensure that the client remains motivated and learns the skills to take over their own therapy.

Initially, clients are given an overview of CBT and shown how the five-part model (illustrated in Figure 24.1) will be used to identify the more serious problems. Clients are asked to identify a situation that caused a strong negative emotional response. Then clients identify their specific emotional responses to that situation as well as their cognitions, physical responses and behaviours. The fifth aspect of the model, the environment, provides the context within which these responses occurred, including culture and personal history. Organising the person's experiences into the categories of thoughts, feelings, behaviour and physical responses is fundamental to CBT (Dattilio & Padesky 1990).

An example of this might be if an employee, 'Jane', received negative feedback about her work performance from her employer and had a strong emotional response. Figure 24.1 shows a description of the emotions, thoughts, actions and physical responses that occurred within the work environment for Jane during this scenario.

The therapeutic relationship in CBT is collaborative. The client is an active participant in the process and is responsible for learning new ways of responding. There is also an emphasis on empiricism, which is the gathering of data to provide evidence to challenge current beliefs. Clients are taught to identify their dysfunctional thoughts and the therapist then tests the validity of those beliefs. For example, in the situation described above and in Figure 24.1, Jane believes that everyone

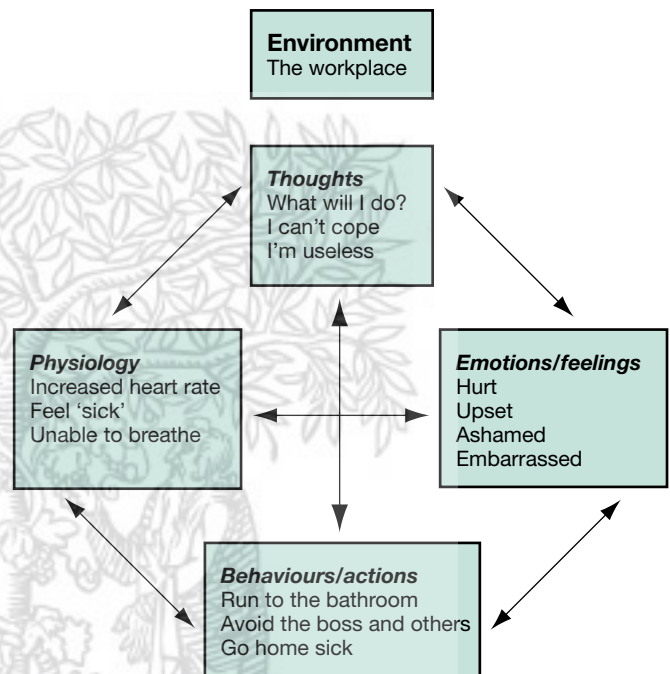


Figure 24.1 The five-part model for problem identification using cognitive behavioural therapy (adapted from Padesky & Mooney 1990)

thinks she is stupid. The therapist would ask Jane for evidence of this. It is most unlikely that Jane would have any evidence. Ultimately, clients learn to evaluate their own thoughts and manage their own responses (Dattilio & Padesky 1990).

CBT has been found to be very effective in the treatment of depression over many years and is now used for a range of health conditions. Its efficacy has been strongly reported for the anxiety disorders (e.g. Barlow et al 2005; Rosser, Erskine & Crino 2004) and for the management of medication non-adherence (Rodrigues 2007). CBT has also been found to be useful in working with people with learning disabilities (Brown & Marshall 2006) and for people requiring cancer and palliative care (Mannix et al 2006; Semple et al 2006).

Dialectical behaviour therapy

Dialectical behaviour therapy (DBT) was developed by Marsha Linehan and first published in 1993. It is a therapeutic technique designed specifically to help people manage parasuicidal behaviours (self-harming without the intention to kill oneself). These people are frequently women with a diagnosis of borderline personality disorder. DBT is highly structured, goal oriented and time limited, and is based on a cognitive behavioural approach.

The client's involvement in DBT is voluntary. Indeed, the client needs to be committed to working towards the behaviour change that is necessary to alter her or his lifestyle and subsequent difficulties. This is known as the pre-treatment phase of DBT. Without commitment from the client, DBT will not proceed. In particular, 'the

client must agree to work on decreasing parasuicidal behaviours and interpersonal styles that interfere with therapy and on increasing behavioural skills' (Swales, Heard & Williams 2000, p 10). The core intervention strategies involved are 'validation' and 'problem solving'. The main work is carried out in weekly individual therapy sessions that focus on targeted behaviours. The therapist accepts the client as a valid human being while at the same time expecting change. The most important behaviour to be addressed is the parasuicidal behaviour. Once this has been brought under control, other issues are addressed.

The group therapy aspect of DBT occurs concurrently with individual therapy and involves skills training. The person with borderline personality disorder has not developed effective coping skills, and so learning how to solve problems effectively is very important. There are four groups of skills, or modules (Linehan 1993):

- core mindfulness skills (derived from Buddhist meditation)
- interpersonal effectiveness skills
- emotion modulation skills
- distress tolerance skills.

As skills are learned in the group sessions they are applied in the real world and also addressed in individual counselling sessions. The therapist acts as coach to support the use of these new skills as they are learned, both within sessions and over the telephone as problems arise (Wolpow 2000). It is the combination of acceptance or validation and active change or problem solving that brings about the alteration in personality style that enables these clients to lead more fulfilling lives.

Before considering DBT, it is important to consider what borderline personality disorder means (see also Ch 17), especially in the context of DBT. People with borderline personality disorder are very challenging to work with because of their personality style, which often develops as the result of a very difficult childhood. According to Linehan (1993), the experiences and responses of the child who develops borderline personality disorder were 'invalidated' or disqualified by the significant others around the child. This means that the child's experiences were not acknowledged or accepted as real. Sexual abuse is considered the ultimate form of invalidation and is frequently an aspect of the history of the person with borderline personality disorder. At the same time, Linehan argues that, for these

people, there exists a biological predisposition within the autonomic nervous system to react poorly to stress. It is important to note that the majority of people who are given the diagnosis of borderline personality disorder are women.

The person with borderline personality disorder classically has a dysfunctional lifestyle and staggers from one crisis to the next. Linehan points out that these clients are unable to regulate their emotions (have extreme emotional reactions to situations), have chaotic interpersonal relationships, have a disturbed sense of self, and are unable to regulate their thoughts and behaviours. They lack problem-solving skills and so respond to life haphazardly. They frequently engage in self-damaging behaviours such as substance abuse, promiscuity and over-eating, but the most common behaviour is self-mutilation. According to the DBT approach, the diagnosis relates to a certain pattern of behaviours and so, once these behaviours cease, the diagnosis also no longer exists (Swales et al 2000).

DBT was originally designed as an individual therapy approach combined with group skills training, telephone contact between sessions and a strong emphasis on therapists also receiving DBT from each other. Therapist consultation is fundamental due to the risk of therapist burnout when working so intensively with clients with such challenging patterns of behaviour. Aspects of DBT can now be applied in a range of settings using the principles of treatment rather than these specific modes (Wolpow 2000), and for a range of conditions (Linehan et al 1999). However, success is determined by the quality of the client-therapist relationship. In particular, the client learns that their own needs and the therapist's needs are both important.

Behaviour therapy

The behavioural model developed from the early work of Pavlov at the turn of the nineteenth century and Skinner during the early twentieth century. Pavlov's early experiments involving dogs showed that involuntary behaviours can be conditioned to occur (classical conditioning) and that, ultimately, this learned response can be unlearned (extinguished). It is normal for salivation to occur in response to the presentation of food, but it is not normal for salivation to occur at the sound of a tuning fork. Pavlov paired the presentation of food

CASE STUDY: GEORGIA

Georgia was a 21-year-old woman admitted to hospital due to self-harming behaviour. She had repeatedly cut her arms and body with razor blades. She said she did this because it helped with her emotional pain. It eventually transpired that when Georgia was a young girl, she had been sexually abused by a neighbour. She was deeply ashamed and embarrassed about what had happened to her and was also worried about how her parents would react once they knew. Georgia's experience was validated by her parents and

friends and by the nurses working with her. Rather than staff feeling anger towards her continued self-harming, it was important for Georgia to be acknowledged as a young person struggling to manage her emotional responses to past traumatic experiences. She needed time and patience before she could begin to learn new ways of responding. Several years on, Georgia is a different person, undertaking postgraduate studies, working and having a life worth living.

with the sound of a tuning fork until eventually salivation occurred at the sound of the tuning fork without the presence of food. The dogs had been conditioned to salivate at the sound of the tuning fork. Persistent sounding of the tuning fork without the presentation of food eventually led to extinction of this learned response—that is, the dogs no longer salivated at the sound of the tuning fork.

CRITICAL THINKING CHALLENGE 24.4

What are some of your conditioned responses? For example, consider how the sound of the school bell at the end of the day results in a lightening of mood for both students and teachers! What happens when you smell toast cooking in the kitchen?

Skinner later developed the early work of Thorndike (1911, cited in Barker & Fraser 1985). He called this *operant conditioning* and showed that behaviours can be learned and unlearned through processes of positive and negative reinforcement. That is, behaviours can be strengthened through positive reinforcement or the presentation of rewards, and weakened through negative reinforcement involving the removal of rewards. Removing a reinforcer to a behaviour, such as walking away from the child having a temper tantrum, results in extinction of the temper tantrum behaviour. Be aware, though, that initially ignoring a behaviour will result in an increase in that behaviour before it begins to subside.

Punishment can also be used to change behaviour. When defined in behavioural terms, punishment refers to procedures designed to suppress behaviours, not the infliction of physical or psychological pain or harm. Punishment decreases the strength of certain behaviours rather than eliminating them (Sundel & Sundel 1993). Punishment can involve applying a punishing stimulus immediately after the unwanted behaviour is performed. An example of this is when the teacher humiliates a student verbally for arriving late at class.

Alternatively, punishment might involve the removal of a positive reinforcer. Examples of this include a child being placed in time out following a temper tantrum, or a client with anorexia who loses weight or doesn't gain weight according to a prescribed schedule, losing the privilege of calling their friends for 48 hours. To be effective, the punisher needs to be applied consistently; that is, each time the behaviour presents, the punisher is applied. Punishment is most effective when applied immediately after the undesirable behaviour. It is also important to specify alternative behaviours that are more appropriate (Sundel & Sundel 1993).

Behaviour therapy has been found to be particularly useful in explaining the development of anxieties and fears and the ways in which these are generalised to a range of stimuli. For example, a person who has a fear of spiders may well find that the fear generalises to a range of crawling insects as well as toys and pictures of spiders. The events that occur prior to or after behaviours determine whether those behaviours will be learned, maintained or changed. For example, the presence of a spider will result in heightened anxiety. Moving away from the spider causes the anxiety to subside. Therefore, the person learns that spiders are to be feared and to avoid spiders. Unfortunately, this will result in avoidance of environments that have the potential to contain spiders, causing constriction of the person's social world.

It is important to point out that in the case study below, George is not aware that his avoidance of anxiety-provoking situations actually increases his anxiety. He will not accept the idea that staying within an anxiety-provoking situation will be helpful in managing his anxiety and in preventing future panic attacks. George believes that he would 'freak out' and that this would be the most awful outcome for him. He would feel vulnerable and he might never get back home. Combined with education, staying with George and verbally supporting him to stay within the anxiety-

CASE STUDY: GEORGE

George suffers from schizophrenia but is more disadvantaged by his social and panic anxiety (see Ch 18). Using Truax's (2002) model for behavioural case conceptualisation, the reinforcers and punishments that cause his anxieties to occur and persist, resulting in increasing social isolation, are:

- *Positive reinforcement*—an increase in a consequence leads to an increased probability that panic attacks will happen in the future. For example, George's family members carry out his weekly grocery shopping and manage his finances and bill paying for him. This reinforcement increases the likelihood of George not engaging in these behaviours and increases the probability of panic attacks occurring should he engage in these behaviours.
- *Negative reinforcement*—a decrease in an uncomfortable or aversive consequence or outcome leads to increased avoidance of anxiety-provoking situations in the future. When

George stays at home rather than engaging in social situations or using public transport, it reduces his anxiety, thereby increasing his avoidance of these anxiety-provoking situations.

- *Positive punishment*—an increase in a negative consequence leads to decreased engagement in anxiety-provoking situations in the future. For example, when George goes for long walks far from his home but within his suburb, his anxiety increases because he fears 'freaking out'. He has now limited his walks to a small radius from his home, and so his social world is shrinking even further.
- *Negative punishment*—a decrease in a consequence leads to a decreased probability that he will stay in anxiety-provoking situations in the future. For example, George is unable to use positive self-talk to manage his anxiety and is therefore unable to stay in anxiety-provoking situations. He is so certain that he will 'freak out' that he no longer puts himself at risk.

provoking situation will show him that his most feared outcome will not be realised. Once he recognises that avoidance only worsens the situation, that he can cope with his anxiety and that terrible things won't happen to him, he can begin to change his behaviour.

In George's case, the target behaviour, the behaviour we wish to change, is the social isolation that George suffers as a result of his avoidance of anxiety-provoking situations. It is important to point out that 'the target behaviour is the behaviour to be observed and measured; it is the focus of modification' (Sundel & Sundel 1993, p 4). The target behaviour can be the behaviour we want to increase (e.g. acceptable or appropriate social behaviour), or the behaviour we want to minimise (e.g. lying on the bed all day). George has hopes and goals that include working and living in a small beachside community. In order to achieve these goals, George needs to be able to cope with driving a vehicle or using public transport, meeting new people, and widening his social world without fear of losing control.

Prior to working with George and his problems, the nurse would need to carry out a behavioural assessment. This requires George to record the triggers, both internal and external to his anxiety, and to identify his physical, cognitive, emotional and behavioural responses. The frequency and duration of anxiety responses would also need to be recorded. This helps to identify specific cues to certain behaviours and also to determine improvement or deterioration. Treatment should address both his behavioural (e.g. social avoidance) and cognitive responses (e.g. believing that he will lose control and perhaps his life). This is because his beliefs continue to limit his ability to act.

After determining what causes and maintains certain behaviours, it is possible to develop a treatment plan together that specifies goals, what will need to be done to achieve those goals, how goal achievement will be measured, and a timeline for goal achievement. For example, George may set as his goal: being able to travel into the city in a car. A plan involving systematically working from sitting in a stationary car to driving short distances in the car, to travelling into the city, will need to be laid out. The plan will also need to indicate how many weeks or months this process will take.

Group therapy

Group therapy involves the engagement of two or more people in therapy at the same time. This mode of therapy is more cost-effective than individual therapies because more people can be treated at once. Group counselling is also more efficient if the group is composed of people with similar problems (the homogeneous group)—for example, a psychoeducational group for families of people with schizophrenia. However, efficiency and cost-effectiveness are not the most important reasons for engaging people in group therapy. There are immense benefits for clients who come together with others who are experiencing the same or similar difficulties. Often

the benefits are derived from interactions with others in the group rather than through the therapeutic efforts of the counsellor (Byrne & Byrne 1996).

There are as many approaches that can be taken in group therapy as there are for individual therapy (for example, see Cowan & Brunero (1997) for a nurse-led group in Australia). Group therapy provides an opportunity for people to explore their thoughts, feelings and behaviours and the impact they have on others. This is achieved through facilitation by the therapist/nurse therapist and through feedback from the other group members. Ultimately, learning occurs about relating to others. One thing that is certain is that almost everyone benefits from healthy interpersonal relationships. We are all social beings and we thrive on relating to others. An important outcome of any type of group is the relationships developed with others and the opportunity to learn better or more effective ways of relating.

Therapeutic groups can be divided into two main categories: general-purpose groups and problem-focused groups (Earley 2000). Addressing specific issues such as grief, sexual abuse or alcohol abuse is the goal of problem-focused groups. They aim to impart information and provide support to people in crisis and consequently are time limited. General-purpose groups attempt to facilitate deeper character change by addressing problems that arise from the interpersonal processes that occur in groups (Earley 2000). This involves the expression of transference and counter-transference as early relationships and customary interpersonal difficulties are re-enacted in the group with other group members. These processes occur unconsciously and interactions within the group provide opportunities for other group members or the therapist to gently make the person aware of what has been happening.

Yalom (1995) determined that there are 11 curative or therapeutic factors that occur in psychotherapy groups. When a psychotherapeutic group is working effectively, these curative factors are operating and group members are benefiting from them. The factors work interdependently—that is, they don't occur or function separately but interrelate with each other. The same factors operate in every type of group but their interplay and importance can vary widely from group to group. In addition, people from within the same group can benefit from differing clusters of therapeutic factors. These factors are:

- *Instilling of hope*—people are inspired by the improvements that others have made and the group provides opportunity for the therapist to point out the improvements people have made.
- *Universality*—entering a group enables people to see that they are not alone in their struggles. Hearing that others have the same difficulties is reassuring because people realise that their problems are not beyond solving.
- *Imparting information*—this might include learning about their illness or how to cope. Education might be an explicit or implicit part of the group.

- *Altruism*—in giving to and supporting others, group members also receive. Finding that they are valuable to others boosts self-esteem.
- *Corrective recapitulation of the family group*—the therapy group represents the family in many ways. This provides the opportunity to act out old family relationships and to recognise how earlier relationships continue to be acted out in current relationships.
- *Development of socialising techniques*—learning social skills might be an explicit part of the group or it may be more indirect, as people observe the socially acceptable behaviour of others.
- *Imitative behaviour*—group therapists influence the communication patterns in members by modelling certain behaviours such as self-disclosure or support.
- *Interpersonal learning*—the group becomes a social microcosm so that members are able to re-enact interpersonal behaviours typical of their lives outside the group. Feedback from others enables a person to see that their behaviours are responsible for their interpersonal difficulties.
- *Group cohesiveness*—cohesiveness is essential for the other curative factors to operate. It involves members feeling warmth and comfort in the group and feeling that they belong and are accepted and supported by others.
- *Catharsis*—this is the expression and mutual working through of strong emotions that have not been previously expressed. The group provides a safe environment for this to happen. Therefore, catharsis will only occur once group cohesiveness develops.
- *Existential factors*—these are the elements in the group process that help members to develop an understanding of their individual existences. This is more likely to occur in groups where there is a focus on thinking, talking and feeling.

Some of these factors are self-evident, while others are more subtle and take an understanding of psychotherapy to enable their facilitation and expression. Nevertheless,

when setting up a group therapy program, it is important to plan it well (Sharry 2001) and to consider the expectations or goals you have for the group. If you are the therapist you will need to decide whether it will be a closed group—that is, one that has a set number of members for a set period of time—or an open group. An open group allows different membership each time the group meets and the group membership at each session will determine to some extent the direction the group takes. Whichever type of group you facilitate, there will be a specific process of coming together or initial engagement, reaction and resistance to working, developing trust, working through issues, and termination or closure (Fehr 1999). In an open group, trust may take longer to develop as membership fluctuates.

Activity groups

Activity groups grew out of the perceived need to occupy people during the long hospital stays of the past. Ultimately, activity groups became a part of psychosocial rehabilitation programs and are also often part of an organised therapy program in psychiatric inpatient units today. While the task of organising an activity program has been taken on largely by occupational therapists, this role was historically a nursing responsibility. Given the amount of time that nurses spend with clients, nurses need to once again embrace this responsibility. Activity groups involve gathering together a group of people interested in a particular activity or those who need to develop skills in a particular area.

Examples of activity groups include those based on cooking skills, gardening, art, walking, newspaper discussion, reminiscence and games and sporting groups. Many inpatient psychiatric units hold daily ‘community meetings’ designed to engage clients in daily planning and organisation. Originally developed to help construct a therapeutic milieu—that is, a physical and emotional ward environment that is therapeutic and empowering for clients—these community groups might also be viewed as activity groups in some respects. Despite the perception that activity groups are not particularly challenging and that they only serve the purpose of

NURSE'S STORY: FACILITATING A GROUP

I used to facilitate a discharge planning group in an acute inpatient setting. This was an open group due to the nature of the rapid turnover of clients in this setting. While I might plan for a reasonably structured group with specific goals, the members inevitably determined the direction of the group. I always began with introductions and gave each person an opportunity to identify short- and long-term goals. I also attempted to discuss any concerns about medications, accommodation, family relationships, employment and money management. However, the acuity of the mental health problems of the group members dictated the issues addressed. For example, a group member with a bipolar mood disorder and somewhat elevated in mood will inevitably find it difficult to stay ‘on track’. As the group facilitator, it's important

to allow everyone to participate in the group. It may be necessary to gently point out the domination by a group member or to encourage others to have some say. Despite this challenge to the group process, it enables several of the curative factors to operate. These include and are probably not limited to: universality, instillation of hope, altruism, interpersonal learning and the development of socialising techniques. So, despite the concerns of nurses that group therapy might not be effective or appropriate in an acute inpatient setting, coupled with the challenges that these groups will pose, group therapy is valuable at a range of levels, not least of which is clients having the opportunity to relate more effectively with others.

keeping people occupied, many of Yalom's curative factors outlined above can operate. Not least of these are the development of socialising techniques and imitative behaviour.

Family therapy

Family therapy developed in the 1950s from the belief that the family was responsible for causing schizophrenia. In particular it was believed that certain communication styles within families were responsible for causing the illness (the skewed and schismatic families). A further belief centred on the communication style of the mother, the so-called schizophrenogenic mother. Although these ideas have long since been rejected, a group of interventions known as family therapy had been born (Goldenberg & Goldenberg 2000). Family therapy shifted the focus on therapy directed at unconscious material (psychotherapy) 'to a focus on the interpersonal process—that is, how family members interact with each other' (Kadis & McClendon 1998, p 6).

Family therapy is an approach to treatment that is based on the fundamental premise that when a person has a problem, it usually involves the whole family (Eisler et al 2007; Mellor, Storer & Firth 2000). Family interactions might be causing the problem or prolonging the problem for the identified client, or the problem or behaviours of the client might be affecting other members of the family. Family therapists aim to effect change in the entire family system. Family therapy usually involves multiple family members, not necessarily the same family members each time, or therapy might involve a single family member (Meech & Wood 2000).

Even when therapy involves a single individual, its impact will be experienced by the wider family. This might be demonstrated through an improvement in family functioning and/or through the alleviation of symptoms (Mellor et al 2000). Unlike individual therapists who believe that problems reside within the person, family therapists believe that 'the dominant forces within our lives are located externally, within the family' (Nichols & Schwartz 2001, p 6). Therapy concentrates on the family and the way it is organised. Ultimately this affects the lives of each family member in some way. That is, the whole system is affected.

Nichols & Schwartz (2001) maintain that family therapy is particularly useful in working with children who are having problems. This is because they are strongly influenced by the family and must remain within its influence. Marital problems, family feuds and difficulties that develop in people when there has been a major family transition, are also particularly amenable to family therapy. The role of the family therapist is to understand the dynamics that occur within families and then to help the family members to reconsider the ways in which they interact with each other. The family therapist then motivates the family members to change.

When working with families, the problem is viewed as dysfunction in the relationship between family

members. The relationship therefore becomes the focus of attention. Sometimes the person identified as 'the problem' behaves in that way in order to hold the family together. For example, consider the child who misbehaves when his or her parents begin fighting. The misbehaviour distracts the parents from their conflict and so further fighting is averted. The parents then work together to manage the child's problem behaviour. Ultimately the problem is not with the child but with the marital relationship.

The two-way mirror is a useful tool in family therapy. While there is a therapist in the room with the family, behind the mirror sit a number of other members of the team observing the therapy in progress. This allows immediate feedback, as the observers call in to the therapy room by telephone to give feedback or direction to the therapist and/or family. Observers may see things (communication styles, body language) that the therapist does not, so these can be communicated *during* the session rather than following it.

Another tool used in family therapy is the genogram, which is a graphic representation of the family and its patterns across generations. The genogram is drawn up with the involvement of the family, helping to engage all family members, as the mapping process seeks input from everyone. Enduring and broken relationships, illegitimate and legitimate children, blended and nuclear family relationships are all depicted on the same page, revealing the emotional processes of the family to both the therapist and the family members (McGoldrick, Gerson & Shellenberger 1999).

Psychoeducation

Initially designed to help families develop skills to understand and cope with a family member with schizophrenia, psychoeducation is now used with families with any type of problem, including families with relationship problems (Goldenberg & Goldenberg 2000). In the mental health field, psychoeducation refers to the provision of information about a person's mental illness to that person and/or his or her family. Psychoeducation grew out of the belief that people with mental illness, particularly those with schizophrenia, are vulnerable to stress and that excessive stress in the person's life is likely to exacerbate the illness—that is, too much stress will cause the person to become unwell or relapse. Therefore psychoeducation is considered an intervention designed to reduce the impact of the illness on the client. For example, it has been found to be effective in reducing the number and duration of relapses for clients with bipolar affective disorders (Colom et al 2003).

The early work of Brown (1958, cited in Bland 1986) claimed that some families contribute to stress through the ways they communicate and behave. These families were deemed to have high levels of expressed emotion (EE) and high EE was considered detrimental to the wellbeing of the client. Expressed emotion was originally defined as consisting of five constructs, including critical comments, hostility, emotional over-

CASE STUDY: BILL AND JOAN

Bill and Joan have been married for 30 years. Joan has a bipolar affective disorder and had been moderately depressed for around two years. At around the time that Joan became well, Bill was made redundant from his job after a very lengthy period of employment with the company. Bill had always been the breadwinner and the caregiver in the family. Now his wife was supporting him emotionally and was independent of him. This role transition resulted in a great deal of conflict in the family. Bill had difficulty adjusting to his new role and in accepting that his wife no

longer relied on him. Their teenage daughter blamed her mother for causing the conflict. Although Joan was being held responsible for the problems, no doubt due to her history of mental health problems, essentially the expected roles of family members had been reversed and there was now confusion about how to function. The therapy concentrated on the patterns of communication within the family and on accepting that Joan was now well and functioning in different and unexpected ways.

involvement, warmth and positive remarks (Jenkins & Karno 1992). Today, however, EE in families tends to be assessed only in terms of the first three, negative, constructs. The level of EE in families is determined through a face-to-face interview with family members, known as the Camberwell Family Interview. Once a family is deemed to indicate high EE, psychoeducation is considered the appropriate intervention.

Psychoeducation programs are usually run in multi-family groups over several weeks but may also be organised around the needs of individual families. The benefit of several families coming together in a group is the sharing of information, the support they provide each other and the experience of universality—that is, the recognition that they are not alone in having these problems. Supportive family education programs need to attempt to reinforce strengths and promote resilience. Psychoeducation will also enable families in particular to understand the medical jargon we use and to appreciate the experience from the perspective of others, including the consumer. A comprehensive psychoeducation program will provide information not only about the specific mental illness, but also about the available resources in the community, as well as information on and practice in applying problem-solving skills (Palmer 1996).

Families and consumers need to be provided with information about mental illness, just as they would if the diagnosis was a physical health problem. Indeed, Mullen, Murray & Happell (2002) argue that family interventions need to be considered ‘core business’ for mental health services. When there is an emphasis on providing information to support consumers and their families, they are more likely to benefit from the intervention. A collaborative approach that recognises the experiences of families and consumers and their unique knowledge of the disorder will convey to them that they are not to blame and that they have something to contribute to the overall care plan. Family problems need to be viewed as normal responses to very difficult situations that tax the family’s usual coping resources (Kavanagh 1992).

Providing psychoeducation to families is designed to alert them to the need to reduce stress at home and to change the ways in which they relate to the person with mental illness. This is thought to reduce relapse rates,

which is argued to be a cost-effective way of managing mental illness. Ultimately, though, the psychoeducation approach designed to reduce EE in families maintains a philosophy that families are responsible for the illness, or at least, responsible for contributing to hospitalisation and subsequent healthcare costs. While historically families were blamed for directly causing mental illness, the shift to assessing EE and providing psychoeducation can be seen as a more subtle form of blaming families. Families experience considerable burden in taking care of family members with mental illness in the community. This perception of responsibility for the client’s illness has the potential to add to that burden.

Psychosocial rehabilitation

Psychosocial rehabilitation is a treatment approach designed for people who are severely disabled by long-term mental illness. Most people with enduring mental health problems have a diagnosis of schizophrenia. However, many people with bipolar affective disorder and depression also have long-term needs (Ekdawi & Conning 1994). The cognitive and emotional problems experienced by people with enduring mental health problems result in social disability, which in turn results in their needing help and support to negotiate the social world (Perkins & Repper 1996). In line with the shift from inpatient to community mental healthcare, most psychosocial rehabilitation is now carried out in the community (see also Ch 2 for issues related to consumers, recovery and rehabilitation).

Psychosocial rehabilitation is the process of assisting people to tap into and learn the internal and external skills, supports and resources necessary to be successful (Vandevooren, Miller & O’Reilly 2007). Success is measured by the individual’s satisfaction in living, learning and working in the environment(s) of their choice. At its most basic level, psychosocial rehabilitation seeks to help people determine and prioritise their goals, identify the pathways for achieving these goals, and develop the necessary skills and supports to achieve these goals (Anthony, Cohen & Farkas 1991; Legere 2007). The concept of recovery from physical illness and disability does not mean that the suffering has disappeared, all the symptoms removed, and/or functioning completely restored. For example, as Deegan (1988) points out,

a person with paraplegia can recover even though the spinal cord cannot. Similarly, a person with mental illness can recover even though the illness is not cured. Recovery is what people with disabilities do. Treatment, case management and rehabilitation are what helpers do to facilitate recovery (Anthony 1993).

It is argued that before a person actively engages the rehabilitation services offered, they will need to have embarked on their personal journey of recovery (Anthony 1993). Psychosocial rehabilitation efforts designed to have a positive impact on severe mental illness can do more than leave the person less impaired, less dysfunctional, less disabled and less disadvantaged. These interventions can result in the person gaining more meaning, purpose, success and satisfaction with their life. Recovery outcomes include more subjective outcomes such as self-esteem, empowerment and self-determination.

Curtis (1997, p 16) has identified a number of recovery principles that, she argues, need to be reflected in the rehabilitation programs we offer:

- Recovery is an active, ongoing and individual process.
- Recovery is not linear; it entails growth, plateaus, setbacks, side tracks and fast tracks.
- Recovery relates not only to the experience of symptoms, but also to the secondary assaults of stigma, discrimination and abuse.
- Hope is the most fundamental factor in recovery.
- Recovery requires the presence of people who believe in and stand by the person.
- Recovery can occur without professional intervention.
- The establishment of a sense of control or free will is critical to recovery.
- ‘Remembering your track record’, or learning from observing your own mental and emotional behaviour, is critical to coping.
- Self-directed coping strategies are effective and can be learned.
- Maintaining or developing connections to valued activities and people is critical to the recovery process.

- Connecting with other people on a human level is important.
- Recovery is a process of ‘finding meaning in your experience’.

There are a number of possible stimulants to recovery. These may include other consumers who are in recovery or recovering effectively. Books, films and therapy groups may lead to unexpected insights into possible life options. Visiting new places and talking to various people are other ways in which the recovery process might be triggered. Critical to recovery is regaining the belief that there are options from which to choose, a belief perhaps even more important to recovery than the particular option one initially chooses (Curtis 1997). Therefore, we need to structure our settings so that recovery ‘triggers’ are present. Boring day treatment programs and inactive inpatient programs are characterised by a dearth of recovery stimulants (Anthony 1993). We need more creative programming. The strongest recovery-oriented programs identified to date are those that arise from and are operated by skilled consumer providers (Curtis 1997).

We cannot presume to know what a person hopes to achieve in life. We are all individual and have different desires and needs. As nurses, we may think we know what is best for a person, but this is at best naive and at worst paternalistic. Before engaging someone in rehabilitation services, it is important to find out what they hope to achieve. A rehabilitation program designed to be completed by everyone is unlikely to suit the needs of all consumers.

Instilling hope

There has been a great deal of research into what helps people with long-term mental illness to recover in such a way that they can live relatively normal and productive lives despite the re-emergence of symptoms of illness from time to time. It has been found that hope is considered fundamental before a person can embark on recovery. Curtis (1997) identified a number of factors considered critical to recovery reported by consumers. The factor that was ranked as the most important was

NURSE'S STORY: GOALS

Goals are integral to living. Without goals we merely react to what happens in our lives. I used to routinely invite into the classroom two people with bipolar affective disorder who lived independently in the community. They talked about their experiences with mental health services to groups of postgraduate nursing students. While one of these people valued himself according to his ability to remain employed, the other accepted that work was too stressful for him. He gained his sense of self-worth from his ability to be a good husband and a good father to his two young daughters. Although the two held different goals, their goals allowed each of them to survive and thrive in the community.

To help identify clients' goals I routinely started my inpatient pre-discharge group therapy sessions with introductions and a

request for people to identify their short-term and five-year goals. The goals were almost always quite different from each other. For some, at this stage of their illness, a five-year projection into the future was impossible. However, everyone has a dream and this should be tapped into, as dreams provide the impetus for goals. Further, it is not our place to decide whether the goals are realistic or not. If a goal seems unachievable, it might be wise to break it down into smaller and more achievable sub-goals. I would usually say, ‘That sounds like a great goal. What do you think you'll need to do to achieve that?’ From there, people are able to contemplate a way forward with something to live for and work towards.

having ‘just one person who believed in me’. This is one of the ingredients thought to be important in promoting a sense of hope. Morse & Penrod (1999) offer a process model for the development of hope following a critical life experience, such as being told that you have breast cancer or that you have a mental illness. This model was developed out of qualitative enquiry exploring emotional responses to the experience of illness.

The Morse & Penrod (1999) model has a number of overlapping phases that begin with a critical life event. People inevitably experience uncertainty, suffering, hope and the challenge of despair and, ultimately, the achievement of a ‘reformulated self’. At each of these phases, a different level of knowing or perceiving is experienced:

- *Enduring*—after a critical life experience we initially focus on cultivating our powers of endurance, which involves suspending or suppressing emotions and remaining in control. We do this because we worry that we will ‘lose it’ or disintegrate. The level of knowing here is awareness.
- *Uncertainty*—this is evident when we recognise what has happened and know what our goals are for the future, but we are unable to choose a course of action from a range of options. This state of uncertainty paralyses hope. At this time we simply exist in an emotional state and suffer as a result of not being able to act. When we are in a state of uncertainty, we have no other choice but to tolerate the present.
- *Suffering*—the level of knowing here is acknowledgement. We begin to grasp the situation and consequently suffer emotionally. Morse & Penrod (1999, p 148) comment that ‘the depth of the state of suffering is despair, utter hopelessness’. Out of this overwhelming emotional experience, we begin to piece together reality and develop a perception of the future. ‘This process of piecing together a new future begins in small incremental pieces, eventually building to . . . acceptance of the event and identification of both a goal and the means to attain it, which eventually leads to hope’ (Morse & Penrod 1999, p 148). So suffering is viewed as integral to moving on and ultimately to repair.
- *Hope*—the level of knowing is now acceptance and we become future-oriented. We are able to develop an action plan designed to achieve desired goals. When we have hope, we understand the reality of the event while also understanding the real possibility of negative outcomes. Indeed, ‘bracing for negative outcomes is a powerful motivating force for developing hope’ (Morse & Penrod 1999, p 148). Supportive relationships are now sought and hope is bolstered.
- *Reformulated self*—there is now a sense of becoming a ‘better person’ for having suffered. This state has been labelled the ‘reformulated self’,

where the past is accepted and we also accept that the future has been irrevocably changed and a choice is made to ‘make the most of life’.

Understanding the process involved in developing a sense of hope for one’s future is fundamental to helping nurses know how to respond to people during the phases of enduring, uncertainty and suffering. If these phases are acknowledged as normal or expected, we won’t make the mistake of attempting to force people to have hope when they are not ready to accept it. The trauma involved in dealing with a critical life experience, such as the diagnosis of a mental illness, results in a range of responses. These responses are part of a process that is not linear—we move back and forth between these phases. Understanding this may also explain the delays for some in developing hope. These are normal responses, and so should not be assessed as being part of an illness.

Deegan (1996, 1997) was diagnosed with schizophrenia at 17 years of age and is very clear about the need for health professionals to treat people with mental illness as human beings. Although this may seem like a simple thing to do, the medically dominant model of disease reinforces the notion of the person as illness. Deegan (1993, p 9) says: ‘it is as if the whole world has put on a pair of warped glasses that blind them to the person you are and leaves them seeing you as an illness’. Stocks (1995, cited in Hayne & Yonge 1997, p 319) agrees, saying, ‘once our personal identities are transformed into a psychiatric label, we are objects that are never allowed to be people again’.

It is clearly important to see the person as separate from the illness. However, there are many ways in which we maintain the view of the person as an illness. These include a tendency to focus predominantly upon problems, interpreting all behaviour as part of the illness, over-emphasising assessment, diagnosis and prognosis, and neglecting to consult the client (Palmer 1999). These are all things that are likely to stifle hope. If nurses cannot accept people with mental illness as human and social beings, who else in society will? After all, we are all human beings with unique abilities, shortcomings and, often, disabilities. We are all a psychological ‘work in progress’ and having a mental illness does not make one ‘weak’ or imperfect.

Social skills training

There are many types of skills training designed to improve problem-solving skills, relaxation skills, assertion skills and coping skills. Similarly, social skills can be learned. We are not born with them. How do you know how to greet someone in a culturally appropriate way? How do you know how to behave when you walk into a university classroom? These are behaviours that we take for granted and therefore tend not to think about before doing. They are also examples of social skills that we have learned as we were socialised into our culture. Much of this learning took place during childhood and adolescence, and so by adulthood we pretty much have these skills well developed.

However, if you develop a mental illness during childhood or adolescence, it is unlikely that you will develop sound social skills. Mental illness can distort communication with family members and peers, and the separations that ensue if a child or adolescent is hospitalised can disrupt family life, social life and schooling, where we learn many early social skills. If you develop a long-term mental disorder later in life, it is likely that you will have fewer opportunities to practise learned social skills, and if you don't use them, you will lose them. Social isolation often occurs for people with serious mental illness because of the stigma and discrimination that result and because it is harder to communicate with others when you have bizarre thoughts and experiences. These interfere with the ability to sustain relationships and develop new ones. Social skills deficits have also been shown to be related to poor vocational (work) outcomes for people with severe mental illness (Cheung, Tsang & Tsui 2006).

Much of the social skills training in mental health services focuses on working with people with schizophrenia (Bellack 2004). People with social phobia and depression are also often in need of social skills training (O'Donohue & Krasner 1995). Essentially, though, most people with mental health problems will have social and interpersonal problems as part of their overall picture. A lack of attention to social skills development may have a negative impact on social functioning (Saravanamuttu & Pyke 2003).

Social skills training is centred on teaching people the skills necessary to communicate effectively with others. There are some general approaches to teaching people social skills. As with most skills training packages, social skills training is usually carried out in groups. However, there are opportunities at almost every encounter to teach skills and to reinforce those skills already taught and being practised. When we role model appropriate social skills we provide opportunities for learning. However, O'Donohue & Krasner (1995) recommend using a model similar in presentation to the group members so that the behaviour has more relevance to them. That is, the role model for a group of adolescents learning how to present for a job interview should be an adolescent who has suffered similar life problems.

Most social skills training groups combine instruction, modelling, rehearsal or role playing as well as coaching, feedback and reinforcement. Rehearsal and role playing involve practising the skill once instruction has been provided. Coaching involves having an instructor or teacher help the group members to practise the skill accurately by giving feedback on performance and praise (positive reinforcement) when the skill is performed well. Homework is an essential component of training packages because without practice in the real world, the goal of improved social skills will never be achieved. That is, social skills are not simply taught, they are developed through practice and the more practice, the more socially able the person will be.

Interviewing

While the skill of interviewing might not strictly be considered an intervention, the nurse's interviewing style may have considerable impact on therapeutic outcomes. When you meet with a client to carry out a clinical interview, you need to engage or connect with that person in the same way that you might when being therapeutic. That is, it is important to develop rapport by being open, thoughtful, caring and honest, both verbally and non-verbally. Interviewing a person to attempt to find out what is happening is likely to be viewed as threatening if the approach taken is to fire off a list of questions that seek to arrive at a medical diagnosis. As part of the process of empowering people with mental illness, the assessment process (usually undertaken via clinical interview) needs to be collaborative and shared (see Ch 11).

It is the client who has the knowledge or information required for them to move towards identifying problems and planning care. As nurses, we currently ask questions from a power base rather than a discovery base. However, the client is the expert in his or her experience of mental illness, so we can share in the discovery of an understanding of the person's experience through the way in which we ask questions. At the outset, set the scene by letting the client know that your goal is to work together with them to arrive at some conclusion regarding what is going on at the moment. You might say something like, 'Let's talk about what is happening for you. You'd probably like to get a clearer idea of what is going on and I need to hear your story so that we can better know what to do next.' Ask questions that help people to understand themselves and, through this, also arrive at some understanding of what is happening. Asking questions that recognise the expertise of the client and summarising that information is a collaborative approach to guided discovery (Palmer 1999).

Case management

Case management describes a pattern of service delivery for clients based in the community that arose as a result of deinstitutionalisation, the term used to describe the return of people to live in the community rather than in psychiatric institutions. The *key worker* is often a nurse but can also be a social worker, an occupational therapist, psychologist or psychiatrist—that is, anyone from the multidisciplinary team. They are considered to have generic skills or a core group of skills that allow them to provide a particular service to clients with enduring mental health problems in the community. People with a long-term mental health problem, or whose mental illness causes them to require frequent admission to hospital, are usually assigned a key worker, sometimes without their consent. If a person does not accept the need for this type of supervision in the community, it may need to be enforced under a Mental Health Act order for community treatment. Most people, however,

agree to and welcome additional support in the community.

Staff who act as key workers deliver a range of services to clients including counselling, assistance with social and financial needs and supervision of medication (Johnston et al 1998). In Australia, the Medicare system of healthcare covers the cost of visits to GPs for the administration of intramuscular injections of antipsychotic medications, so this is usually not a requirement of key workers, although there may well be times when it is necessary (e.g. when a client refuses to visit a GP). In New Zealand, however, no such system exists, so key workers are also responsible for the administration of these medications. In addition, key workers are responsible for ongoing mental state assessment as well as risk assessment to ensure the person's safety and the safety of the community. Because case management is often carried out in the person's own home, there is often greater contact with family members and, therefore, greater opportunity to work with families.

Early models of case management had the client working through the key worker to access other services in the community. Although this seemed reasonable, it made the client dependent on the key worker. Today, the client is considered central and the key worker is just one form of community support. The client is encouraged and supported to access other community services independently. If, for example, the client seeks support in accessing social security services, the key worker would certainly be supportive. However, unless this help was requested, the key worker would expect the client to negotiate the community without support. The responsibility of the key worker might be to teach the negotiation and social skills necessary to do this independently. This model of case management supports consumer empowerment through partnership (Howgego et al 2003).

Routine case management usually involves caseloads or numbers of clients of around 30–40 per case manager. For the more seriously disabled, there are now teams that provide intensive case management. This involves low client numbers with ratios of around 8–10 people per key worker. A cost-effectiveness analysis carried out in Sydney (Johnston et al 1998) comparing the cost of routine case management with

intensive case management revealed that there were greater improvements in functioning and higher rates of engagement in treatment in the intensive case management group. However, it costs considerably more for this type of support and, for this study, there was no reduction in hospital use after 12 months of intensive case management. Importantly, though, the routine case management group required four times as many visits from the community crisis team. This means that clients who have limited key worker support inevitably require more support from the community crisis team. Therefore, this study suggests that people with enduring mental illness require more intensive support than we realise, so cost savings are not realised.

A word of caution: the term 'case management' carries with it certain messages. It implies that people are cases that require *managing*. These words are loaded towards paternalism at a time when we are encouraged to view consumers/clients/service users as active participants in their own care and in their recovery from mental illness. The term 'case management' was used here because it is a term used universally, but the term 'key worker' better describes the role of the 'case manager', and is less paternalistic.

Electroconvulsive therapy

Invented in 1938 in Italy by two eminent psychiatrists (Ugo Cerletti and Lucio Bini), electroconvulsive therapy was investigated at a time when a number of physical treatments were developed, including insulin coma therapy, metrazole convulsive therapy and psychosurgery. Electroconvulsive therapy (ECT) is the only one of these treatments used routinely today. Much of the controversy surrounding ECT grew out of its initial indiscriminate use and abuse. At first ECT was used without anaesthetic or muscle relaxation, with many adverse effects such as fractures, pain and cardiovascular problems.

Today, however, once a person is considered a candidate for ECT, that is, the person has an illness that may respond well to ECT, a full psychological and physical assessment is carried out. Wherever possible, consent for treatment is sought from the client. If this is not possible, the Mental Health Acts in Australia and

NURSE'S STORY: THE THERAPEUTIC ENCOUNTER

As a key worker in the community, most of my time with people was spent talking through any current concerns, from weight gain to marital difficulties. These are the personal issues that contribute to difficulties in living and they are the mental health issues that we all experience and need an active listener for. However, most of us don't have the additional burden of a serious mental illness. The therapeutic encounter is designed to provide support and to enable people to solve their problems through exploring their difficulties in greater depth. When a person has a recurrence of

symptoms, we attempt to manage them (the symptoms) together in the community with more frequent visits and telephone contact. Whenever someone required hospitalisation, I would liaise with staff working in the ward and visit the person there throughout the hospitalisation. I was also involved in discharge planning and family meetings. This clearly communicated to people that I was there with them throughout the ordeals that they experienced. This is particularly important if you, as the nurse, were responsible for effecting their admission in the first place.

CULTURAL NOTE

Because of the bicultural nature of New Zealand, there are Kaupapa Māori mental health services designed to meet the specific needs of Māori consumers (tangata whaiora). Kaupapa Māori services are Māori working with Māori. In addition to being assigned a clinical key worker in these services, each client is usually also assigned a cultural worker. This ensures that cultural protocols are observed and cultural needs are addressed. This arrangement is also in place in designated mental health services for Pacific Island people.

New Zealand allow for treatment to proceed, but only pending wider consultation in Australia. Section 62 of the New Zealand *Mental Health (Assessment and Treatment) Act 1992 (1993)* allows the administration of ECT without consent only if it is considered necessary in order to save the person's life or to prevent serious damage to the person's health.

Electroconvulsive therapy involves the application of two metal electrodes to the head, through which an electric current is delivered. The electrodes can be applied either bilaterally (one on each side of the head, usually in the frontotemporal region) or unilaterally (both on the same side of the head). Whether applied bilaterally or unilaterally, the treatment is almost equally effective. However, different adverse effects can be experienced. According to Endler & Persad (1988, p 26), 'unilateral ECT to the non-dominant hemisphere is less stressful for the patient than bilateral; it minimises confusion and memory loss; and it is almost as efficacious as bilateral in terms of alleviating the symptoms of depression'.

Indeed, in a more recent study, high-dosage right unilateral ECT showed an equivalent response rate (Sackeim et al 2000). This study also supported other findings that bilateral ECT results in greater impairment in memory (both anterograde and retrograde amnesia). These authors concluded that: 'right unilateral ECT at high dosage is as effective as a robust form of bilateral ECT, but produces less severe and persistent cognitive effects' (Sackeim et al 2000, p 425). And, in response to concerns about the effects of ECT on cerebral function, a study by Ende et al (2000, p 941) found evidence that ECT does not cause tissue damage and that 'there is no hippocampal atrophy, neuronal damage, or cell death induced by ECT'. Nevertheless, ECT has been found to cause memory impairment that cannot be attributed to the original illness state (MacQueen et al 2007; Watkinson 2007).

Electroconvulsive therapy is widely accepted as an effective intervention in the treatment of severe depression, although it remains controversial (Persad 2001). There is contention not only among the public regarding ECT (Teh, Helmes & Drake 2007), but also within the mental health professions, as many professionals question its efficacy (Barker 2003; Challiner & Griffiths 2000). However, recent publications support earlier conclusions that antidepressants and ECT are effective

and safe treatments for depressed elderly patients (Salzman, Wong & Wright 2002) and for people who are suicidal (Persad 2001).

In the past, ECT has been used to treat a wide range of mental disorders, including schizophrenia. An examination of both older and more recent research has revealed that ECT is as effective as antipsychotic medications in the treatment of schizophrenia, particularly with people experiencing an acute episode. When used in combination with antipsychotic medications, it has been found to be more effective than ECT or medication used alone (Keuneman, Weerasundera & Castle 2002).

Whether conducted in a general theatre or a specialised ECT suite attached to the inpatient psychiatric unit, ECT remains a physically intrusive treatment that requires specialised nursing skills. Generally, though, the role of the nurse in working with a person preparing for ECT is to support the person and to prepare them for the procedure, both physically and psychologically, just as you would for any procedure requiring a general anaesthetic. Other responsibilities for the nurse are also the same as for any operative procedure conducted under general anaesthesia. For example, you may be required to provide close observation to ensure that the client does not eat or drink prior to the procedure. You would also need to make certain that make-up and jewellery have been removed. These are basic safety measures to prevent complications and to ensure an accurate assessment of skin colour during the anaesthetic.

Electroconvulsive therapy remains a controversial intervention in psychiatry today. Much of this controversy stems from the historical use of ECT and from its representation in films such as *One Flew Over the Cuckoo's Nest* (Vermeulen 1999). This is despite substantial research and descriptive evidence testifying to its effectiveness. Those who have not observed ECT and who base their understandings on historical and media representations of it are likely to be surprised at how innocuous it is. A positive attitude to ECT has been found to be directly related to greater exposure to and knowledge about ECT (Endler & Persad 1988; Gass 1998). Nevertheless, concern persists because we are not entirely certain how ECT works and because of the cognitive side effects experienced. Ultimately, clients and families still express fears about the long-term effects on brain function.

Conclusion

This chapter has given some fundamental information about a number of therapeutic intervention strategies that will assist you in being with and working with people with mental illness. Some of these intervention strategies apply to specific situations or client difficulties but there is always a way of working effectively with people experiencing challenging mental health problems. Some are more technical than others and require further education and practice to master. But many of the skills outlined here can be learned and applied to the

NURSE'S STORY: ECT

A woman in her mid-thirties with whom I had worked many years ago left a lasting impression on me regarding the efficacy of ECT. She was a very attractive woman with a supportive husband and two young children. However, she suffered from major depression. When depressed she experienced feelings of hopelessness and delusions of worthlessness. She believed that she was so worthless that her family would be better off without her and that we really shouldn't bother helping her. As with any delusion, her thoughts could not be countered.

She began treatment with ECT at the usually prescribed rate of three times each week. She had a very quick recovery and I recall her saying to us not long before she was discharged home, 'Thank

you for keeping me alive until I got well'. She was also overheard recommending ECT to other depressed clients in the hospital.

This was a very important lesson for me as a mental health nurse. I was able to see someone move from a very distressed and debilitated state. She had been profoundly suicidal, but came to find pleasure in her life again following ECT. While ECT has the usual risks associated with a general anaesthetic, the risk of suicide from major depression seemed to be far greater for this woman. Every person needs individual assessment when making clinical decisions about treatment and certainly current ECT research has been more explicit in relation to its adverse effects, but this experience and many others testify to its continued utility.

interactions you will experience now as a novice nurse and later, as your experience develops.

Novice nurses have frequently expressed their concern to me that they might 'say the wrong thing' and make the situation more challenging for the client. If you take a caring and thoughtful approach that avoids the generous delivery of advice, it is unlikely that you will cause harm. However, if you take with you some specific skills and models for your practice, you are likely to feel more confident and to understand the goals of your interaction. It is also hoped that, through reading this chapter, you have developed a sense of the importance of treating people with mental health problems as valid human beings who require your support and help through a particularly troubling time.

EXERCISES FOR CLASS ENGAGEMENT

A number of exercises are presented here to help you to engage with and consolidate what you have learned from this chapter. You should discuss the issues raised with your group or class members. Some of these activities also ask you to reflect on your personal values, beliefs and actions so that this greater insight into yourself will help you to be more effective in your interactions with others.

- What are the main stressors in your life? Consider relationship problems, difficulties with children, problems with parents, financial worries, physical conditions, environmental factors, study pressures, work factors, nutrition and exercise, in addition to chemical factors such as nicotine, alcohol, caffeine and other substances. Identify those that you can learn to manage and list the stressors in terms of their importance or greatest impact.
- Using the written text from a book or an audiotape, follow the instructions for carrying out progressive muscle relaxation. Were you able to relax? What effect did the exercise have on your respiratory and heart rates?
- Which of the assertion skills (making requests, refusing requests, accepting and giving compliments, expressing opinions, giving negative feedback or being confrontational, initiating conversations, sharing intimate feelings and experiences with others and expressing affection) do you find difficult to manage? Why do you think this is? Of the situations that you find difficult to manage, which one in particular presents the greatest

challenge to you? How do you feel whenever you fail to manage these situations assertively?

- Consider the kinds of life events that might cause an individual to experience crisis, such as rape, loss of a job, unplanned pregnancy, or death of a loved one. How would you respond to being admitted to hospital for colorectal surgery? How would you respond to being admitted involuntarily to an acute psychiatric unit?
- Mark is a 25-year-old single male. He has just been diagnosed with genital herpes and is extremely distressed. Although he is intelligent and has coped well with previous life crises and has good relationships with family and friends, he feels so ashamed that he can't discuss this with anyone he knows well. He believes that life is no longer worth living as he believes he will never have a normal sex life or a meaningful relationship again. What do you make of Mark's perception of his problem? Which interventions do you think are necessary according to Aguilera's model for crisis intervention?
- What are your short-term goals (that is, what do you hope to achieve over the next few weeks or months)? What is your main five-year goal? What will you need to do over the next five years to achieve that goal? What is likely to interfere with your achievement of that goal? What is likely to support your achievement of that goal?
- As a group, rent and watch a DVD/video of *One Flew Over the Cuckoo's Nest*. What stereotypes are portrayed in this movie? Which of these persist today? How does the portrayal of ECT in this movie make you feel about ECT? In addition, what are your thoughts about the nurse-patient and doctor-patient relationships as portrayed for that era? How do you think a movie made today would portray these things?
- Consider your values concerning health and wellness as well as self-determination. What issues might arise for you if you were responsible for preparing a client for ECT against that person's wishes? How would you deal with this situation?

References

- Abderhalden C, Needham I, Miserez B 2004 Predicting inpatient violence in acute psychiatric wards using the Broset Violence Checklist: a multicentre prospective cohort study. *Journal of Psychiatric and Mental Health Nursing* 11(4):422-427

- Aguilera D 1994 *Crisis intervention: theory and methodology*, 7th edn. Mosby, St Louis
- Anthony W A 1993 Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal* 16(4):11–23
- Anthony W A, Cohen M, Farkas M 1991 *Psychiatric rehabilitation*. Centre for Psychiatric Rehabilitation, Boston
- Ayers C R, Sorrell J T, Thorp S R et al 2007 Evidence-based psychological treatments for late-life anxiety. *Psychology and Aging*, 22(1):8–17
- Barker P 2003 Barker's beat. *Mental Health Practice* 6(10):38–39
- Barker P J, Fraser D (eds) 1985 *The nurse as therapist: a behavioural model*. Croom Helm, London
- Barlow J H, Ellard D R, Hainsworth J M et al 2005 A review of self-management interventions for panic disorders, phobias and obsessive-compulsive disorders. *Acta Psychiatrica Scandinavica* 111(4):272–285
- Battison T 1997 *Beating stress*. Allen & Unwin, London
- Bellack A S 2004 Skills training for people with severe mental illness. *Psychiatric Rehabilitation Journal* 27(4):375–391
- Blackburn I, Davidson K 1990 *Cognitive therapy for depression and anxiety*. Blackwell Scientific, New York
- Bland R 1986 Family Support Program. Occasional Paper 86(1). University of Queensland, Brisbane
- Bloom B L 1997 *Planned short-term psychotherapy: a clinical handbook*, 2nd edn. Allyn & Bacon, Boston
- Brown M, Marshall K 2006 Cognitive behavioural therapy and people with learning disabilities: implications for developing nursing practice. *Journal of Psychiatric and Mental Health Nursing* 13(2):234–241
- Butterworth S, Linden A, McClay W et al 2006 Effect of motivational interviewing-based health coaching on employees' physical and mental health status. *Journal of Occupational Health Psychology* 11(4):358–365
- Byrne J, Byrne D G 1996 *Counselling skills for health professionals*. MacMillan Education, Melbourne
- Byrne A, Watson R, Butler C et al 2006 Increasing the confidence of nursing staff to address the sexual health needs of people living with HIV: the use of motivational interviewing. *AIDS Care* 18(5):501–504
- Calvert P, Palmer C 2003 Application of the cognitive therapy model to initial crisis assessment. *International Journal of Mental Health Nursing* 12(1):30–38
- Carels R A, Darby L, Cacciapaglia H M et al 2007 Using motivational interviewing as a supplement to obesity treatment. *Health Psychology* 26(3):369–374
- Challiner V, Griffiths L 2000 Electroconvulsive therapy: a review of the literature. *Journal of Psychiatric and Mental Health Nursing* 7(3):191–198
- Cheung L C C, Tsang H W H, Tsui C U 2006 A job-specific social skills training program for people with severe mental illness: a case study for those who plan to be a security guard. *Journal of Rehabilitation* 72(4):14–23
- Clark M D, Walters S, Gingerich R et al 2006 Motivational interviewing for probation officers: tipping the balance toward change. *Federal Probation* 70(1):38–44
- Colom F, Vieta E, Martinez-Aran A et al 2003 A randomised trial on the efficacy of group psychoeducation in the prophylaxis of recurrences in bipolar patients whose disease is in remission. *Archives of General Psychiatry* 60(4):402–407
- Cowan D, Brunero S 1997 Group therapy for anxiety disorders using rational emotive behaviour therapy. *Australian and New Zealand Journal of Mental Health Nursing* 6(4):164–168
- Curtis L 1997 New directions: international overview of best practices in recovery and rehabilitation services for people with serious mental illness. New Zealand Mental Health Commission, Wellington
- Cutcliffe J R, Barker P 2004 The nurses' global assessment of suicide risk (NGASR): developing a tool for clinical practice. *Journal of Psychiatric and Mental Health Nursing* 11(4):393–400
- Dattilio F M, Padesky C A 1990 *Cognitive therapy with couples*. Professional Resource Exchange Inc., Sarasota, Florida
- Davis C M 1989 *Patient-practitioner interaction*. Slack, Thorofare, New Jersey
- Davis M, Robbins Eshelman E, McKay M 2000 *The relaxation and stress reduction workbook*, 5th edn. New Harbinger, Oakland, California
- Deegan P 1988 Recovery: the lived experience of rehabilitation. *Psychosocial Rehabilitation Journal* 11(4):11–19
- Deegan P 1993 Recovering our sense of value after being labelled mentally ill. *Journal of Psychosocial Nursing* 31(4):7–11
- Deegan P 1996 Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal* 19(3):91–97
- Deegan P E 1997 Recovery and empowerment for people with psychiatric disabilities. *Social Work in Health Care* 25(3):11–24
- Doyle M, Dolan M 2002 Violence risk assessment: combining actuarial and clinical information to structure clinical judgements for the formulation and management of risk. *Journal of Psychiatric and Mental Health Nursing* 9(6):649–657
- Earley J 2000 *Interactive group therapy: integrating interpersonal, action-oriented, and psychodynamic approaches*. Brunner/Mazel, Philadelphia
- Edwards D, Hannigan B, Fothergill A et al 2002 Stress management for mental health professionals: a review of effective techniques. *Stress and Health* 18(5):203–215
- Egan G 1998 *The skilled helper: a problem-management approach to helping*, 6th edn. Brooks/Cole, Pacific Grove, California
- Eisler I, Simic M, Russell G F M et al 2007 A randomised controlled treatment trial of two forms of family therapy in adolescent anorexia nervosa: a five-year follow-up. *Journal of Child Psychology and Psychiatry* 48(6):552–560
- Ekdawi M Y, Conning A M 1994 *Psychiatric rehabilitation: a practical guide*. Chapman & Hall, London
- Ende G, Braus D F, Walter S et al 2000 The hippocampus in patients treated with electroconvulsive therapy: a proton magnetic resonance spectroscopic imaging study. *Archives of General Psychiatry* 57(10):937–943
- Endler N S, Persad E 1988 *Electroconvulsive therapy: the myths and the realities*. Hans Huber, Toronto
- Escot C, Artero S, Gandubert C et al 2001 Stress levels in nursing staff working in oncology. *Stress and Health* 17(5):273–279

- Evans A M 2007 Transference in the nurse–patient relationship. *Journal of Psychiatric and Mental Health Nursing* 14 (2):189–195
- Fehr S S 1999 Introduction to group therapy: a practical guide. Haworth Press, New York
- Finnell D S 2003 Use of the transtheoretical model for individuals with co-occurring disorders. *Community Mental Health Journal* 39(1):3–15
- Freud S 1938/1965 The basic writing of Sigmund Freud. Modern Library, New York
- Gallop R, O'Brien L 2003 Re-establishing psychodynamic theory as foundational knowledge for psychiatric/mental health nursing. *Issues in Mental Health Nursing* 24(2):213–227
- Gambril E 1995 Assertion skills training. In: O'Donohue W, Krasner L (eds) *Handbook of psychological skills training: clinical techniques and applications*. Allyn & Bacon, Boston
- Gass J P 1998 The knowledge and attitudes of mental health nurses to electroconvulsive therapy. *Journal of Advanced Nursing* 27(1):83–90
- Goldenberg I, Goldenberg H 2000 Family therapy: an overview, 5th edn. Brooks/Cole, Belmont, California
- Greenstone J L, Leviton S C 2002 Elements of crisis intervention: crises and how to respond to them, 2nd edn. Brooks/Cole, Pacific Grove, California
- Hayne Y, Yonge O 1997 The lifeworld analysis of the chronically mentally ill: an analysis of 40 written personal accounts. *Archives of Psychiatric Nursing* 11(6):314–324
- Health and Disability Commissioner 2002 Southland District Health Board Mental Health Services February–March, 2001: a report by the Health and Disability Commissioner. Health and Disability Commissioner, Auckland, New Zealand
- Howego I M, Yellowles P, Owen C et al 2003 The therapeutic alliance: the key to effective patient outcome? A descriptive review of the evidence in community mental health case management. *Australian and New Zealand Journal of Psychiatry* 37(2):169–183
- Jenkins J H, Karno M 1992 The meaning of expressed emotion: theoretical issues raised by cross-cultural research. *American Journal of Psychiatry* 149(1):9–21
- Johnston S, Salkeld G, Sanderson K et al 1998 Intensive case management: a cost-effectiveness analysis. *Australian and New Zealand Journal of Psychiatry* 32:551–559
- Kadis L B, McClendon R 1998 Concise guide to marital and family therapy. American Psychiatric Press, Washington
- Kavanagh D J 1992 Recent developments in expressed emotion and schizophrenia. *British Journal of Psychiatry* 160:601–620
- Kelly T, Simmons W, Gregory E 2002 Risk assessment and management: a community forensic mental health practice model. *International Journal of Mental Health Nursing* 11(4):206–213
- Keuneman R, Weerasundera R, Castle D 2002 The role of ECT in schizophrenia. *Australasian Psychiatry* 10(4):385–388
- Knight K M, McGowan L, Dickens C et al 2006 A systematic review of motivational interviewing in physical health care settings. *British Journal of Health Care Psychology* 11(2):319–332
- Legere L 2007 The importance of rehabilitation. *Psychiatric Rehabilitation Journal* 30(3):227–229
- Lester D 2002 Crisis intervention and counselling by telephone, 2nd edn. Charles C Thomas, Springfield, Illinois
- Linehan M M 1993 Cognitive behaviour therapy of borderline personality disorder. Guilford Press, New York
- Linehan M M, Schmidt H, Dimeff L A et al 1999 Dialectical behaviour therapy for patients with borderline personality disorder and drug-dependence. *American Journal on Addictions* 8:279–292
- McGoldrick M, Gerson R, Shellenberger S 1999 Genograms: assessment and intervention, 2nd edn. W W Norton, New York
- MacQueen G, Parkin C, Marriott M et al 2007 The long-term impact of treatment with electroconvulsive therapy on discrete memory systems in patients with bipolar disorder. *Journal of Psychiatry and Neuroscience* 32(4):241–249
- Mannix K, Blackburn I M, Garland A et al 2006 Effectiveness of brief training in cognitive behaviour therapy techniques for palliative care practitioners. *Palliative Medicine* 20(6):579–584
- Meech C, Wood A 2000 Reconnecting past, present and future lives: therapy with a young person who experienced severe childhood privation. *Australian and New Zealand Journal of Family Therapy* 21(2):102–107
- Mellor D, Storer S, Firth L 2000 Family therapy into the 21st century: can we work our way out of the epistemological maze? *Australian and New Zealand Journal of Family Therapy* 21(3):151–154
- Mental Health (Assessment and Treatment) Act (1992) 1993*, New Zealand Government, Wellington
- Mental Health Commission 1998 Report on the present state of clinical risk management in mental health services. Documentation provided Crown Health Enterprises, Mental Health Commission, Wellington, New Zealand
- Miller W 1998 Toward a motivational definition and understanding of addiction. *Motivational Interviewing Newsletter* 5(3):2–6
- Miller W R, Zweben A, DiClemente C C et al 1992 Motivational enhancement therapy manual: a clinical research guide for therapists treating individuals with alcohol abuse and dependence. National Institute on Alcohol Abuse and Alcoholism, Rockville
- Monahan J, Steadman H J, Silver E et al 2001 Rethinking risk assessment: the MacArthur Study of Mental Disorder and Violence. Oxford University Press, Oxford
- Morse J, Penrod J 1999 Linking concepts of enduring, uncertainty, suffering, and hope. *Image: Journal of Nursing Scholarship* 31(1):145–150
- Mullen A, Murray L, Happell B 2002 Multiple family group interventions in first episode psychosis: enhancing knowledge and understanding. *International Journal of Mental Health Nursing* 11:225–232
- Mullen P 2002 Marijuana and mental illness. Paper presented at the Mental Health Services Conference Inc. of Australia and New Zealand (The MHS), Sydney, 21 August
- Murphy N 2004 An investigation into how community mental health nurses assess the risk of violence from

- their clients. *Journal of Psychiatric and Mental Health Nursing* 11(4):407–413
- Murray B L, Wright K 2006 Integration of a suicide risk assessment and intervention approach: the perspective of youth. *Journal of Psychiatric and Mental Health Nursing* 13(2):157–164
- Myer R A 2001 Assessment for crisis intervention: a triage assessment model. Wadsworth, Toronto
- Myhr G, Payne K 2006 Cost-effectiveness of cognitive-behaviour therapy for mental disorders: implications for public health care funding policy in Canada. *Canadian Journal of Psychiatry* 51(10):662–670
- Nichols M P, Schwartz R C 2001 Family therapy: concepts and methods, 5th edn. Allyn & Bacon, Boston
- O'Donohue W, Krasner L 1995 Handbook of psychological skills training: clinical techniques and applications. Allyn & Bacon, Boston
- Padesky C A, Mooney K A 1990 Presenting the cognitive model to clients. *International Cognitive Therapy Newsletter* 6:6–7
- Palmer C J 1996 Education and support for families and friends of people with schizophrenia. Masters dissertation. Queensland University of Technology, Brisbane
- Palmer C J 1999 Recovery-focused mental health nursing: a model for the future? Paper presented at the Scientific Meeting of the Australian and New Zealand College of Mental Health Nurses (ANZCMHN), Tasmania, 9–12 September
- Patel C 1991 The complete guide to stress management. Plenum Press, New York
- Perkins R E, Repper J M 1996 Working alongside people with long term mental health problems. Chapman & Hall, London
- Persad E 2001 Electroconvulsive therapy: the controversy and the evidence. *Canadian Journal of Psychiatry*, 46(8):702–703
- Petchkovsky L, Morris P, Rushton P 2002 Choosing a psychodynamic psychotherapy model for an Australian public sector mental health service. *Australasian Psychiatry* 10(4):330–334
- Prochaska J O 2001 Treating entire populations for behaviour risks for cancer. *Cancer Journal* 7(5):360–368
- Prochaska J O, DiClemente C C 1983 Stages and processes of self-change of smoking: toward an integrative model of change. *Journal of Consulting and Clinical Psychology* 51(3):390–395
- Rausch S M, Gramling S E, Auerbach S M 2006 Effects of a single session of large-group meditation and progressive muscle relaxation training on stress reduction, reactivity, and recovery. *International Journal of Stress Management* 13(3):273–290
- Rodrigues L J 2007 A closer look: the benefits and effectiveness of CBT on a female-specific unit for treatment of bipolar disorder. *Issues in Mental Health Nursing* 28(5):533–542
- Rollnick S, Miller W R 1995 What is motivational interviewing? *Behavioural and Cognitive Psychotherapy* 23:325–334
- Romas J A, Sharma M 1995 Practical stress management. Allyn & Bacon, Boston
- Rosser S, Erskine A, Crino R 2004 Pre-existing antidepressants and the outcome of group cognitive behaviour therapy for social phobia. *Australian and New Zealand Journal of Psychiatry* 38(4):233–239
- Sackeim H A, Prudic J, Devanand D P et al 2000 A prospective, randomised, double-blind comparison of bilateral and right unilateral electroconvulsive therapy at different stimulus intensities. *Archives of General Psychiatry* 57(5):425–434
- Salzman C, Wong E, Wright B C 2002 Drug and ECT treatment of depression in the elderly, 1996–2001: a literature review. *Biological Psychiatry* 52(3):265–284
- Sanders P 1996 An incomplete guide to using counselling skills on the telephone, 2nd edn. PCCS Books, Manchester
- Saravanamuttu R, Pyke J 2003 Interaction: case managers and social skills teaching. *Psychiatric Rehabilitation Journal* 27(1):79–82
- Simple C J, Dunwoody L, Sullivan K et al 2006 Patients with head and neck cancer prefer individualised cognitive behaviour therapy. *European Journal of Cancer Care* 15(3):220–227
- Sharry J 2001 Solution-focused groupwork. Sage, London
- Slaikeu K A 1990 Crisis intervention: a handbook for practice and research, 2nd edn. Allyn & Bacon, Boston
- Sundel S S, Sundel M 1993 Behaviour modification in the human services: a systematic introduction to concepts and applications, 3rd edn. Sage, Newbury Park, California
- Swales M, Heard H L, Williams J M G 2000 Linehan's dialectical behaviour therapy (DBT) for borderline personality disorder: overview and adaptation. *Journal of Mental Health* 9(1):7–23
- Teh S P C, Helmes E, Drake D G 2007 A Western Australian survey on public attitudes toward and knowledge of electroconvulsive therapy. *International Journal of Social Psychiatry* 53(3):247–273
- Timmins F, McCabe C 2005 Nurses' and midwives' assertive behaviour in the workplace. *Journal of Advanced Nursing* 51(1):38–45
- Treasure J, Sepulveda A R, Whitaker W et al 2007 Collaborative care between professionals and non-professionals in the management of eating disorders: a description of workshops focused on interpersonal maintaining factors. *European Eating Disorders Review* 15(1):24–34
- Truax P 2002 Behavioural case conceptualisation for adults. In: Hersen M (ed) *Clinical behavioural therapy: adults and children*. John Wiley & Sons, New York
- Vandevoreen J, Miller L, O'Reilly R 2007 Outcomes in community-based residential treatment and rehabilitation for individuals with psychiatric disabilities: a retrospective study. *Psychiatric Rehabilitation Journal* 30(3):215–217
- Varcarolis E M 1998 Foundations of psychiatric-mental health nursing, 3rd edn. WB Saunders, Philadelphia
- Vermeulen J 1999 A personal reflection by a psychiatric nurse: electroconvulsive therapy: history, perception, knowledge and attitudes. Paper presented at the Scientific Meeting of the Australian and New Zealand College of Mental Health Nurses (ANZCMHN), Launceston Tasmania, 9–12 September
- Vos T, Gorry J, Haby M M et al 2005 Cost-effectiveness of cognitive behavioural therapy and drug interventions for major depression. *Australian and New Zealand Journal of Psychiatry* 39(8):683–692

Watkinson A 2007 ECT: a personal experience. *Mental Health Practice* 10(7):32–35

Watson R J, McDonald J, Pearce D C 2006 An exploration of national calls to Lifeline Australia: social support or urgent suicide intervention? *British Journal of Guidance and Counselling* 34(4):471–482

Wolpow S 2000 Adapting a dialectical behaviour therapy (DBT) group for use in a residential program. *Psychiatric Rehabilitation Journal* 24(2):135–141

Yalom I D 1995 *The theory and practice of group psychotherapy*, 4th edn. Basic Books, New York



ELSEVIER