An introduction to psychological interventions

Grahame Smith

Chapter aim and objectives

Aim

- To provide a contextualized overview of the book.

Objectives

- To define the term psychological interventions and its relationship to collaboration, risk and making sense of the evidence.
- To provide a chapter-by-chapter overview.

Psychological interventions in context

This book is primarily aimed at pre-registration mental health nursing students, though aspects of the book will be just as useful to other health-care students or professionals who are looking for specific information about how to care for individuals with mental health needs. Qualified mental health nurses as well as other mental health professionals who want to want to refresh their knowledge-base may also find this book useful.

The core idea for this book stems from recognizing mental health nurses’ increasing use of psychological therapies within their practice (Department of Health, 2006a; 2006b; Callaghan, 2009; Norman and Ryrie, 2009). So why not write a book about a psychological therapy or about a number of psychological therapies rather than focusing on a more nebulous topic such as psychological interventions? Well this book is based on the premise that the core work of the mental health nurse is to deliver a variety of psychological interventions, some of which are framed by a specific therapeutic approach but most are eclectically taken from a number of therapeutic approaches (Paley and Shapiro, 2001; Department of Health, 2006a; 2006b; Callaghan, 2009). This eclectic approach to the use of psychological interventions starts during the mental health nurse’s pre-qualifying journey and usually continues throughout a mental health nurse’s career, though of course some mental health nurses may go on to specialize in the use of a specific psychological therapy (Paley and Shapiro, 2001; Department of Health, 2006b). This book is, therefore, intended to assist the pre-registration mental health nurse in this developmental journey by providing a good
2 PSYCHOLOGICAL INTERVENTIONS IN MENTAL HEALTH NURSING

grounding in the use of psychological interventions (Department of Health, 2006b; Callaghan, 2009; Nursing and Midwifery Council, 2010). It will signpost to a specific psychological therapy where appropriate, but it is not a replacement for the number of excellent texts available for mental health nurses that deal with the delivery of a specific psychological therapy.

What is a psychological intervention? For the purposes of this book a psychological intervention is broadly understood as a mental health nursing intervention which is underpinned by psychological methods and theory. It also has the intention of improving biopsychosocial functioning and it is usually delivered via a therapeutically structured relationship (Paley and Shapiro, 2001; Hurley and Rankin, 2008; Thompson et al., 2008; Department of Health, 2006a; Callaghan, 2009; Gournay, 2009).

It is important to note that these interventions should be clinically effective, where possible evidenced based, and they should also consider the values and meanings that are inherent within the therapeutic relationship (Bracken and Thomas, 2005; Callaghan and Crawford, 2009; Cooper, 2009; Playle and Bee, 2009). To take this considered approach the mental health nurse must acknowledge that their professional understanding of a service user’s experience is not necessarily the same as the service user’s understanding of their experience, and that by doing this the nurse creates an opportunity to preserve rather than potentially lose the true meaning of the service user’s experience (Merleau-Ponty, [1945]1962; Austin, 1968; Brimblecombe et al., 2007; Simpson, 2009).

The following two extracts from a journal by Mary O’Hagan (1996) kept during her time on an in-patient mental health unit illustrates this point. The first extract describes a specific experience that Mary had at the start of her stay on the unit, and the second extract is a mental health professional’s interpretation of that experience, which was accrued by Mary from both the medical and nursing notes.

Mary’s experience: ‘I stand alone, unable to move inside a dark bubble. I have no face or hands or feet. My veins are broken and my blood has nowhere to travel. Outside the bubble it is day. A rainbow appears but I cannot see it. I remain in the bubble, broken and hidden from life around me’ (O’Hagan, 1996: 199). The mental health professional’s interpretation: ‘Mary has an inadequate and confused sense of identity. She also has a long-standing picture of being an isolate; tending to live in her own world and always finding it difficult to fit in. In this way she presents a schizoid personality picture’ (O’Hagan, 1996: 199).

The differences can clearly be seen to have arisen from the mental health professional’s need to find a ‘professional meaning’ and in doing so they have ‘over-analysed’ and moved substantially away from ‘Mary’s’ meaning (Merleau-Ponty, [1945]1962; O’Hagan, 1996; Bracken and Thomas, 2005; Hamilton and Roper, 2006). Once Mary had identified the differences she made this point: ‘Several years later I read what they had written about me and I couldn’t believe that my journal and their notes referred to the same person and events. The incongruity between these two accounts of my mental distress is disturbing and I believe exposes the fundamental reason why mental health services so often fail to help people’ (O’Hagan, 1996: 199).

To avoid falling into this trap, the mental health nurse needs to be ‘aware of their underlying assumptions’ about the service user’s story, which is why being
collaborative and person-centred is such an important part of the therapeutic relationship (Bracken and Thomas, 2005; Hamilton and Roper, 2006; Department of Health, 2006a; Simpson, 2009).

The importance of collaboration

As previously highlighted, one of the difficulties inherent within the therapeutic relationship is that the mental health nurse, in their search for professional understanding, can fall into the trap of reconstructing meanings to the point where an agreed true meaning is lost (Merleau-Ponty, [1945]1962). As a further example the experience of hearing voices may have the meaning for an individual that ‘God is communicating with them’, but for the mental health nurse the meaning of these ‘voices’ is at first shaped by professional understanding such as a medical diagnosis and second by the professional ‘helper’s’ need to find a remedy (Watkins, 1998; Simpson, 2009). In essence the individual’s experience is being ‘reconstructed’ to fit the mental health nurse’s professional understanding, motivations and values (Bertram and Stickley, 2005). This can in turn create a potential divide between the individual’s meaning of their experiences of mental distress and the mental health nurse’s ‘reconstructed’ understanding. However, for the relationship to be fruitful this divide will need to be managed (Hamilton and Roper, 2006; Wilkin, 2006; Simpson, 2009).

Understanding different values is part and parcel of the mental health nurse’s role, although sometimes this can be clouded by the belief in a single objective truth, a belief that emanates from an evidence-based practice approach (Bracken and Thomas, 2005; Simpson, 2009). Key to exploring other truths is for the mental health nurse to work collaboratively within the therapeutic relationship (Bracken and Thomas, 2005; Simpson, 2009). A starting place for collaborative working is to encourage the exploration of multiple or plural truths by empowering the mental health service user to ‘become the authors of their own stories’ and at the same time the mental health nurse should take the position of being interested in a way that is similar to ‘reading a novel for the first time’ (Bracken and Thomas, 2005; Simpson, 2009). By taking this viewpoint the mental health service user’s narrative becomes real and the mental health service user’s experience is understood as something unique rather than a written and static case history based on objectifying nursing problems (Bracken and Thomas, 2005; Martinez, 2009).

This narrative approach gives the mental health nurse the opportunity to open themselves up to being more thoughtful about the interventions they deliver within the therapeutic relationship; interventions can then be formulated through a collaborative understanding rather than being based on an ‘illusion of understanding’ (Bracken and Thomas, 2005; Simpson, 2009). This illusion of understanding can be seen in the case where a mental health service user views their ‘voice-hearing’ as part of their spiritual development and, as such, a positive experience, despite taking time adapting to this change in their life, but this experience could be potentially reconstructed by the mental health nurse as appearing negative (Watkins, 1998). Negativity may be transmitted through the use of common psychological terms such as not coping
PSYCHOLOGICAL INTERVENTIONS IN MENTAL HEALTH NURSING

(negative) rather than focusing on the positive element of the mental health service user’s story (Romme, 1993; Bracken and Thomas, 2005).

Using a narrative approach also gives the mental health nurse the scope to understand the complex ethical nature of delivering psychological interventions within the mental health field (Martinez, 2009). Mental health nurses have the sanctioned power, where risk indicates to use coercion, to restrict the freedoms of a mental health service user, which can impact upon the therapeutic relationship and any subsequent psychological interventions that are delivered (Bracken and Thomas, 2005; Roberts, 2005).

The risk dimension

The therapeutic relationship within the mental health field, unlike most health-care relationships, tends to be both the medium for treatment as well as, in most cases, the main treatment itself (Radden, 2002; Department of Health, 2006a; O’Carroll and Park, 2007; Hurley, 2009). For the therapeutic relationship to be effective it has to follow a process which is built upon the mental health nurse using both reason and emotion not as separate entities, but as entities working in unison (Department of Health, 2006a; 2006b; Simpson, 2009). On this basis the mental health nurse might reason that a core statutory component of the therapeutic relationship is to manage risk. However, there may also be an emotional context that needs to be taken into account, such as making difficult emotional decisions around managing risk through temporarily restricting liberty (Roberts, 2005; Eales, 2009). In this type of situation the effective mental health nurse needs to be ‘emotionally responsive’ both to how the mental health service user is experiencing their mental distress and also to how the mental health service user feels about the restriction of their liberty (Roberts, 2004).

Being able to restrict a person’s liberty means that the mental health nurse has society-sanctioned power, which will impact upon the collaborative element of the therapeutic relationship and, in turn, needs to be recognized and understood by the mental health nurse (Roberts, 2004; 2005). A starting place to understand the impact of power is to look at the role of the mental illness label. The concept of mental illness is conceptually controversial but, even so, once an individual is labelled mentally ill then, if required, the mental health nurse has the power given by society to control that individual (Radden, 2002; Roberts, 2004; 2005). This approach emanates from the view that an individual who is labelled mentally ill has an increased potential to exhibit diminished judgement and because of this they are then perceived as being more risky or dangerous than the ‘average person’ in society (Radden, 2002; Eales, 2009).

The effect of this view upon mental health nursing practice is that mental health nurses, when working with individuals who are labelled as mentally ill, have to then consider risk containment and risk minimization as a central approach (Duffy et al., 2004; Roberts, 2005; Eales, 2009). In terms of the therapeutic relationship this means that even though it is intended to be collaborative and person-centred this intention is dependent on risk. So where a mental health service user’s behaviour is deemed to be ‘low risk’ the approach can be more collaborative. It becomes more difficult however in the case of working with high-risk behaviours such as self-harm and harm to others
AN INTRODUCTION TO PSYCHOLOGICAL INTERVENTIONS (Roberts, 2005; Perraud et al., 2006; Wilkin, 2006). At the higher level of risk the mental health nurse would still be empathetic and collaborative but they would also be looking to control any perceived risk and, if required, the mental health practitioner would have the power to fully control the situation, which could mean taking a mental health service user’s freedoms away (Duffy et al., 2004; Roberts, 2005; O’Carroll and Park, 2007; Eales, 2009).

Identifying, predicting and managing risk is an important part of the mental health nurse’s role. The nurse needs to use both reasoning and person-centred skills to collaboratively formulate the best way to manage the presenting risk (Duffy et al., 2004; Eales, 2009). During this process the nurse will be required to use different forms of knowledge to make sense of the evidence, such as scientific knowledge, and also personal or tacit knowledge (Welsh and Lyons, 2001).

Making sense of the evidence

A mental health nurse’s knowledge is developed in a number of ways. The basic foundation of their knowledge is based on their professional training where different forms of knowledge are introduced. In the main this emanates from the human and physical sciences (Welsh and Lyons, 2001; Department of Health, 2006a; 2006b). This knowledge is further developed into ‘ways of knowing’, such as scientific, naturalistic, personal and ethical (Carper, 1978). Added to these layers of knowledge is the nurse’s own experiences of being a practitioner which, in turn, subsequently shapes their practice and their understanding of their practice (Welsh and Lyons, 2001; Hardy et al., 2002).

Scientific evidence is a key form of knowledge used in mental health nursing practice, which is referred to as evidence-based practice (Callaghan and Crawford, 2009). It is recognized that the best evidence is that which is based on the ‘systematic review of randomized controlled trials’, but for this evidence to be effective it has to also be situated within the mental health nurse-service user relationship, reflecting the specific needs of the mental health service user (Welsh and Lyons, 2001; Callaghan and Crawford, 2009). On this basis, the implication is that scientific knowledge may struggle to provide an ‘established truth’, therefore there is a need to complement scientific evidence with situational-type evidence (Benner and Tanner, 1987; Welsh and Lyons, 2001; Franks, 2004). Certainly having a ‘one fits all’ approach can be seen as a limited way of understanding mental distress; a better understanding can be generated through integrating understandings, especially as a service user’s experience can have multiple meanings (Carper, 1978; Lakeman, 2006).

One way in which mental health nurses complement scientific knowledge is through using naturalistic knowledge or tacit knowledge (Benner and Tanner, 1987; Welsh and Lyons, 2001; Department of Health, 2006a). This tacit realm of knowledge, or what has become called ‘tacit knowledge’, is also known originally via the work of Polanyi (1958) as the ‘tacit component of knowledge’. Tacit knowledge can be seen as implicit knowledge which is based on personal experience. It has an automatic feel to it, in that a person may act effectively but they may not be aware of acting – for example, driving your car home safely but not being able to recall the journey
PSYCHOLOGICAL INTERVENTIONS IN MENTAL HEALTH NURSING

(Carlsson, et al., 2000). Welsh and Lyons (2001: 301) further describe tacit knowledge as 'a synthesis of the formal knowledge and clinical expertise which nurses have accumulated over the years'. One of the difficulties of using tacit knowledge on its own is that it often is seen as not being scientific and therefore must be based on guesswork (Benner and Tanner, 1987; Welsh and Lyons, 2001). Some of these negative views arise from the stance that the best professional knowledge can only be scientific; one of the weaknesses of this absolute view is that it does not account for knowledge that is based on experience and expert understanding, which is the realm of the expert mental health nurse (Schon, 1983; Benner and Tanner, 1987; Welsh and Lyons, 2001).

Closs (1994) makes the point that although science is about 'understanding the world' it will 'not produce absolute truths' especially in relation to 'human behaviours and emotions'. Closs goes on to say that science is not the only 'useful knowledge' which can be used by nurses; more subjective ways of knowing, such as intuition, can be just as useful. On this basis it is important to recognize that the use of tacit knowledge in mental health nursing is not seen as a replacement for scientific knowledge; it is also seen as a way to complement and enhance the use of scientific knowledge (Welsh and Lyons, 2001; Callaghan and Crawford, 2009).

An overview of the book

As previously mentioned, this book has been written primarily for pre-registration mental health nursing students, so the chapters of this book are organized in a way that is intended to support the student’s learning journey. This book is not a substitute for learning by fully engaging with the theory and practice elements of your programme; instead it focuses on helping you to make sense of those learning experiences that relate to the use of psychological interventions (Arnold and Thompson, 2009).

Generally each chapter in the book will build on the points made in this introductory chapter, paying careful attention to the importance of collaboration, the risk dimension and making sense of the evidence. There is an emphasis on capturing the service user’s narrative by taking a scenario-based approach. Also the chapters have been organized in such a way that there is a sense of consistency if you want to read the text from cover to cover and a sense of individuality if you just want to dip in to the chapters on a stand-alone basis. It is important to re-state that although this book provides a good grounding in the use of psychological interventions, it is not a psychological therapies text. It will, where required, signpost to a specific psychological therapy and any relevant clinical guidelines or any planned changes to those guidelines (see the review process for DSM V via the American Psychiatric Association website) (Department of Health, 2006a; 2006b; Callaghan, 2009; Callaghan and Crawford, 2009).

You will find that every chapter will state its aim(s) and objectives, giving a sense of what it is about. A scenario approach will be used in each chapter to demonstrate how this knowledge can be applied to practice. This approach does not stop you from applying your own experiences to test this knowledge; indeed this is encouraged as part of the supervised process of you critically thinking and reflecting about your practice.
experiences (Department of Health, 2006b; Nursing and Midwifery Council, 2010). You may find that you do not agree with a given approach and on this basis you are further encouraged to undertake supervised research to support your views (Arnold and Thompson, 2009). Each chapter will then provide a summary of the key points and a quick quiz which will give you the opportunity to interact further with both the chapter and with your learning (Arnold and Thompson, 2009).

In summary, the first two chapters will provide you with a working definition of psychological interventions that is utilized throughout the text; a good grounding in how risk is managed within the mental health field, paying particular attention to psychological interventions; and how the use of communication skills provides a fundamental basis for the delivery of these interventions. The next eight chapters are the core of the text, both describing and analysing how psychological interventions, within the field of mental health are used in a variety of conditions and contexts. Chapter 11 pays particular attention to the ethical context of psychological interventions. It does not specifically explore the use of legal frameworks but its approach to a moral reasoning process ensures that it is compatible with the use of these frameworks. The concluding chapter focuses on tying the book’s themes together; it also provides some insights into the newly qualified mental health nurse’s future use of psychological intervention, especially in relation to the journey towards expert practice.

**Summary of the key points**

Mental health nurses commonly use psychological interventions which may or may not be formally framed by a specific psychological therapy.

To be clinically effective psychological interventions need to be framed by the respective service user’s narrative.

Mental health nurses need to recognize the coercive element present within their practice.

It is important for mental health nurses when making decisions to consider all forms of knowledge and not to rely on one form alone.

This book is primarily intended to assist the student’s learning journey.

**Quick quiz**

1. Define psychological interventions.
2. Why is collaboration important?
3. How do you pay attention to the service user’s narrative?
4. Why is the therapeutic relationship between the mental health nurse and the mental health service user potentially different than other health-care relationships?
5. What impact does the issue of risk have on the therapeutic relationship?
6. Describe two forms of knowledge that mental health nurses use.
7. What is tacit knowledge?
8 PSYCHOLOGICAL INTERVENTIONS IN MENTAL HEALTH NURSING

References

AN INTRODUCTION TO PSYCHOLOGICAL INTERVENTIONS


10 PSYCHOLOGICAL INTERVENTIONS IN MENTAL HEALTH NURSING


