




PART I
Theory and context
in mental health
nursing





1

Theoretical Perspectives in Mental Health Nursing

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What will I learn in this chapter?

The aim of this chapter is to introduce you to the various, often competing, theories and perspectives that have had an influence on contemporary mental health nursing practice. In doing so, it will be necessary to explore the interrelated concepts of 'mental health' and 'mental illness', and to look briefly at the history of mental health nursing, its current state of play, and the directions it may take in the future.

After reading this chapter, you will be able to:

- differentiate between the concepts of mental health and mental illness and explain the interrelationships between the two;
- appreciate how the history of mental health nursing impacts on contemporary mental health nursing practice;
- compare and contrast the variety of competing theoretical perspectives that underpin mental health nursing practice, making particular reference to their respective evidence bases;
- reflect upon the questions surrounding mental health nursing's future direction.

Introduction: What Is Mental Health?

You are obviously reading this because you have an interest in mental health nursing (or, at the very least, mental health), but what exactly is mental health? And why does this book and much of current parlance refer to **mental health** nursing and not **psychiatric** nursing? Indeed, those practising in this area who are on the Nursing and Midwifery Council's statutory register find themselves officially (and legally) **Registered Nurses, Mental Health** and not 'Registered Psychiatric Nurses'. Hopefully, you will find some answers to these questions in this chapter although, as a critical reader (which is what we want modern mental health nurses to be), you do not necessarily have to agree with those answers.

To return to our principal question – what is mental health? – take a few moments to consider the questions below.



Mental health and ill-health

How do you know if you are mentally healthy? What factors do you think influence someone's mental health?

What's the relationship between 'health' and 'illness'? Is it possible to define illness without defining health or to define health without knowing what illness is?

One answer to our principal question is provided by the World Health Organisation, which defines mental health as 'a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community' (WHO, 2001). In using the World Health Organisation's definition to answer our principal question, we may have opened a can of worms however. Consider the reflection point below.



Stress and coping

So, according to the World Health Organisation's definition, is someone mentally 'unhealthy' if they can't cope with the normal stresses of life, work productively or make a contribution to his or her community?

Where does mental *illness* fit into this picture?

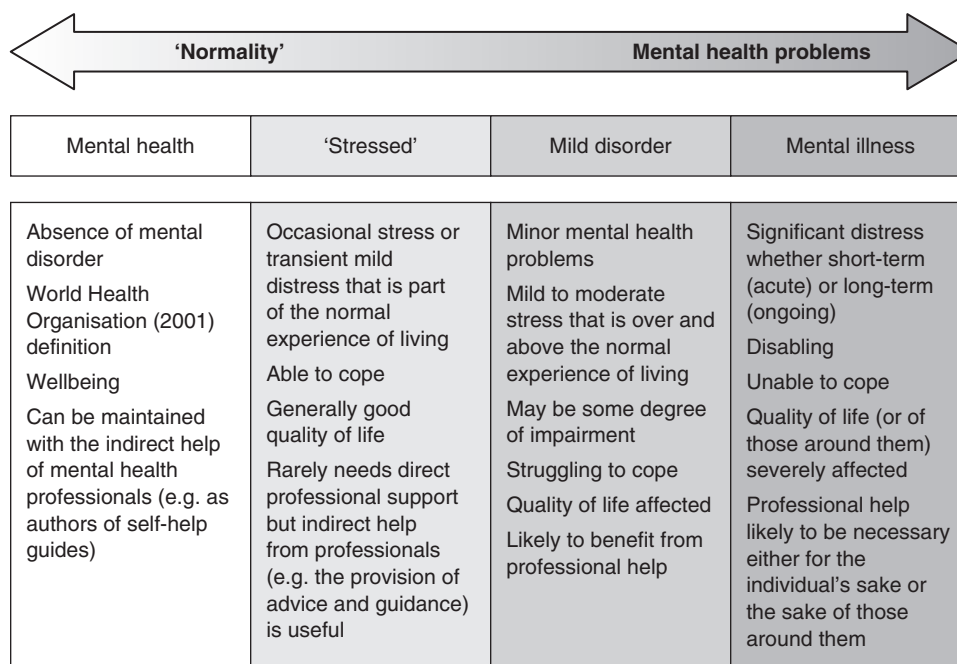


FIGURE 1.1 The mental health/mental illness continuum

One solution to all of this is to consider mental health and mental illness as the two extremes of a **continuum**. Such a continuum is represented by the double-*arrowed* bar in Figure 1.1. A continuum is essentially a link between two extremes – normality and mental health problems, in our case – where the transition from one to the other is gradual and seamless. The four discrete columns in Figure 1.1 are an attempt to integrate some commonly used terms into the continuum. Note that although there are solid lines between the discrete columns in Figure 1.1, this is more about a human tendency to ‘pigeonhole’ people than about defining rigid boundaries between categories. Indeed, it can be very difficult at times to distinguish between the categories, especially at the boundary points: at what point does ‘stressed’ become a mild disorder and mild disorder become a mental illness, for example?

The right-hand side of the continuum in Figure 1.1 is associated with terms like ‘mental illness’, ‘mental health problems’ and ‘mental ill health’; terms that are used throughout this book. Another term that fits in with this side of the continuum and one to which we need to give special consideration is **mental disorder**. It needs special consideration because United Kingdom (UK) law uses it to determine who should be forcibly treated or detained under mental health legislation. All four countries of the UK use the

TABLE 1.1 Definitions of mental disorder across the countries of the UK

Country	Primary legislation	Definition	Exclusions (i.e. cannot be seen as mental disorder)
England and Wales	Mental Health Act 1983, as amended by the Mental Health Act 2007	Section 1(2): 'any disorder or disability of the mind' <i>[Original Section 1(2) of the 1983 Act repealed by the 2007 Act: 'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind']</i>	Section 1(2A): learning disability. Section 1(3): 'Dependence on alcohol or drugs is not considered to be a disorder or disability of the mind' <i>[Original Section 1(3) of the 1983 Act repealed by the 2007 Act: 'promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs']</i>
Scotland	Mental Health (Care and Treatment) (Scotland) Act 2003	Section 328(1): 'any (a) mental illness; (b) personality disorder; or (c) learning disability, however caused or manifested'	Section 328(2): '(a) sexual orientation; (b) sexual deviancy; (c) transsexualism; (d) transvestism; (e) dependence on, or use of, alcohol or drugs; (f) behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person; (g) acting as no prudent person would act'
Northern Ireland	Mental Health (Northern Ireland) Order 1986	Article 3(1): 'mental illness, mental handicap and any other disorder or disability of mind'	Article 3(2): 'personality disorder, promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs'

term in this way, though its definition varies from country to country (see Table 1.1); learning disability, for example, is a mental disorder in Scotland and Northern Ireland but not in England and Wales.

We can also make some comments about the roles that mental health nurses can play as we move along the continuum outlined in Figure 1.1. While most people would expect mental health nurses to be involved in helping people on the 'mental health problems' side of the continuum, many are surprised to find (and you may be too) that mental health nurses can be – indeed, are – involved in assisting and supporting people with no history of mental health problems in the maintenance of their mental health. They might do this via various **mental health promotion** activities, be they

direct (such as planning and running work-based stress management programmes or working in a primary care service such as a GP clinic or NHS Direct) or **indirect** (such as authoring self-help guides in relation to stress or 'common mental health problems' like anxiety and depression). This important aspect of mental health nursing is often overlooked, perhaps because of the dominant stereotypes relating to what mental health nurses do – stereotypes that almost always involve the dishing out of medication or dealing with disturbed individuals in straitjackets. At this point, it's appropriate to consider where some of these stereotypes may have come from by looking briefly at the history of mental health nursing.

The History of Mental Health Nursing

Attendant or nurse?

The history of British mental health nursing is intrinsically tied up with the history of **psychiatry**. The turning point in psychiatry (hospital psychiatry, at least) was the passing, in England and Wales, of the interrelated and interdependent Lunacy and County Asylums Acts of 1845. These Acts set up the **Lunacy Commission**, a body Roberts (1981) refers to as the 'The Victorian Ministry of Mental Health'. The Lunacy Commission established an obligation for local authorities (the counties and boroughs of the time) to provide asylums for 'pauper lunatics', that is, those without the financial means to obtain care in the privately run madhouses. The Lunacy (Scotland) Act of 1857 underpinned a similar growth in the number of public asylums in Scotland. Interestingly, and in contrast to England and Wales, the Scottish lunacy act formalised the practice of **boarding-out to the community** the 'harmless and chronically insane' (Sturdy & Parry-Jones, 1999), a practice that was, to some extent, a precursor to modern-day community care. Northern Ireland has a shorter history in terms of mental health policy since the province only came into being as a political entity in 1921; prior to 1921, most of Northern Ireland's mental health policy was rooted in the lunacy legislation of pre-partition Ireland (Prior, 1993).

The Lunacy Acts of the mid-nineteenth century essentially created an institutional base for the emerging discipline of psychiatry (Nolan, 1998). Prior to these Acts, those looking after the mentally ill were often referred to as 'keepers', a somewhat dehumanising term (think about it: keepers are often associated with collections of some sort, be they animals or objects). After

these Acts, the more humane term **attendant** became a more prevalent description of those who undertook the day-to-day work in asylums. The explicit link with **nursing** started to come about owing to the fact that female attendants were often referred to as nurses and that formal training for attendants implied that nursing was part-and-parcel of what they did. For example, the Royal Medico-Psychological Association (RMPA), which would later become the Royal College of Psychiatrists, formalised training in 1891, awarding those who successfully completed training a 'Certificate of Proficiency in Nursing the Insane'.

The RMPA's dalliance with nursing was not without controversy, however. There was opposition from the asylum attendants themselves, who did not necessarily want to be associated with general nursing. More domineering in the debate, however, was Mrs Ethel Bedford-Fenwick, Matron of St Bartholomew's Hospital, and the force behind a nineteenth-century drive to professionalise nursing via a statutory register. Mrs Bedford-Fenwick had already staked her claim as to what nursing was and what nurses were and her claim did not include asylum workers whom, she argued, should not be called nurses (Nolan, 1998). Since most asylum attendants were male and almost all of Mrs Bedford-Fenwick's 'true' nurses were female, her objections may well have been nothing more than a gender issue (Chatterton, 2004).

Nursing councils

In 1919, Mrs Bedford-Fenwick got her way when statutory nursing registration became law and **General Nursing Councils** were set up for the separate countries of the United Kingdom. The animosity, evident in the likes of Mrs Bedford-Fenwick and her contemporaries, between general nurses and asylum attendants (or **mental nurses** as they would become known) continued in some subtle and not so subtle ways. Mental nurses, along with male nurses (who were, in turn, mainly mental nurses), were only allowed onto a supplementary – some would say, inferior – part of the nursing register, although the RMPA certificate was recognised as a means of admission to this supplementary part. Moreover, in 1925 the General Nursing Councils attempted to wrench control of mental nurse training away from the RMPA, a hostile battle that resulted in two separate systems of training operating until the post-war establishment of the NHS in 1946 (Chatterton, 2004).

Following the establishment of the NHS, the General Nursing Councils reigned supreme until the Briggs Report (DHSS, 1972) led to the Nurses, Midwives and Health Visitors Act 1979 which in turn led to the dissolution

of the General Nursing Councils and the creation, in 1983, of the **United Kingdom Central Council for Nursing, Midwifery and Health Visiting** (UKCC) and a national board for nursing education in each of the four countries of the UK. The national boards were significant in being responsible for the '1982' syllabus, essentially a national curriculum for mental nursing (as it was then called). The 1982 syllabus was heavily influenced by the social sciences and it allowed mental health nursing a degree of separation and autonomy from the other branches of nursing (general, children's and learning disability) in that the entire three years of training were focused on mental health and delivered independently from the other branches of nursing.

In 1986, the UKCC's desire to further professionalise nursing led to the establishment of **Project 2000** (UKCC, 1986), a government-backed initiative designed to align nurse education with the education of other health professionals by transferring responsibility for education and training from the hospital-based schools of nursing to the higher education (HE) sector. At its core was the wholesale replacement – by the year 2000 – of the traditional, work-based apprenticeship models of nurse *training* with the academically grounded diploma and degree programmes of nurse *education*. For mental health nursing, Project 2000 brought about another significant change: the introduction of an 18-month **common foundation programme** (CFP), which all nursing students needed to complete before being allowed to specialise in the remaining 18 months of the programme. Many mental health nurse educators were particularly frustrated to find that Project 2000 had essentially halved the time available to learn to be a mental health nurse. Moreover, to some, this was the beginning of an attempt to make the basic training of nurses **generic** – as is the case in many other countries – where specialties such as mental health nursing and children's nursing would only be available after registration.

Reviews of mental health nursing

Elements of a general review of mental health nursing in 1994 (the Butterworth Report; MHNRT, 1994) also permeated nurse education during the 1990s. Most of the institutions training mental health nurses incorporated at least some of this review's recommendations, especially those relating to partnership working (where the patient/client is at the centre of care), the prioritising of patients/clients with severe and enduring mental illness and the use of clinical supervision to underpin high-quality mental health nursing.

In 1998, the UKCC started a review of pre-registration nurse education, partly because it had a statutory duty to periodically do so and partly because

some issues around Project 2000 were beginning to emerge, specifically claims that Project 2000 nurses lacked the practical skills expected by employers and the public. The UKCC reported the results of its review in 1999 (UKCC, 1999), the same year that the government issued a major strategy document for nursing, *Making a Difference* (DH, 1999). The consensus in both *Making a Difference* and the UKCC review was that Project 2000's integration of nursing education into HE was largely positive but changes needed to be made to address the concerns of the public and employers as well as those of qualified nurses and nursing students. As such, nurse education changed again in 2001 when HE institutions implemented the so-called 'Making a Difference' curricula. These curricula had to incorporate more opportunities for students to acquire practical skills and involved greater cooperation between healthcare providers (the NHS mainly) and the HE institutions providing nurse education. Perhaps the most significant change, however, was the one that reduced the length of the CFP (now termed simply the 'foundation programme') from 18 to 12 months, consequently increasing the branch programme to two years.

The government's *Making a Difference* strategy document also outlined changes to the **regulation** of nursing and, in 2001, the Nursing and Midwifery Order 2001 provided for the UKCC and the four national boards for nursing education to be replaced with a single body – the **Nursing and Midwifery Council** (NMC).

In 2005, the Chief Nursing Officer for England requested a review of mental health nursing to answer the question 'How can mental health nursing best contribute to the care of service users in the future?' A similar review of mental health nursing (the first of its kind) was undertaken in Scotland shortly afterwards. Both review teams reported the following year (DH, 2006; Scottish Executive, 2006). Like the Butterworth Report of 1994, these two reviews are *general* reviews of mental health nursing; nevertheless, both contained recommendations that have implications for the education and training of mental health nurses. At the time of writing, these two reviews are still very much current and we will revisit them in the next chapter when we attempt to unpick the elements of a 'good' mental health nurse.

More recently, the NMC embarked on another statutorily required periodic review of pre-registration nurse education in 2009; a review that is likely to lead to further changes in the way in which UK nurses are educated and trained. Significant changes that have already been announced include a move to **all-degree** programmes (i.e., the cessation of diploma-level training), the renaming of the specialist branches of nursing to **fields** of nursing

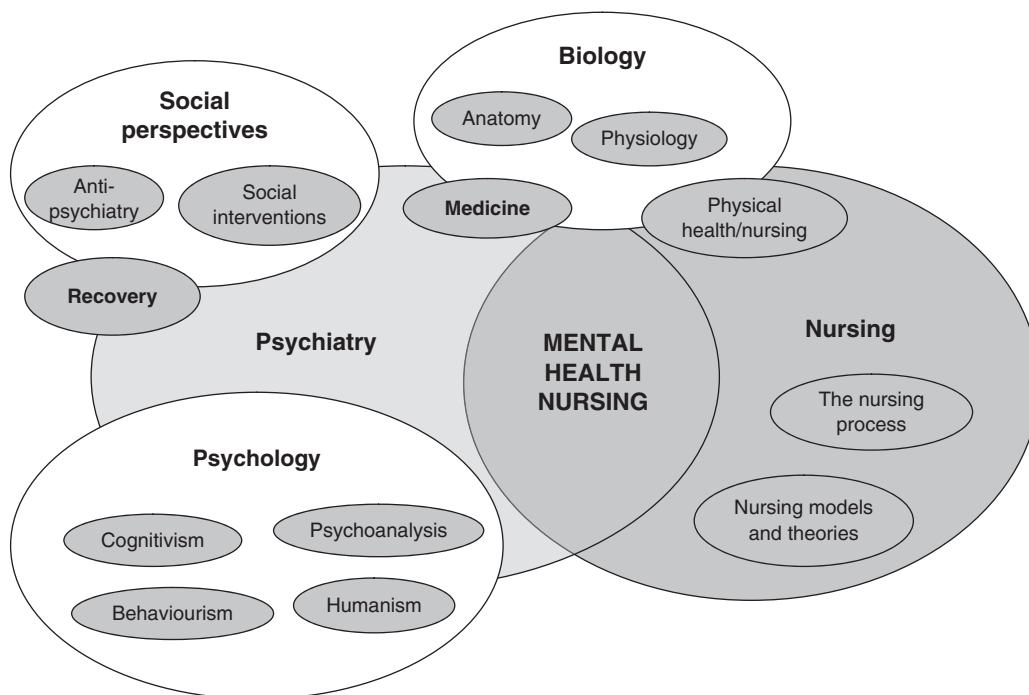


FIGURE 1.2 Theoretical perspectives in mental health nursing

and the **abolition of the first year foundation programme** to be replaced by a combination of generic (core) and field-specific learning across all three years of training.

Theoretical Perspectives in Mental Health Nursing

As we have seen in our historical overview, mental health nursing owes its parentage to both psychiatry and nursing; it is, to use a common saying, the ‘bastard offspring’ of the two disciplines! This explains why theoretical perspectives from both psychiatry and nursing have permeated mental health nursing (see Figure 1.2) and, to some extent, why the ‘generic nurse vs. specialist mental health nurse’ debate surfaces every now and then (a debate we will revisit in Chapter 3).

Since psychiatry and its parent, medicine, are not pure sciences, the **psychiatric perspectives** that influence mental health nursing have largely been appropriated from biology, psychology and the social sciences; the **nursing**

perspectives generally come in the guise of nursing theories and models. As you will see, these two perspectives are sometimes complementary and sometimes diametrically opposed.

Psychiatric Perspectives

We mentioned earlier that the psychiatric perspectives on mental health and mental ill health are largely appropriated from biology, psychology and the social sciences. Let's explore the extent to which each of these disciplines has influenced psychiatry and, in turn, mental health nursing practice.

Biological perspectives: the medical model

The practice of medicine, psychiatry's parent discipline, is intrinsically linked to the biological sciences of **anatomy** (the study of the physical structure of organisms) and **physiology** (the study of the functions of the structural parts of organisms). Physical medicine is underpinned by the principle that there is a 'normal' anatomy and physiology that is sometimes rendered 'abnormal' by physical trauma, illness and disease. The practice of physical medicine is thus premised on the identification (**diagnosis**) of these anomalies and the selection of appropriate **treatments** designed to return the body's anatomy and physiology to normality. Throughout medicine's history, this diagnosis–treatment model – **the medical model** – has been the mainstay of medical practice: diagnosing an imbalance in the humours in ancient times will have led to the bloodletting and induced vomiting treatments of those time just as a diagnosis of diabetes leads to treatment with insulin, or a diagnosis of appendicitis leads to an appendectomy, today.

In collaboration with the biological sciences, the medical model has had some remarkable successes over the past 50 years or so. Physical medicine has made significant progress in dealing with the consequences of trauma, illness and disease: it has cured people of terrible diseases such as smallpox; it has enabled people to survive following traumatic injuries; and, through transplantation, it has even extended the lives of those with failing organs. No wonder then that medicine has staked its claim to other aspects of the human condition even when the evidence of abnormality is less than clear-cut. Two good examples are childbirth which, as most midwives will point out, has nothing to do with illness or disease, and madness which, as you will soon discover, can be explained in ways other than that of physiological or anatomical abnormality.

Nevertheless, biological psychiatry¹ works on the same principle as physical medicine but with a specific focus on the brain and nervous system (hence this perspective is sometimes called the **psychophysiological** or **neuropsychological** perspective). Thus dysfunctions in, or damage to, the brain and nervous system lead to observable signs and symptoms that we label 'mental illness' just as dysfunctions in, or damage to, say, the circulatory system or the urinary system might cause physical illnesses associated with those systems. As with physical illness, correcting these dysfunctions involves a range of physical treatments, the most common being the **psychoactive drugs**. Another physical treatment in common use in psychiatry is **electroconvulsive therapy** (ECT). A physical treatment commonly used in the past but which is very rarely used nowadays is **psychosurgery**. Psychosurgery attempts to alleviate mental illness by surgically cutting connections in, or removing parts of, the brain, the most well known form of psychosurgery being the **lobotomy**, a procedure involving surgery to the frontal lobes.

That certain drugs (such as LSD and mescaline) induce states similar to those observed in some mental illnesses, and the observation that psychoactive drugs such as chlorpromazine do appear to alter the course of mental illness in a positive way adds some credibility to the biological perspective. On the other hand, the fact that no specific physiological correlates have been found for any of the mental illnesses (except perhaps some of the dementias) – despite there being plenty of speculation – creates problems for this viewpoint. Nevertheless, there is still a core of biomedical research into mental illness that is driven by the belief that, one day, specific physiological anomalies (such as neurological damage or an imbalance in brain chemicals) will be found for all of the major mental illnesses. We will consider some further criticisms of the biological perspective later on when we discuss psychological and social perspectives on mental illness.

The medical model dominates the delivery and organisation of physical healthcare: medical specialties in most hospitals reflect the physiological systems of the body. Its influence is somewhat less in mental healthcare (and, as you will discover later when we talk about 'recovery', its influence is diminishing further); however, it still impacts significantly on the practices of many mental health professionals including mental health nurses. For example, psychiatrists are still generally seen as the lead clinicians in mental health practice (though, as we will see

¹Biological psychiatry is a bit of an extreme position; while most modern-day psychiatrists embrace elements of the biological perspective (they are trained in medicine, after all), many also integrate psychological and social elements into their practices.

in Chapter 3, this is being challenged by ‘new ways of working’ in mental health), and the two main classification systems of psychiatric disorders and mental health problems – the *International Classification of Diseases* (ICD) (currently in version 10; WHO, 2007) and the *Diagnostic Statistical Manual* (DSM) (currently in version IV; APA, 2000) – are both products of the medical model.

While the debate about how well the biological perspective can explain mental health and mental ill health is an important one, as nurses we should not ignore the fact that people with mental health problems are *biological* entities. In other words, we need to be aware of the fact that people with mental health problems may also have physical health needs; indeed, there is often a complex interplay between the physical and mental (Seymour, 2003). An understanding of **basic human biology** (and not just of the brain and nervous system) is essential, therefore, if we are to do our best to help people with mental health problems. This will become all the more clear when we focus on the necessary knowledge required to help people with specific kinds of mental health problem in Part II of this book.

Psychological perspectives

Psychology is the study of mind and behaviour (Gross, 2010). Since psychiatry is explicitly associated with the mind and (abnormal) behaviour, it is hardly surprising that its practices have been influenced heavily by psychology. Indeed, as we will see in Chapter 3, there have been some tensions between psychiatrists and those psychologists who work in mental healthcare – clinical and counselling psychologists – within whose remit the mentally unwell come.

There are four main psychological perspectives on mental health and mental ill health: **behaviourism**, **psychoanalysis**, **cognitivism** and **humanism**. In addition, a number of ‘hybrid’ approaches have emerged as a result of dissatisfaction with one or other of the major perspectives, especially in relation to treatment outcomes. It is perhaps easiest to look at the perspectives and the subsequent hybrids chronologically. With each, we will briefly outline its historical development, its principal proponents, the ways in which it explains mental illness and the implications it has for treatment.

Behaviourism

Behaviourism was developed in the early part of the twentieth century by the American psychologists John B. Watson, B.F. Skinner and Edward Lee

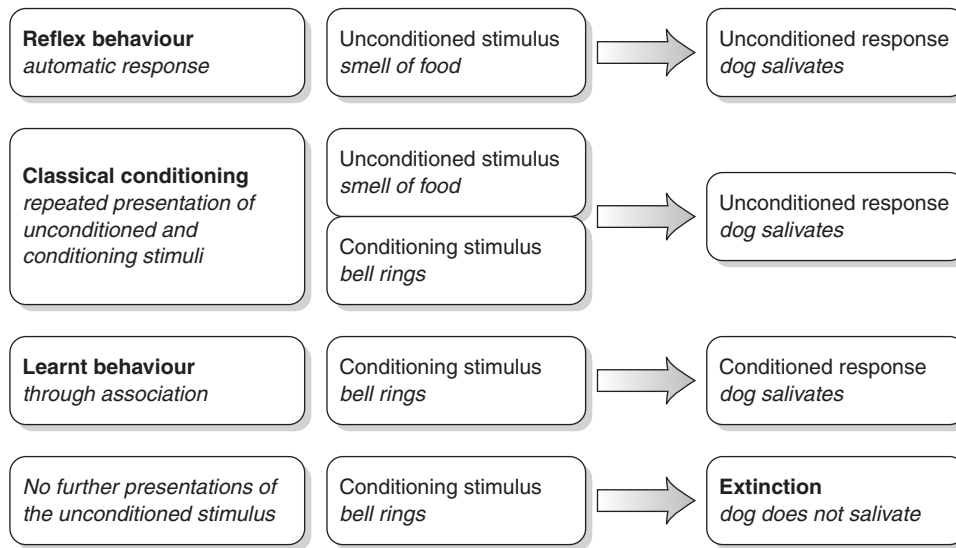


FIGURE 1.3 Classical conditioning in Pavlov's dogs

Thorndike and the Russian physiologist famous for his work with dogs, Ivan Pavlov. It was the dominant force in British psychology right up until the 1950s and remains influential today. Behaviourism focuses only on **observable behaviour**; it sees behaviour merely as a **response** to some external **stimulus** and it is not interested in hypothetical constructs such as the mind. To a behaviourist, all behaviour is **learnt**. Moreover, the ways in which such behaviour is learnt can be manipulated using a variety of techniques known collectively as **conditioning**.

In **classical conditioning**, behaviour is learnt through **association**. Pavlov's studies involving dogs demonstrated that, under certain conditions, an existing response (salivation) could be associated with a new stimulus (a bell ringing) (see Figure 1.3).

Something worth noting from Figure 1.3 is the notion of **extinction**. In classical conditioning, this means that the conditioned response fades when there is no further presentation of the unconditioned stimulus. Extinction is an important aspect of behaviourist theory and is something we will return to shortly.

In **operant conditioning** (sometimes called instrumental conditioning), behaviour is learnt through the principles of **reward** and **punishment**. Operant conditioning is underpinned by the notion that humans are

TABLE 1.2 Factors that determine learning in operant conditioning

Increasing specific behaviours	Decreasing specific behaviours
Positive reinforcement – the addition of something the individual finds rewarding and/or pleasurable, e.g. giving money, food or praise for ‘good’ behaviour	Punishment – something unpleasant is presented in order to discourage behaviour, e.g. physical pain through smacking or electric shock
Negative reinforcement – the removal of something the individual finds annoying or unpleasurable, e.g. a loud noise is removed for ‘good’ behaviour	Sanctions – something pleasant is removed to discourage behaviour, e.g. not earning pocket money
	Extinction – if a specific behaviour is no longer reinforced, then as with classical conditioning, the operantly conditioned behaviour will extinguish

essentially **hedonistic** or pleasure-seeking – that what we find pleasurable (or not, as the case may be) can determine how and what we learn (see Table 1.2).

As you can see from Table 1.2, **reinforcement** increases desired behaviours while **punishment** (and its less contentious cousin, the sanction) and **extinction** are techniques for decreasing unwanted behaviours. Bear in mind also that reinforcement does not have to be tangible – social reinforcers such as praise, acceptance and positive regard can all have a significant impact on the way people behave in society.

Since behaviourists see all human behaviour as learnt behaviour, they see the behaviours associated with what we call ‘mental illness’ simply as behaviours that have been learnt. Once learnt, these behaviours persist because they have been reinforced or there has been no punishment. Take phobias, discussed in much more detail in Chapter 5, for example. Behaviourists claim that phobias arise because of a learnt association between a specific object/situation and fear, and that they persist because avoidance of the object/situation acts as a negative reinforcer.

Since behaviourists believe that mental health problems are the result of learning, they also believe that these behaviours can be unlearnt or **modified** through conditioning techniques; indeed, a whole new field of ‘applied behaviourism’ – **behaviour therapy** – emerged during the 1960s and 1970s (see, for example, Wolpe, 1969). Specific behaviour therapies include **aversion therapy**, **systematic desensitisation** (also called **graded exposure**), **flooding** and the **token economy**. Aversion therapy, used extensively in the 1960s and 1970s (particularly to treat ‘sexual deviants’) is based on classical

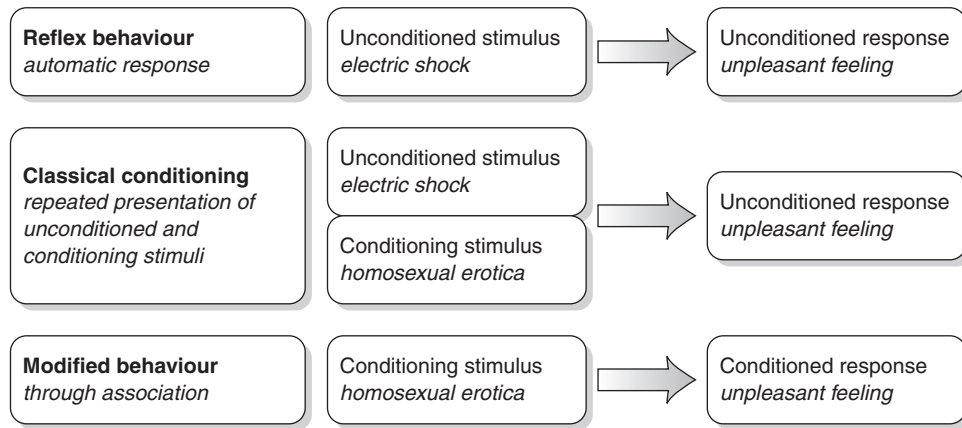


FIGURE 1.4 Aversion therapy for homosexuality

conditioning principles. Figure 1.4 illustrates aversion therapy as a ‘cure’ for homosexuality.

Aversion therapy has been abandoned as a treatment for sexual deviancy (primarily because it doesn’t work but also because of the ethical issues involved in trying to change people’s sexuality). It is sometimes still used in the treatment of alcohol misuse. Since certain drugs (e.g. disulfiram) produce a very unpleasant effect when combined with alcohol, the theory goes that people who voluntarily take such drugs and then drink alcohol will associate drinking alcohol with unpleasant effects and will thus avoid alcohol. Unfortunately, adherence to aversive treatment regimens is, understandably, very low (Garbutt, 2009) and, as you will discover in Chapter 11, much more effective ways of helping people who misuse alcohol exist.

Systematic desensitisation, a technique also based on classical conditioning principles, has had some success in the treatment of phobias, as you will discover in Chapter 5. It assumes that a phobic object/situation has somehow become associated with fear and anxiety (as a conditioned response) and that this response can be ‘deconditioned’ by replacing the anxiety associated with the phobic object/situation with relaxation. This is done via a number of steps (hence why it is sometime called ‘graded exposure’), with less anxiety-provoking exposures to the phobic object/situation (such as merely thinking about it) being dealt with first and more severe anxiety-provoking exposures (such as full contact with the object/situation) at later stages in the therapy.

Flooding, another treatment for phobias, works on operant conditioning principles. In flooding, the person with a phobia is forced to confront the

phobic object/situation with no opportunity for escape (e.g. someone with a dog phobia would be locked in a room with a dog). Since behaviourists believe phobias persist because avoidance of the object/situation acts as a negative reinforcer, flooding prevents this avoidance and so the phobia extinguishes as a consequence.

The token economy, which peaked in popularity in psychiatry in the 1970s and 1980s, is an operant conditioning approach on a large scale. Tokens are (or, indeed, money is) handed out as a reward for desired behaviours. These tokens can subsequently be exchanged for pleasurable activities. Though the token economy is little used in psychiatry nowadays, the operant conditioning principles underpinning it still form the basis of endeavours such as performance related pay, the 'star charts' common in child rearing (see Chapter 9) and 'contingency management' in substance misuse (see Chapter 11).

That behavioural methods are effective with some mental health problems (phobias and conduct disorders in children being two examples) adds some weight to the behaviourist perspective. However, purely behavioural techniques are relatively ineffective with major mental illnesses such as the psychoses² and behaviourism has come in for much criticism (especially in its most extreme form, radical behaviourism) because it fails to appreciate the influence of internal mediating processes (like thoughts, moods and desires) that are an essential part of the human condition. These internal mediating processes are, on the other hand, central to two other psychological perspectives: psychoanalysis and cognitivism.

Psychoanalysis

Psychoanalysis is, to some extent, the antithesis of behaviourism in that its focus is the internal psychological processes the behaviourists deem to be unimportant. It was founded in Europe at the turn of the twentieth century by the Austrian physician Sigmund Freud (hence it is sometimes called **Freudian psychology**), around the same time as behaviourism was being developed in the United States. Several other theorists (Carl Jung, Alfred Adler and Melanie Klein, for example) have built upon the work of Freud to produce their own versions of psychoanalytical therapy and the perspective also encapsulates the briefer and less intensive forms of therapy known as **psychodynamic psychotherapy**.

²Although cognitive behavioural approaches may have some impact on the so-called 'positive' symptoms of psychosis – see Chapter 6.

Psychoanalysis and its derivatives are principally concerned with the **unconscious** mind. Common to all psychoanalytical theories is the notion of **conflict** between the various parts of the unconscious mind and the emotional energy associated with such conflicts (hence the reason why ‘psychodynamic’ is often used in psychoanalytical writings). Mental illness thus arises as a result of unresolved subconscious conflicts between various abstract parts of the unconscious mind. These conflicts often arise in childhood, persisting into adulthood and manifesting as mental illness simply because they are unresolved. Perhaps the most well-known conflict is that between the **id** (our real, deep-seated, often irrational desires) and the **superego** (to some extent, the conscience). Treatment centres on resolution of these conflicts, via a prolonged analysis of the individual’s experiences and feelings (hence the term ‘psychoanalysis’). During psychoanalysis, the therapist interprets various aspects of the individual’s experience – their dreams, thoughts, words and feelings – in the hope that the seemingly irrational will become understandable and so the conflicts will resolve.

The observation that childhood experiences often greatly affect our psychological development in later life adds some support to this perspective. Psychoanalysis has, however, fallen out fashion in the UK over the last couple of decades amid concerns over its evidence base. As Fonagy (2003) points out, the evidence base for psychoanalysis is relatively thin and the long-term, intensive nature of much psychoanalytical practice is often at odds with the contemporary emphasis on cost-effective treatments. Nevertheless, many people report a great sense of personal development after undergoing psychoanalysis and psychodynamic psychotherapy – its less rigid cousin – still has many adherents.

Cognitivism

Advances in computer technology during the 1950s and 1960s offered psychologists a new perspective. Analogies between humans and machines were frequently drawn with an emphasis on humans as **information processors** and thus the cognitive school of psychology – cognitivism – was born. Like psychoanalytical theorists, cognitive theorists are interested in the abstract mental processes that underlie our behaviour and thought processes though their focus is not unconscious conflicts but the processes concerned with the acquisition or manipulation of knowledge: the cognitive processes of perceiving, remembering, reasoning, judging, thinking, etc. Moreover, unlike psychoanalytical approaches, cognitive approaches are bound by rigid scientific and experimental methods. The most well-known cognitive theorist is

Jean Piaget, whose theory of cognitive development has had a huge influence on the education policies of the Western world. Cognitivism is currently the dominant perspective in academic psychology and it has been making significant inroads into mental health practice over the last decade or so.

According to the cognitive perspective, mental illness occurs when problems arise in any or all of our cognitive processes and it is our ability to **think** that provides the treatment rationale within this perspective. The control (albeit sometimes limited) that we have over our cognitive processes allows us to 'retune' our thinking and thus produce a world-view that is more healthy to our mental wellbeing. Depression is a good example (and one considered in much more detail Chapter 4). Aaron Beck's cognitive theory of depression (Beck, 1967) argues that depression occurs because of cognitive 'distortions' brought about by **automatic thinking, erroneous assumptions and beliefs** and the ways which assign **meaning** to our experiences (see Box 1.1). By tackling these distortions ('retuning' our thinking through **cognitive therapy**), it is possible to change automatic and erroneous beliefs about ourselves and our experiences and consequently change the way we feel about ourselves.

Box 1.1 Principles of Beck's cognitive theory of depression (after Beck, 1967, 1976)

- The interpretation or **meaning** that an individual gives to an event impacts on their emotions and on how they behave.
- The interpretation or meaning is subject to some '**automatic**' ways of thinking.
- People with depression tend to have a negative **schema** – or theme – about the world, brought on through childhood experiences such as the loss of a parent, rejection by peers or criticism by teachers or parents.
- There is a **negative triad** about:
 - (1) the self ('I am defective or inadequate');
 - (2) the person's life experiences ('everything I do ends in defeat or failure'); and
 - (3) the future ('the future is hopeless').
- Cognitive **biases** and **distortions** fuel the negative schema.

The **rational emotive therapy** of Albert Ellis (Ellis, 1962) is another cognitive approach that has many similarities to Beck's cognitive therapy. Interestingly, both Beck and Ellis started off as psychoanalysts before developing their cognitive theories.

Humanism

During the late 1960s and early 1970s, a new school of psychology emerged that questioned whether the objective, cold, rational approach of science was appropriate to a discipline ultimately concerned with human experience. Humanistic psychology places great emphasis on the **subjective** value of our experiences. Major theorists of humanism include Abraham Maslow and Carl Rogers (who we will meet again in the next chapter). Humanistic approaches underlie the majority of modern-day counselling approaches and have been hugely influential in mental health nursing. You might see humanistic approaches referred to as **phenomenological, experiential, existential** or **personal growth** approaches. Box 1.2 provides some brief descriptions of the meanings of these terms within the context of humanism.

Box 1.2 Terms associated with the humanistic perspective

- **Humanistic:** seeing the person as a **human being**, rather than as an illness or collection of symptoms
- **Phenomenological:** phenomenology is the study of phenomena (the plural of phenomenon), which are simply everyday occurrences or things that happen
- **Experiential:** what a person **experiences** is of primary interest to the practitioner
- **Existential:** concerned with **existence**; a theoretical viewpoint stressing the importance of the individual's own experiences
- **Personal growth:** concerned with the belief that humans have a reservoir of untapped potential and the opportunities for personal growth that arise as a result of tapping this potential can have benefits for not only the individual but society as a whole

To a large extent, humanism is a framework for mental *health* rather than mental illness. Humanists believe that increasing the value – the self-esteem – of an individual ultimately leads to greater mental wellbeing. Personal growth is seen as the answer to mental distress in the world. Signs and symptoms

of what we call mental illness arise when individuals fail to take responsibility for their own lives, or when they cut themselves off from their own experiences. In therapeutic environments, such personal growth is facilitated through what Rogers (1980) calls the core conditions of the therapist: **unconditional positive regard**, **empathic understanding** and **genuineness** (we will consider these core conditions in more detail in the next chapter).

The fact that many people benefit from humanistic styles of counselling provides some support for this perspective. However, humanism is not without criticism. For example, a focus on personal growth may not be particularly effective with someone experiencing an acute psychotic episode. And while the (unashamed) positioning of the individual at the centre of care may appear laudable, the individual's place in society or any of its structures, such as the family or community, often gets overlooked. Humanism has also been criticised for being too optimistic and perhaps a little unrealistic: Rogers' notion of unconditional positive regard, for example, can be difficult to accept when individuals have done truly evil things and when there is evidence from the cognitive psychologists that we are inherently judgemental when we process information about people.



Reflection
Point

Being non-judgemental

Humanistic practitioners often talk of being 'non-judgemental'. How easy do you think this is?

When answering this question, think about when you meet someone for the first time. Do you make assumptions about him or her based on the way they look, the way they speak or the way they act? Do these assumptions make you act in a different way to how you might otherwise act?

What if you read in a service user's case notes that they had been accused of rape? Would your judgement of that person be different from the judgement you would have made had you not read the notes?

Social perspectives

The biological and psychological perspectives discussed thus far have one thing in common: they all focus on the **individual**. However, individuals

do not exist in isolation from one another; they exist within social groups such as families, peers, communities and societies. Social perspectives have influenced mental health practices in two main ways: by encouraging practitioners to embed the individual service user's experience into a wider social context, devising appropriate 'social' interventions as a consequence; and challenging the very concept of mental illness itself.

Social interventions

Social interventions can be seen as those interventions that address the individual's role within various social groups. Social interventions as such include group approaches, family approaches and interventions linked to 'normal' life activities such as work, leisure and play, forming relationships, and so on. As you will discover throughout this book, social interventions are becoming increasingly important in the repertoire of interventions available to mental health practitioners.

Family approaches, for example, have been routine in child mental health (see Chapters 9 and 10) for decades because society generally conceptualises children as part of a family unit than as individuals. On the other hand, most adults belong to a family unit or to wider social networks and a growing acknowledgement of this means that family approaches are increasingly being seen as valuable in adult mental health (see, for example, Chapters 6 and 8). The influence of work, another social activity, on an individual's mental health has also come to the fore in recent times, forming a core part of the government's latest mental health strategy, *New Horizons* (see HM Government, 2009). There is also evidence that, in some circumstances, group approaches to mental healthcare may be more effective than individual approaches. Examples include the care of older people with depression or dementia (see Chapter 8), the care of young people who self harm (see Chapter 10), and the care of people with an antisocial personality disorder (see Chapter 12).

Challenging mental illness: anti-psychiatry

Anti-psychiatry (sometimes **critical psychiatry**) essentially began with the publication of *Madness and Civilization*, a history of madness by the French sociologist and philosopher Michel Foucault (see Foucault, 1965). Foucault challenged the fundamental assumption of biological psychiatry by claiming that madness had nothing to do with biology but was instead a product of a

given society's attitudes and values. Other well-known 'anti-psychiatrists' include R.D. Laing (himself a psychiatrist) and Thomas Szasz, who coined the phrase 'the myth of mental illness' with his book of the same name (Szasz, 1961). Anti-psychiatry argues that mentally ill people are deemed to be mentally ill not because they have, say, an imbalance in brain chemistry but because their behaviours are at odds with what society expects or will tolerate. As such, the mentally ill merely have problems with living or difficulty in conforming to the rules of society. And since society defines madness, psychiatrists (and those who work for them) are seen not as therapists but merely as 'social police'.

This perspective has some credibility. History is littered with examples of those who refuse to conform being seen as deviant or abnormal in some way and society's view of deviance or abnormality can vary both across time and across cultures. Homosexuality, for example, was seen as a treatable mental illness by the psychiatric classifications ICD and DSM for most of the twentieth century (it was removed from DSM in 1973 and from ICD in 1990).

Since it focuses on people as human beings – albeit within the constraints of society's rules and regulations – rather than on illness, anti-psychiatry has some overlap with humanistic perspectives. Other influences in anti-psychiatry include Erving Goffman's work relating to **stigma** (Goffman, 1963) and Thomas Scheff's work on **labelling theory** and madness (see Scheff, 1966). Stigmatisation refers to those 'disqualified from social acceptance' and since it includes those deemed to be mentally ill, it is a concept we will return to throughout this book. Labelling theory is a theory that implies that society's very act of labelling certain people (e.g. as 'criminal', 'immoral' or 'mad') leads to those people developing identities that conform to the label, i.e. the very act of labelling becomes a self-fulfilling prophecy.

More recent commentators who could be said to fit broadly into an anti-psychiatry perspective include: the psychologists Mary Boyle (see Boyle, 2002) and Richard Bentall (see Bentall, 2009), both of whom question the scientific validity of so-called (in their view) mental illnesses such as schizophrenia; the Dutch psychiatrist Marius Romme and Dutch journalist Sandra Escher, whose HearingVoices movement sees voice hearing not as a symptom of mental illness but as a normal part of the makeup of many individuals; and the lobby group the Campaign for the Abolition of the Schizophrenia Label (see www.caslcampaign.com).

Treating schizophrenia

Below you will find how each of the main perspectives in psychiatry explains schizophrenia. Which do you prefer? Can you think of how treatments might be developed within each of the perspectives?

- **Biological perspective:** Schizophrenia is a genetic condition caused by an imbalance of brain chemicals that affects certain brain systems in particular.
- **Behavioural perspective:** Schizophrenia is simply a set of learnt behaviours.
- **Cognitive perspective:** Schizophrenia arises because of a breakdown in the processing of information. Perhaps internal mechanisms for information processing have become distorted or damaged in some way. Schizophrenia may merely be the human equivalent of computer problems: bugs, viruses, garbled characters on the screen, and so on.
- **Psychodynamic perspective:** Schizophrenia is caused by internal unconscious conflicts, probably arising during the early years of our lives. These conflicts remain unresolved and as a consequence, innate, irrational demands surge into consciousness and manifest as schizophrenia.
- **Humanistic perspective:** A person with so-called 'schizophrenia' is merely exploring their own personality, in particular the 'hidden', deeper parts of the self. It is an experience which, though uncomfortable and distressing at times, can ultimately lead to a greater knowledge of the self – after all, many so-called mentally ill people are extraordinarily creative.
- **Social perspective:** Schizophrenia is not an illness. Some individuals merely refuse to comply with society's rules and regulations and live unmoderated lives, free from the restrictions of society.

If you have had a chance to consider the discussion point above, one of the difficulties you may have encountered is that looking at mental illness from one or other of the specific perspectives listed means you can only partially explain or resolve things. Many theorists and practitioners have been stymied by this limitation and as such two main solutions have emerged, both common in current mental health practice. The first is the establishment of what might be called **hybrid** perspectives, where elements from various perspectives are combined into new theoretical perspectives; the second is **eclecticism**, which is about taking the best elements from each of the perspectives (having no particular loyalty to any of the perspectives) to create your own unique model of practice. We shall discuss hybrid models next but leave eclecticism for a short while as it is best considered when we talk about individual philosophies of mental health nursing a little later.

Hybrid perspectives

The main hybrid perspectives you are likely to come across in mental health practice are **social cognitive theory**, **cognitive analytical therapy**, **interpersonal therapy**, **cognitive behaviour therapy** and the so-called **third wave therapies**. While **the recovery model** can also be seen as a hybrid perspective, it is more of an overall philosophy of mental health practice. Moreover, since recovery is central to much modern-day mental health practice, it will be given special consideration later on in this chapter.

Social cognitive theory

Social cognitive theory (also known as **social learning theory**) is a cognitive theory of learning that emphasises social interactions, in particular the notion of learning through the observation of model behaviour or people (i.e., **role models**). It is, in essence, a hybrid of social and cognitive perspectives, stemming from the work of Albert Bandura in the 1960s. It is still influential today, particularly in consumer and social marketing. A good example is the 2008/9 advertising campaign run by Trident (an anti-gun crime organisation targeting young black Londoners) in which positive black role models were used to illustrate that 'respect' could be garnered, not through guns, but through success in sports, the arts and business.

Social cognitive theory has implications for nursing practice in that it implies that service users may well see nurses as role models.

Discussion Point

Nurses as role models

How should you behave in practice if you are to act as a role model? Should nurses be role models? How important do you think each of the following factors is in mental health nursing?

- How you dress
- Your hairstyle
- Your weight
- Whether you smoke cigarettes or not
- Your alcohol intake
- Whether you lose your temper easily
- Whether you use recreational drugs
- Whether you are on time for duty or habitually late
- Whether you have body adornments such as tattoos or piercings

Cognitive – psychodynamic hybrids

Two cognitive – psychodynamic hybrids that have made some inroads into current mental health practice in recent years are **cognitive analytical therapy** (CAT) and **interpersonal therapy** (IPT).

Developed by Anthony Ryle (see Ryle & Kerr, 2002), CAT is a brief therapy designed for use in depression, anxiety and, more recently, personality disorder (see Chapter 12). CAT integrates cognitive therapy principles such as formulation, homework and problem-solving with the analytical elements of psychoanalysis – although the analysis is descriptive and collaborative rather than interpretive as it is in traditional psychoanalysis (Denman, 2001).

IPT, developed by Gerald Klerman (see Klerman et al., 1984) as a treatment for depression, is heavily influenced by interpersonal psychoanalysis, a style of psychoanalysis developed by Harry Stack Sullivan that focuses on interpersonal relationships rather than the intra-psychic conflicts of traditional Freudian psychoanalysis. IPT combines Sullivan's interpersonal psychoanalysis with the structured elements of cognitive behavioural therapy (see the next section) such as time limited therapy, clinical assessment tools and homework.

While the evidence base for CAT is somewhat limited, the evidence for IPT suggests it has potential in the treatment of depression; indeed, it is recommended as a treatment option in both the English National Institute for Health and Clinical Excellence (NICE, 2009) and the Scottish Intercollegiate Guidelines Network (SIGN, 2010) guidance on depression.

Cognitive behavioural approaches

Perhaps the most well-known hybrid approach is **cognitive behaviour therapy** or **CBT**. Unsurprisingly, it is an approach that combines cognitive and behavioural approaches to therapy. Its roots lie in attempts to merge the successes of cognitive approaches like Ellis's rational emotive therapy and Beck's cognitive therapy with the successes of Wolpe's behavioural approaches. CBT has had some remarkable successes, especially with the so called 'common mental health problems' of anxiety and depression (see Chapters 4 and 5), and it is very much a dominant model in current mental health practice. Given its dominance, and the fact that it is permeating areas of mental health practice as diverse as psychosis and self-harm, we will say little more about CBT here since we will make frequent reference to it throughout Part II of this book. Importantly, this does not mean that we have ignored any other

therapeutic approaches for which robust evidence exists; CBT crops up so much in the areas and conditions that we look at in Part II of this book simply because its evidence base is significantly better than that of many competing therapies.

The hybrid nature of CBT also seems have sparked a thirst to integrate additional elements into the cognitive behavioural model, resulting in a whole host of what might be called 'third wave' behavioural therapies (behaviour therapy being the first wave and CBT the second; Hayes, 2004). The third wave therapies often have what might be termed an added **spiritual** dimension to them and include: **cognitive behavioural hypnotherapy** (adds hypnosis to CBT); **dialectical behaviour therapy** (DBT; inspired by Buddhist teaching, it adds the notion of 'mindfulness' to CBT); **schema therapy** for personality disorder (adds elements of mindfulness and psychoanalysis to CBT; see also the previous section and Chapter 12) and **acceptance and commitment therapy** (ACT), a therapy that focuses on individuals noticing, accepting and embracing their thoughts and feelings rather than trying to change them as in CBT.

The Recovery Model

While the recovery model is more of a philosophy of mental health-care than a specific theoretical perspective, it does nevertheless draw some of its influence from some of the specific perspectives we have explored thus far, most notably the humanistic and social perspectives. It also draws on the consumer and survivor movements of the 1980s and 1990s as well as concepts related to these movements such as **self-help**, **empowerment** and **advocacy** (Shepherd et al., 2008). In addition, recovery's focus on hope rather than despair and ability rather than disability has some affinity with **positive psychology**, a relatively new development in psychology that focuses on mental wellness rather than illness (see Seligman, 2003).

Recovery is perhaps best understood by examining the principles that underpin it (see Box 1.3). There will, however, be many more opportunities to grasp what recovery means because it is so central to contemporary mental health practice and, as such, is a common theme throughout this book.

Box 1.3 The principles of recovery (adapted from NIMHE, 2005)

- **Choice:** the service user decides if and when to begin the recovery process and directs it.
- **Avoiding dependency:** the mental health system must be aware of its tendency to promote service user dependency.
- **Holism:** recovery from mental illness is most effective when a holistic approach is considered including psychological, emotional, spiritual, physical and social needs.
- **Hope:** service users are able to recover more quickly when hope is encouraged, life roles are defined, spirituality is considered, culture is understood, educational and socialisation needs are identified, and they are supported to achieve their goals via trusting relationships.
- **Diversity:** individual differences and diversity should be considered and valued.
- **Eclecticism:** a recovery approach embraces medical/biological, psychological, social and values based approaches to mental health care.
- **Involving significant others:** involvement of a person's family, partner and friends may enhance the recovery process. The service user should define whom they wish to involve.
- **Cultural sensitivity:** mental health services are most effective when delivery is within the context of the service user's locality and cultural context.
- **Community:** community involvement, as defined by the service user, is central to the recovery process.

Shepherd et al. (2008) outline four elements to the recovery process: (1) the instillation of **hope**; (2) the (re)establishment of a **positive identity**; (3) the building of a **meaningful life**; and (4) the taking of **responsibility and control**. In adopting a philosophy of recovery, Shepherd et al. see the role of nurses and other mental health practitioners as guides, facilitators and coaches to service users attempting to progress along the road to recovery.

Recovery is not without its critics. Slade & Hayward (2008), for example, argue that without research evidence of recovery's effectiveness, it is hard to tell what the future holds for recovery. Will it result in the paradigm shift in service provision that its advocates claim? Will it go the way of many other ideas in mental health and simply disappear into obscurity? Perhaps the worst outcome is that nothing changes – that services are renamed to include

‘recovery’ in their titles without any real change in their function or in the attitudes of the staff who work for them.

At this point, we have considered what we have called the ‘psychiatric’ perspectives on mental health and mental health care (we have essentially dealt with the left-hand side of Figure 1.2), even though some of these perspectives are in reality diametrically opposed to traditional psychiatry. As mental health nurses, we also need to deal with our other parent – nursing – and explore how nursing perspectives have influenced our practices.

Nursing Perspectives

Psychiatric nurses or mental health nurses?

In recent years there has been some debate over whether we are **psychiatric nurses** (i.e., we practise within psychiatry) or whether we are **mental health nurses** (i.e., our roles are concerned with mental health rather than mental illness). Hopefully, by now you will have begun to understand the origins of this debate and the factors that continue to influence it: our history, the tensions between psychiatry and anti-psychiatry, and the recent upsurge in conceptualisations and models of psychiatry/mental health that focus on wellbeing and health rather than disease and ill-health.

As mentioned earlier, by virtue of the NMC, we are legally ‘mental health nurses’. Chambers (2006), in a debate on the topic with du Mont (2006), has pointed out the irony of this since much of the work we do relates to *mental illness* rather than mental health. Chambers adds, however, that ‘mental health nurse’ is a much more forward-looking title that is less stigmatising and one that embraces the philosophy of recovery. Du Mont (2006), however, argues that since much of what we do is focused on the mentally ill, and since we are likely to play a greater role in directly treating people with mental health problems in the future (even to the point of prescribing medication – see Chapter 3) then we should just be honest and call ourselves ‘psychiatric nurses’ or, at the very least, ‘mental illness nurses’. An alternative is to adopt the term that is in frequent use in the United States, **psychiatric/mental health nurse**, but it’s a somewhat inelegant term that has not really caught on in the UK. One radical proposal is that, like physical health, we split the profession into two. In physical health, those nurses concerned with the promotion of health – public health nurses – have a separate identity as **health visitors**, while ‘illness nursing’ is carried out by general (adult) nurses.

This may be happening already in mental health (nursing) inasmuch as mental health promotion is steadily becoming, as you will see in Chapter 3, the remit of a separate worker, the ‘psychological wellbeing practitioner’.

Whatever the debates about the profession – whether we are psychiatric or mental health nurses, or whether what we do is actually *nursing* given the public’s stereotypical views of nurses and the recent advances in mental healthcare provision – nursing has had an unquestionable influence on the profession. Its influence has been three-fold: (1) it has reminded us that minds do not exist independently of bodies; (2) it has provided us with **the nursing process**, a specific way of helping people; and (3) it has provided us with a plethora of **nursing models**.

Mind and body

Reminding us that the people we work with have physical bodies can be a two-edged sword. On the one hand, understanding that there is a connection between physical ill health and mental ill health (especially long term conditions such as heart disease, diabetes and ‘medically unexplained symptoms’, see Lyons et al., 2006) and vice versa (mentally ill people often have poor physical health, see Osborn, 2001; Seymour, 2003) can only improve the care we give. On the other hand, an overemphasis on the physical can bring about the rigidity and rituals that are often associated with adult (general) nursing. Moreover, such an overemphasis on the physical may be off-putting to many potential applicants for mental health nursing since people wanting to work in mental health generally want to work with the mind rather than the body! The sensible approach here is to have a balance between the two, though arguments about the degree of balance tend to elicit the ‘generic nurse vs. specialist mental health nurse’ debates we alluded to earlier. Still, few mental health nurses would argue against including basic anatomy and physiology, basic physical nursing care and basic first aid in a mental health nurse preparation programme; many mental health nurses would, however, argue fervently that you do not need to be a generically qualified nurse before you become a mental health nurse, as is the case in many other countries around the world.

The nursing process

The nursing process is a **problem-solving** approach to care. It is frequently described in the British nursing literature as being cyclical and having four

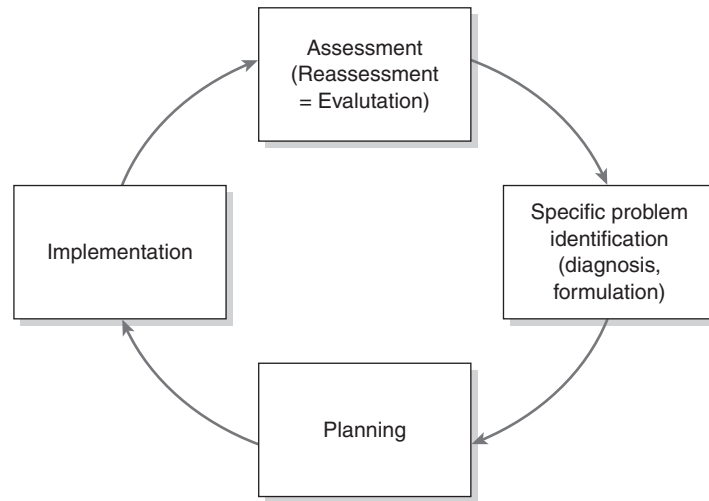


FIGURE 1.5 A modified version of the nursing process

stages: **assessment, planning, implementation** and **evaluation** (McKenna, 1997). There are two problems with this particular view of the nursing process, however: (1) the leap from assessment to planning is missing an interim stage where the results of the assessment are crystallised in order to guide planning; and (2) since evaluation has many of the same elements of assessment (evaluation can be seen as re-assessment) and requires the same skills, it could be argued that there is really a single stage here and not two. These shortcomings are addressed via a modified version of the nursing process outlined in Figure 1.5.

The missing stage between assessment and planning has been termed ‘specific problem identification’ (which is quite a useful thing to have in a model based on problem-solving!) but elsewhere in this book you might also find it referred to as **diagnosis** or **formulation**.

Use of the nursing process in mental health nursing is pretty uncontroversial. After all, as you will discover throughout this book, a problem-solving framework is a reasonable one for guiding practice. It has one flaw, however; a flaw that is not fatal but one that yet again opens up the question of mental health nursing’s identity. As McKenna (1997) points out, though called the *nursing* process, it is hardly unique to nursing, it being a process that most health-care professionals employ. McKenna adds further that what makes it a *nursing* process is the addition of nursing theory or the practical implementations of those theories, the **nursing models**. And herein lies another problem.

Nursing models

One thing you may notice about the ensuing chapters of this book is the lack of specific reference to nursing models. This is partly because, as Gournay (1995) argued some time back, those nursing models that have been used in mental health are archaic and fall short when it comes to an evidence base. There is perhaps a more compelling argument against their use from those who have contributed to this book. In our experiences of educating and training a variety of mental health professionals – mental health nurses in particular – we know that we can teach students to effectively help people with mental health problems without the need for specific *nursing* theories or models. Notice the emphasis on nursing here: almost all of us (as you will discover) use theoretical models of some sort to aid practice and at the root of most of our models is something akin to the problem-solving approach of the nursing process; it's just that we are not particularly precious about those models being nursing models. This is not to say that nursing models *cannot* be used, however, and we appreciate that many clinical areas and many mental health nurse educators still find nursing models useful, especially as a framework for helping learners undertake assessments with service users. To this end, a summary of the nursing models that have been used by mental health nurses is presented in Table 1.3. If any particular model sparks your interest, or if you find yourself in a practice area that is fixated with a particular model, then further reading will be beneficial – whether you want merely to satisfy your interests or do something a little more rebellious like constructing a case for discontinuation of a particular model in practice.

Models underpinning nursing practice

Next time you're in practice, ask your colleagues and mentors if they can name any specific models or theoretical frameworks that underpin or influence their practice.

Ask them how rigidly they adhere to the models or frameworks. Have they made adaptations to the model to make it 'fit' better to practise? Can they tell you what the evidence base is for the particular models or frameworks they use?

Discussion
Point
GoC

TABLE 1.3 Nursing models in mental health nursing

Model, originator, locale	Brief details of the model	Comments and criticisms
<p>Activities of Daily Living Roper, Logan & Tierney (see Roper et al., 2000) UK</p>	<p>Assessment and identification of problems in each of several 'activities of daily living': maintaining a safe environment; communication; breathing; eating/drinking; elimination; washing/dressing; controlling temperature; mobilisation; working/playing; expressing sexuality; sleeping; death/dying</p>	<p>Physically oriented model Little applicability to mental health though often used in physically demanding areas of mental health care such as inpatient dementia care</p>
<p>Orem's Self Care Model Dorothea Orem (see Orem, 2001) USA</p>	<p>Identification of self care deficits in the 'universal self-care requisites for health': air; water; food; elimination; activity/rest; solitude/social interaction; hazard prevention; promotion of normality Provision of three levels of support depending on the degree of deficit: total compensation (the person is unable to self-care); partial compensation (the person needs help with self-care); education and support (the person is taught to self-care)</p>	<p>Overlooks some of the profound and complex self care difficulties experienced by those with mental health problems (Gournay, 1995) Illness-oriented approach</p>
<p>Roy Adaptation Model Sister Callista Roy (see Roy & Andrews, 2008) USA</p>	<p>Based on the concept of adaptation: the process by which living creatures enhance their survival and development Sees the individual as a set of interrelated biological, psychological and social systems in constant interaction with the environment Goal of nursing is to promote adaptive responses in each of the four adaptive modes: physiologic-physical (focuses on the body); self concept-group identity (focuses on the psychological and spiritual aspects of the human system); role function (focuses on the individual's various roles); interdependence (focuses on the individual's close relationships)</p>	<p>Anachronistic (Gournay, 1995) Complex model that is difficult to understand Takes no account of contemporary theories associated with adaptation such as self-efficacy and resilience</p>

TABLE 1.3 (Continued)

Model, originator, locale	Brief details of the model	Comments and criticisms
<p>Interpersonal Relations Model Hildegard Peplau (see Peplau, 1991) USA</p>	<p>Nursing is seen as an interpersonal process, with the nurse adopting a number of roles: stranger (useful in building up a relationship); teacher; resource (supplier of information); counsellor; surrogate (clarifying where dependence, interdependence and independence are appropriate and acting as an advocate); leader (helping the individual maximise their responsibility in achieving their goals)</p> <p>Four phases of the nurse–patient relationship (driven by the individual rather than nurse): (1) orientation (the individual and nurse mutually identify the problem); (2) identification (the individual identifies with the nurse in order to be helped); (3) exploitation (the individual exploits the nurse's skills and resources); and (4) resolution (the individual resolves the problems and frees him or herself from the relationship with the nurse)</p>	<p>Developed by a psychiatric nurse Influenced by psychodynamic psychology Little emphasis on the individual's wider social roles (e.g. family, community) Little focus on health promotion or prevention Anachronistic</p>
<p>Tidal model Phil Barker and Poppy Buchanan-Barker (see Barker & Buchanan-Barker, 2005) UK</p>	<p>Uses the metaphor of water to enable people with mental health problems to tell their stories and move towards recovery. Key assumptions:</p> <ul style="list-style-type: none"> • the primary therapeutic focus of mental health care is the 'world of ordinary life', i.e. the community • change is an ongoing constant process and small changes are important • empowerment, in that the helper has to give up the power relationship characterising normal professional–service user relationships • nursing is about caring <i>with</i> people rather than caring for them 	<p>Developed by a psychiatric nurse Recovery-focused model Can be seen as bordering on the mystical Limited evidence base though qualitative evaluations exist (see Stevenson & Fletcher, 2002)</p>

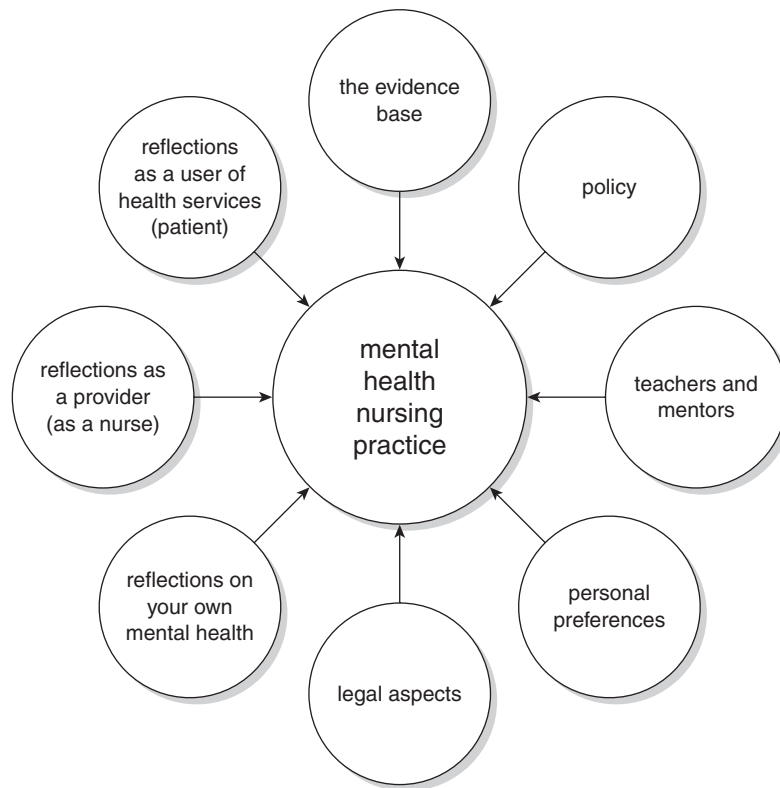


FIGURE 1.6 Eclecticism in mental health nursing

Individual philosophies in mental health nursing: eclecticism

As far as individual nursing practice is concerned, mental health nurses more often than not adopt the perspective(s) that most appeal to them. However, given the current emphasis on evidence-based practice, it is important that we do not let ideological dogma alone dominate our practices. Though there are some practitioners who rigidly adhere to one or other of the theoretical frameworks, these are the exception rather than the rule. Most skilled practitioners take an **eclectic** approach: they have an awareness of the strengths and weaknesses of the various perspectives and models, and they use their professional judgement to select a treatment approach most suitable for a given set of circumstances.

Eclecticism in mental health nursing is normally a combination of: (1) mental health nurses' own experiences; (2) the models and frameworks they have been exposed to by those with influence (such as their teachers and

clinical colleagues; government policy and legal requirements also play a role here); (3) the available evidence base; and (4) personal preferences (see Figure 1.6).

Conclusion

In this chapter we have explored the nature of both mental health and mental health nursing. We have set the medical model against a range of other theoretical perspectives with a particular emphasis on recovery as a dominant philosophy of mental health practice and CBT as a dominant therapeutic approach. We have emphasised that these perspectives are dominant not necessarily because they are 'the best' but because they are either, as is the case with recovery, timely in terms of the political appetite of the policymakers and the general public, or because, as is the case with CBT, they have the most robust evidence base when compared to alternatives.

Along our journey we have also raised many questions about the future of mental health nursing. We have considered whether we are, indeed, mental health nurses or whether we are mental illness or psychiatric nurses, and we have questioned the value (or not, as the case may be) of nursing-specific models in a multi-professional environment. Hopefully, by being party to these debates, you have got a taste for modern mental health nursing (or whatever you choose to call it!) and that, as such, your enthusiasm for the profession has grown in what is a very exciting time for mental health nursing.

Further Reading and Resources

Key texts – psychiatric critiques and social perspectives

- Boyle M (2002). *Schizophrenia: A Scientific Delusion?*, 2nd edition. London: Routledge.
Modern-day classic questioning the scientific validity of schizophrenia.
- Szasz, TS (2010). *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, 50th Anniversary edition. London: Harper Perennial.
A 50th Anniversary edition of Szasz's critique of psychiatry, with a new preface for the age of modern psychotropic medication.
- Bentall RP (2009). *Doctoring the Mind: Is Our Current Treatment of Mental Illness Really Any Good?* London: Penguin.
Accessible critique of modern psychiatry questioning, like Boyle and Szasz, the validity of psychiatric disorders and the ethics and politics of psychiatric medication.

Key texts – nursing perspectives

- Aggleton P & Chalmers H (2000). *Nursing Models and Nursing Practice*, 2nd edition. Basingstoke: Palgrave.
The key British text on nursing models for those interested in finding out more about specific nursing models.
- Nolan P (1998). *A History of Mental Health Nursing*. Cheltenham: Nelson Thornes.
Classic text for those interested in the history of British mental health nursing.
- Stevenson C & Fletcher E (2002). The Tidal Model: the questions answered. *Mental Health Practice*, 5(8), 29–38.
Simple introduction to the Tidal Model from the Royal College of Nursing's Continuing Professional Development series.

Key texts – general

- Appignanesi R & Zarate O (2003). *Freud for Beginners*. New York: Pantheon.
Fun, cartoon-style introduction to Freudian theory – a theory that can be quite daunting and complex.
- Beck AT (1976). *Cognitive Therapy and the Emotional Disorders*. New York: International Universities Press.
Classic text on cognitive therapy; much of it is still relevant today.
- Cooper M, O'Hara M, Scmid P & Wyatt G (2007). *The Handbook of Person-Centred Psychotherapy and Counselling*. Basingstoke: Palgrave Macmillan.
Comprehensive, modern text on all aspects of person-centred (humanistic) therapy.
- Pilgrim D (2009). *Key Concepts in Mental Health*, 2nd edition. London: Sage.
Accessible text in Sage's 'Key Concepts' series that explores a wide range of key concepts, terms, therapies and approaches in mental health.
- Repper J & Perkins R (2003). *Social Inclusion and Recovery: A Model for Mental Health Practice*. London: Ballière-Tindall.
Key text on the recovery model, written by acknowledged experts in this area, and including service user perspectives.
- Shepherd G, Boardman J & Slade M (2008). *Making Recovery a Reality*. London: Sainsbury Centre for Mental Health.
Key policy document on recovery, written by national experts and published by a leading mental health charity.

Web resources

- Campaign for the Abolition of the Schizophrenia Label: www.caslcampaign.com
Interesting and perhaps radical website of an organisation campaigning for the label 'schizophrenia' to be consigned to the 'diagnostic dustbin'.
- The Tidal Model website: www.tidal-model.com
Official website of the Tidal Model with a whole host of resources about this particular approach to mental health care.

Hearing voices network: www.hearing-voices.org

Website of an organisation committed to helping people who hear voices, providing alternative explanations to the medical viewpoint of 'voices' as auditory hallucinations.

Mental health history timeline: www.studymore.org.uk/mhhtim.htm

The design is basic, but this website offers detailed and thorough information for those interested in the history of mental health practice.

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