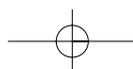
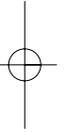
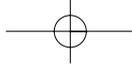


# Part 1

## The Principles of Mental Health Care in the General Hospital

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# Chapter 1

## The Provision of Holistic Care

### Chapter aims

#### This chapter will:

- introduce the context for contemporary nursing care
- provide an overview of mental health problems commonly experienced in the general hospital
- describe the process of mental health assessment in the general hospital
- outline the mental health needs of the patient and how these can be met within the context of the nurse–patient relationship
- explore how structural support mechanisms can assist nurses in these aspects of their work.

### Introduction

This chapter is, essentially, in two parts. The first explores some of the theory relating to, and the context of, holistic care and the nurse–patient relationship. It outlines some of the practical, organisational and educational issues involved in enabling nurses to meet the mental health needs of their patients. The second part provides clinical guidelines on mental health problems commonly encountered in the general hospital, alongside an identification of the processes involved in undertaking a baseline mental health assessment. This is followed by a discussion of the practicalities of the nurse–patient relationship. Written about extensively, it is this relationship that lies at the absolute core of the work nurses do. It is a complex and challenging process to make contact with people on a deep emotional level and requires very specific skills. This chapter emphasises that it is not an ‘add on’ to the physical care provided: therapeutic communications are the means by which nurses facilitate that relationship. A necessary focus on how this is delivered and supported is required, not just on the part of the individual nurse, but ward teams and

senior managers as well. While focusing on the issues outlined above, other parts of this book will return to these themes and some of the associated difficulties are explored in more detail in Chapters 4 and 13.

## The focus of nursing and its relationship to holistic care

Holistic care is underpinned by two basic assumptions:

- The individual always responds as a unified whole.
- Individuals as a whole are different from, and more than the sum of, their parts (Pearson *et al.*, 1997).

The *Oxford Concise Medical Dictionary* (1996) defines the term *holistic* as 'an approach to patient care in which the physical, mental and social factors in the patient's condition are taken into account, rather than just the diagnosed disease'. Thus, despite the apparent expansion of the nursing role, holistic care has proved to be largely incompatible with the practicalities of contemporary nursing. Another irony lies in the way the academic and theoretical base of nursing and nursing models is interpreted and implemented. On the one hand, a theory is

*'a set of concepts, definitions and propositions that project a systematic view of phenomena by designing specific interrelationships among concepts for purposes of describing, explaining and predicting'* (Chinn & Jacobs, 1987).

On the other hand for Henderson (1969):

*'The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or a peaceful death) that the patient would perform unaided if the patient had the necessary strength, will or knowledge, and to do so in such a way as to help the patient gain independence as rapidly as possible.'*

Both imply a holistic approach, with the nurse attempting to meet all of the patient's needs. Going beyond the act of physically tending to the care needs of someone who is 'ill' or 'injured' and meeting the needs of the whole individual thus requires nurses to adopt a bio-psychosocial perspective and have the skill and ability to develop a therapeutic relationship. While Table 1.1 outlines the different stages of the nurse-patient relationship, Peplau (1969) stated this was demonstrated by the nurse 'bringing all her capacities, talents and competencies to bear upon the life of another person'. It requires a closeness, 'not so much . . . to the person who is ill, but rather one of being "closer to the truth" of that person's current dilemma'.

Peplau's (1969) view was that the nurse has to 'put herself aside', or remain detached to achieve this, learning particular skills to demonstrate concern, interest and competence. Subsequent authors have emphasised the importance of partnership, mutuality and reciprocity as being the key elements of the

**Table 1.1** Stages in the development of the nurse–patient relationship.

Pre-orientation phase	Gathering data and information from all available sources
Environmental phase	Creating as safe and confidential an environment as possible
Orientation phase	Establishing a rapport and using a variety of skills to develop a therapeutic relationship within the available time, specific to the task and to facilitate the function of assessment
Working phase	Identifying elements critical to the patient's physical and psychological health and safety, as well as therapeutic elements which aid personal control and coping. Undertake a mental state assessment at this stage
Formulation	Identifying risk, unmet needs, adopt a problem solving approach, managing risk and detailing a clear rationale for actions taken
Termination	Liaising with other health care professional and carers, referrals to specialist agencies

Modified from Fortnash and Holoday-Worret (2000); Roberts and Mackay (1999).

ideal therapeutic relationship (Savage, 1995). When studying nurses' relationships with patients and the work they were doing, Smith (1992) concluded that caring does not come naturally, and that nurses have to develop themselves emotionally to appear to care, irrespective of their personal feelings about themselves, the patient, and the conditions and circumstances in which they work. In doing so, they can be taught to manage their emotions more effectively. Vitally, Smith understood that if this 'essential ingredient of what nurses do is to be recognised and valued [it must be] supported organisationally and educationally'.

The actual skills employed within the therapeutic relationship are explored later in this chapter, but Smith's observations aside, it is obvious that the evolution of the nursing role must be supported by changes in education and training, not only for pre-registration students but also for qualified nurses. Concerns have long been voiced about both, for example, by nursing's former regulatory body the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1999) and the Department of Health (DoH) (1999a). Educationalists, meanwhile, have struggled to prevent nurse education being steered too strongly by the short-term needs of the service. Continuing professional development programmes are also affected by the broader context of health care provision and are thus not immune from financial constraints or organisational, structural and policy changes. This makes holistic care more difficult, due to factors beyond the control of the nurses expected to do

it, with funding problems and staffing shortages maintaining the discredited system of task allocation (Baly, 1980).

Nursing models might have seemed another way in which holistic care could be embedded into practice. Ersser and Tutton (1991) acknowledged 'the explicit reference to the broad humanistic and holistic principles underlying nursing models'. A model has been portrayed as 'a descriptive picture of practice which adequately represents the real thing', which can lead to greater consistency in patient care by providing a framework for the direction, understanding and delivery of that care (Pearson *et al.*, 1997). There are numerous models, but many have problems in meeting the mental health needs of patients in an acute hospital setting. This is exemplified through a brief examination of Roper, Logan and Tierney's *Activities of Living Model for Nursing* (2000), which comprises five major concepts:

- Activities of living (of which 12 types were identified)
- Lifespan
- Dependence/independence continuum
- Factors that influence an individual's activities of living (including psychological)
- Individuality in living

Based upon an assessment of the 12 activities of daily living listed in the first concept, the nurse can utilise a focused approach to the planning, implementation and evaluation of the patient's care from admission through to discharge. Integral to the model is the notion that the nurse gets to know the patient and understand him as an individual. However, many nurses using it remain activity focused and often neglect the more complex and less easily accessed elements of the fourth major concept, when the individual's psychological needs are explicitly identified.

## The context of care: mental health in the general hospital

The general hospital nurse will face large numbers of patients presenting with a wide variety of mental health conditions. Ramirez and House (1997) identified three main types of mental health-related clinical problem:

- (1) Acute primary psychiatric disorder including:
  - (a) self-harm
  - (b) psychiatric crises and emergencies
- (2) Psychiatric disorder in patients with any type of physical illness<sup>1</sup>
- (3) Psychologically based physical symptoms, e.g. somatisation (Harrison, 2001).

<sup>1</sup> This should be taken to include co-existing mental illness, e.g. schizophrenia or mental health problems as a result of physical illness such as adjustment disorder and depression.

More than half a century ago, in *The Work of Nurses in Hospital Wards* (Goddard, 1953) it was noted that there was difficulty in meeting specific patient needs in isolation, and task allocation meant that little time was given to emotional care (White, 1985). The evidence suggests little has changed. Benjamin *et al.* (1994) estimate that between 20% and 40% of all people referred or admitted to the outpatients department of a general hospital will have psychological disorders or mental health problems in addition to the physical disorders that prompted their original referral or admission. It has also been estimated that between 20% and 30% of those attending emergency departments will have mental health problems co-existing with physical disorders and 5% will have presented due to mental health problems alone (Royal College of Physicians/Royal College of Psychiatrists, 1995; Storer, 2000). Yet the mental health needs of patients who are admitted into the general hospital often remain overlooked or ignored. For example, while 11% of all medical inpatients are depressed, only 50% of depression is actually recognised on medical wards (Feldman *et al.*, 1987).

This difficulty in recognising and responding to such high rates of psychological morbidity in general hospitals not only presents a challenge in itself, but it also reflects older dualistic concepts of philosophers such as Descartes, who conceived the idea of the separation of mind and body (Turp, 2001). This is exemplified in the artificial divide between physical and mental health services at educational, organisational and funding levels, with serious consequences for individual patients and families, as well as the service as a whole (Box 1.1; see Chapter 2).

Although numerous policies such as the *National Service Framework for Mental Health Services* (DoH, 1999b) or national guidelines for self-harm (National Institute for Clinical Excellence, 2004) fail to identify any structure or

**Box 1.1** Potential consequences of psychological conditions being unrecognised.

- Decrease in the quality of life of the patient, and possibly their relatives/carers
- Physical recovery will often be affected
- Longer inpatient stay in hospital can lead to further physical investigations in a search for 'answers' which may not be necessary
- Cost implications for the National Health Service (NHS) as a result of lengthy inpatient stays and associated treatments
- A longer period off work and related financial problems as a result
- Social isolation
- Severity of mental health problems can be increased
- Higher risk of suicide

(Robinson *et al.*, 1986; Robinson, 1987; Egan-Morriss *et al.*, 1994; Mayou, 1995; Maguire & Haddad, 1996; Morriss, 1999; Mayou *et al.*, 2000)

**Table 1.2** Summary of safety of clients/patients with mental health needs in acute mental health and general hospital settings (DoH, 2003).

Factor	Benchmark of best practice
Orientation to the health environment	All patients/clients are fully orientated to the environment, in order to help them feel safe
Assessment of risk of patients/clients with mental health needs harming self	Patients/clients have a comprehensive, ongoing assessment of risk to self with the full involvement of patient to reduce potential for harm
Assessment of risk of patients/clients with mental health needs harming others	Patients/clients have a comprehensive, ongoing assessment of risk to others with full involvement of patient to reduce potential for harming others
Balancing observation and privacy in a safe environment	Patients/clients are cared for in an environment that balances safe observation and privacy
Meeting patients'/clients' safety needs	Patients/clients are regularly and actively involved in identifying care that meets their safety needs
A positive culture to learn from complaints and adverse incidents	There is a no blame culture which allows a vigorous investigation of complaints and adverse incidents and near misses and ensures that lessons are learnt and acted upon

requirements for the provision of mental health care in the general hospital, *Essence of Care* (DoH, 2003) does provide a mental health benchmark, 'The safety of clients/patients with mental health needs in acute mental health and general hospital settings', and offers a framework for establishing and monitoring standards of mental health care. This benchmark enables practitioners, patients and carers to influence and participate in developing best practice that is linked to comparison and sharing. It is one of eight benchmarks that focus on fundamental aspects of care, developed after feedback from patient groups, identification of recurring themes from the ombudsman's complaints and analysis of common complaints from mental health service users (see Table 1.2).

The *Essence of Care* initiative is still being implemented across the UK, but strategic health authorities have been set targets for implementation that bring together senior hospital and mental health personnel. If a meaningful dialogue can be established, this offers the possibility of finally establishing an integrated approach to the care needs of the hospital population (Harrison & Devey, 2003; Harrison & Bessant, 2004).

## Stigma and mental health in the general hospital

Apart from organisational difficulties, stigma also contributes to the problem of meeting the mental health needs of patients, marking an individual out as being different and evoking some form of sanction. While stigma related to illnesses such as cancer has declined, people with mental disorders remain some of the most stigmatised. Stigmatising beliefs often result in discrimination, and for people with mental illness, stigma is the largest single obstacle to improving their quality of life (Sartorius, 1998). The stigmatisation of mental illness among clinicians has been less studied than in the wider population, where it is acknowledged as being deep-seated (Royal College of Psychiatrists/Royal College of Physicians/British Medical Association, 2001). However, junior medical staff appear to have more negative and unrealistic attitudes towards mental illness than more senior colleagues (Mukherjee *et al.*, 2002) and a whole swathe of pejorative terms such as 'nutter' are still fairly common currency in organisations which are actively trying to stamp out other prejudices such as racism and sexism. More positively, as with any form of prejudice or ignorance, there is the implication that such attitudes may respond to education and training, which might explain the more positive attitudes of senior medical staff (Bolton, 2003).

## The impact on nurses of meeting the mental health needs of the patient

It is not just negative attitudes and stigma that affect clinicians and their response to patients with psychological distress and mental health problems. Menzies' (1970) groundbreaking study of nurses and nursing in a London teaching hospital sought to explain how complex social systems were established as a means of defence against anxiety. Menzies discovered that the petty rules, traditions of behaviour and conduct, strongly hierarchical structures, and intricate dress codes were all designed to keep at bay the intense physical and, particularly, psychological discomfort that arose from caring for, and tending to, the sick and dying. The problem was, however, that such techniques were ineffective. Worse, because there were no mechanisms for recognising and addressing nurses' collective anxieties, these were displaced and added to the dysfunctional nature of the system in which they were working. Integral to this system had been task allocation, with the nurse-patient relationship fragmented. Decision-making was distant from the nurses delivering care, the workforce was de-personalised by such things as the use of the term 'nurse', responsibility was minimised by needless things like checking and counter-checking, avoidance of change and the denial of feelings. Menzies concluded that the unconscious anxieties persisted in a vague and debilitating fashion, contributing to the high number of nurses leaving the service.

However, as changes were made to the systems of nursing, little attention was paid to providing problem-solving mechanisms that would allow nurses to improve their working situation, and little in the way of clinical supervision that would allow them to articulate and work through the (often appropriate) anxieties and distress experienced as a consequence of more intense work with patients. In this context, nurses who were already operating within an 'increasingly de-humanised process [that is] the practice of medicine' (Cobbs, 1975), would inevitably find it even more difficult to care for overtly distressed and/or disturbed patients who would challenge them on almost every level. Although, as we have seen, there has been some reversion to tasks, little has been done to provide contemporary nurses with the necessary authority to match their levels of responsibility. Few have access to effective structures for problem-solving, such as shared governance, which engages them in addressing the practical issues they grapple with. Most receive little or no psychological support or clinical supervision, or even an acknowledgement that it is necessary, despite the intensity of their clinical work (Dartington, 1994). Meeting the mental health needs of their patients remains at least as difficult as it has in any of the preceding decades (Box 1.2).

**Box 1.2** Summary of the factors that impact upon the nurse when addressing patients' psychological needs.

- Different elements of nursing care have now been segregated and are carried out by specialist staff, e.g. discharge co-ordinators
- The emphasis on more technology and competing organisational targets and needs create an environment where many hospital patients have shorter stays and the nurse has less time to develop a relationship
- Nursing models do not always relate to the psychological needs of the patient
- Many nurses perceive the busy physical demands and environments of the ward as not allowing them the time, opportunity or privacy to be able to deal with the patient's 'psychological needs', whereas addressing the activities of daily living fits well in that type of environment
- Nurses might be tempted to think it is 'not their job', or that they do not have the skills, to deal with patients' psychological problems (particularly if they have access to a mental health liaison service)
- A lack of understanding of the relationship between physical and psychological factors, and of a patient's psychological state and behaviour – particularly if this is challenging – can lead to resentment, with nurses feeling it is better for them to meet the 'real' physical needs of 'more deserving' patients
- The administrative burden has increased exponentially, with more documentation and more meetings for senior nursing staff to attend, removing them from the clinical area and which coincide with a far greater managerial role that limits their involvement in clinical work

## Overview of mental health problems commonly encountered in the general hospital

This section cannot provide an exhaustive list of every mental health problem and psychiatric condition that will be found in patients with physical illnesses, but offers an overview of some of the most common conditions that nurses working with physically ill patients will encounter (Table 1.3).<sup>2</sup> Some are maladaptive responses to physical ill health, for example, adjustment disorders, while others may exist as co-morbid disorders, such as psychosis.

Most people become distressed in response to developing major health problems, particularly if this requires hospitalisation, where the environment is so different from their everyday experience, and often perceived as unpredictable and beyond their control (Royle & Walsh, 1992). Nurses and medical staff often – rightly – view this as being ‘normal’ and ‘understandable’ when physical illness is present and some of the conditions identified lie on a continuum between adaptive and maladaptive responses (see Chapter 2). Anxiety is a case in point, being a ‘pervasive aspect of everyday life’ (Stuart, 2001), and a basic survival response that is both necessary and normal (Rogers *et al.*, 2004). Nonetheless, it is important that the nurse makes it a regular feature of her nursing care and relationship building with the patient that she finds time to talk with him about his individual emotional and psychological response to his illness. This allows for the patient reaction to be addressed over time and prevents a ‘healthy’ response developing into a more serious problem. In order for nurses to be able to do this they need have little more than a fundamental knowledge of different conditions and assessment techniques and of how to apply their nursing skills.<sup>3</sup>

It is important to remember that each individual’s reaction is unique and influenced by a variety of factors, related to their illness or injury, personal characteristics and the health care environment (Moos, 1977). It is necessary, therefore, to assess each person as an individual and, wherever possible, discuss with them options for further care and treatment. Assessment will also help the nurse decide about further referral to specialist mental health staff within the hospital (see Chapter 6).

<sup>2</sup> Further information on most of these conditions, nursing care and treatment can be found in more depth in other chapters. Aspects of the nurse–patient relationship, assessment and care can also be found later in this chapter.

<sup>3</sup> The common psychiatric conditions described in this chapter are categorised, where appropriate, using the two main standardised criteria that are used for diagnosing psychiatric disorders – the International Classification of Diseases (ICD-10) (World Health Organization, 2003) and the Diagnostic and Statistical Manual (DSM-IV) (American Psychiatric Association, 1987).

**Table 1.3** Summary of the mental health problems and mental illnesses commonly encountered in inpatients, people attending outpatient clinics and the emergency department.<sup>4</sup>

Condition	Presenting symptoms will include:	Treatment options include:
<p><b>Adjustment disorder</b> A maladaptive reaction in response to an identifiable event or situation that is stress-producing. Adjustment disorders occur in one quarter of general medical patients (Royal College of Psychiatrists/Royal College of Physicians, 1995)</p>	<p>Impaired social or occupational functioning that is more intense than the 'normal' expected response Reaction occurs within approximately three months of the stressor event Reduction of the reaction generally occurs when the identified stressor diminishes or is no longer present (i.e. resolves within six months of the cessation of the stressor or its effects) (Fortnash &amp; Holoday-Worret, 2000)</p>	<p>Psychological interventions and social support, focusing on education and psychotherapeutic clarification of the individual's particular stressor or conflict (McDaniel <i>et al.</i>, 2000)</p>
<p><b>Somatisation (medically unexplained symptoms)</b> A condition where the person presents with a bodily symptom which has no organic cause, i.e. all medical investigations have ruled out an underlying physical cause. It may also be described as a medically unexplained symptom or symptoms (Harrison, 2001)</p>	<p>The most common symptoms are headache, back pain, abdominal pain, fatigue, chest pain, and dizziness (Kroenke &amp; Mangelsdorff, 1989) Up to half the patients presenting with medically unexplained symptoms have underlying anxiety or depressive disorders which may pass unrecognised in a medical clinic (Katon <i>et al.</i>, 1991) Distress, disability and panic attacks are common in patients with chronic somatisation</p>	<p>Cognitive behavioural approaches can be a successful treatment. If somatisation is quickly and correctly diagnosed, prognosis is good</p>

<sup>4</sup> Self-harm, alcohol and drug misuse are dealt with in Chapters 8 and 11, respectively.

### Anxiety

A feeling of apprehension, uncertainty and fear without apparent stimulus or an objective source of danger, associated with physiological changes. It ranges from moderate to severe, with the latter often leading to progressive avoidance and withdrawal from the feared situations and stimuli. A panic attack is a discrete period of intense fear or discomfort in which symptoms develop abruptly and peak within 10 minutes (Stuart, 2001)

Feelings of apprehension, discomfort, dread, fear, impending doom and panic. Physical symptoms include palpitations, diarrhoea, headache, nausea, frequency of micturition, increased respiration and muscle spasm. Anxiety often co-exists with one or other psychiatric disorders and careful assessment and diagnosis is vital if the patient is to be treated appropriately

Psychological therapies, i.e. cognitive and behavioural therapies, anxiety management (involves relaxation techniques) and pharmacotherapy, i.e. benzodiazepine and antidepressant medications<sup>5</sup>. A combination of medication and psychological therapies has also been found to be successful (National Institute for Clinical Excellence, 2004)

### Hypochondriasis

A preoccupation with a persistent fear or belief of having a serious disease based on the individual's interpretation of physical sensations as signs of physical illness. This is rarely assuaged by positive results from physical examinations and tests

This will depend on the particular individual and may not be consistent with an actual illness or physiological responses

As with somatisation, cognitive behavioural therapy can be a successful treatment

### Post-traumatic Stress Disorder (PTSD)

Classified as an anxiety disorder, occurring as a delayed psychological response – within six months – after an individual has been 'exposed to an extreme traumatic stressor involving actual or threatened death or serious injury, or a threat to the physical integrity of self or others' (Rogers *et al.*, 2004). The individual will have experienced intense fear, pervasive distress and helplessness. The vast majority of individuals exposed to a traumatic event will adapt, with only a small percentage developing PTSD. In the first month following the event it is very difficult to differentiate from a normal reaction which includes a grief reaction, e.g. loss of a limb following an accident

Repetitive, intrusive recollection or re-enactment of the event in memories, daytime imagery or dreams. Conspicuous emotional detachment and numbing of feelings. Avoidance of stimuli or activities that may arouse recollection of trauma is often present, but this symptom is not essential for a diagnosis to be made. Hyper-arousal, manifesting as irritability, panic attacks and hyper-vigilance

Some models of psychotherapy such as cognitive therapy, family therapy, behavioural therapy and psychodynamic therapy. Antidepressant medication. NB: No positive effect has been shown for individual brief psychological intervention and some trials have even shown a worse outcome (Davidson, 1997; Wessely *et al.*, 2000)

<sup>5</sup> Benzodiazepines such as diazepam and lorazepam are intended for short-term management of generalised anxiety disorder (2–4 weeks duration only) but not panic disorders. Certain antidepressants have also been successfully used in the treatment of anxiety.

**Table 1.3 (Cont'd)**

Condition	Presenting symptoms will include:	Treatment options include:
<p><b>Depression</b>                      Diagnosed when a patient's mood is consistently depressed or there is loss of interest and pleasure for at least two weeks and accompanied by four or more other symptoms from those listed in the next column. Physical illnesses such as cancer, respiratory and cardiovascular disease, diabetes, stroke and neurological conditions increase the risk of depression. Similarly, depression following a cerebral vascular accident, myocardial infarction or prolonged physical illness is associated with increased mortality (Robinson <i>et al.</i>, 1986; Robinson, 1987; Egan-Morriss <i>et al.</i>, 1994; Mayou, 1995; Maguire &amp; Haddad, 1996; Morriss, 1999; Mayou <i>et al.</i>, 2000)                      Symptoms of depression can be difficult to identify in physically ill patients as they are often the same as symptoms of the physical illness and associated treatments such as medication, chemotherapy, radiotherapy, etc. (e.g. changes in sleep and appetite). It is therefore important to focus upon the further assessment of the psychological symptoms</p>	<p>Feelings of worthlessness or guilt                      Impaired concentration                      Loss of energy/fatigue                      Suicidal thoughts                      Appetite/weight change                      Altered sleep pattern                      Tearfulness                      Depressive body posture                      Retardation                      Agitation                      Social withdrawal                      Inability to be 'cheered up'</p>	<p>Treatment can include medication (antidepressants), psychological interventions, social support and physical care if this is compromised (National Institute for Clinical Excellence, 2004)</p>
<p><b>Psychotic disorder</b>                      A 'severe mental disorder in which the person's ability to recognise reality and his or her emotional responses, thinking processes, judgement and ability to communicate are so affected that his or her functioning is seriously impaired' (Warner, 1994)</p>	<p>Positive symptoms, including:                      Delusions, or false beliefs, firmly held, despite objective and contradictory evidence                      Hallucinations – false sensory perceptions, or perceptual phenomena arising without any external stimuli, e.g. hearing (most common), seeing, smelling, feeling or tasting things that other people do not</p>	<p>Psychosocial interventions                      Stress reduction                      Antipsychotic medication</p>

Thought disorders, or interference with thinking  
 Anxiety  
 Negative symptoms, including:  
 Blunted emotions, social withdrawal, cognitive deficits and apathy

### Eating disorders

Conditions in which there is excessive preoccupation and concern with control of body weight and shape, with grossly restricted food intake (Basu, 2004)  
 Most patients in a general hospital with conditions such as anorexia nervosa or bulimia nervosa will have been admitted for physical problems related to the eating disorder

An eating disorder may also be found in patients admitted with another condition or illness. It may also be a factor to consider in patients with medically unexplained symptoms, e.g. weight loss, vomiting, abdominal or menstrual complaints (Sharpe & Peveler, 1996)

Eating disorders are more prevalent in industrialised countries where food is plentiful and 'being thin' is considered attractive. There are 14.6 cases of anorexia per 100 000 per year in females and 1.8 cases per 100 000 per year in males. Only one in ten bulimia sufferers seeks help and is having treatment to overcome the condition. The onset of eating disorders is most common in adolescents and up to 90% of both anorexia and bulimia sufferers are female. The prognosis for eating disorders varies widely. Steinhausen (2002) found that 50% of patients with anorexia still never fully recover with overall mortality at 5%, while 20% of patients stay chronically ill

### Anorexia nervosa

Failure to maintain minimum weight for age and height  
 Determined food avoidance  
 Extreme fear of gaining weight  
 Disturbed perceptions of self, i.e. sees self as fat even when very underweight  
 In females, amenorrhoea in post-menarcheal adolescents or delayed or arrested puberty (Basu, 2004)

### Bulimia nervosa

Repetitive episodes of binge eating, i.e. uncontrollably eating a large quantity of food in a defined period of usually less than two hours  
 Intense craving for and/or preoccupation with food and overeating  
 Methods to prevent weight gain, i.e. self-induced vomiting, the misuse of laxatives and/or diuretics and excessive exercise  
 Intense preoccupation with body weight and shape

Specialist mental health teams will provide a wide range of treatments for people with eating disorders, including individual and group psychotherapy, cognitive behavioural therapy, and pharmacological treatments

The issue of re-feeding the patient is highly emotive and raises a number of ethical and legal issues. It is, however, the only time that the Mental Health Act 1983 can be used to physically treat someone but should only be used in life-threatening situations  
 In most cases, the patient will already be linked with mental health services. The clinical team should utilise their mental health colleagues' experience and knowledge of the patient in order to provide consistency with the overall management plan, particularly around eating and meal times, boundary setting and physical care

Table 1.3 (Cont'd)

Condition	Presenting symptoms will include:	Treatment options include:
<p>Mental health problems are common in eating disorder sufferers. Depression and obsessive compulsive characteristics are often found in eating disorder patients, particularly in anorexia. Low self-esteem, impulsivity, conflicts with intimacy and dependency, and difficulty managing anger are common traits in bulimia patients</p> <p>There is a range of medical complications that can be experienced. These affect all body systems but, in addition to amenorrhoea, osteoporosis, hypometabolic symptoms such as cold intolerance, bradycardia, hypotension and constipation will be common in patients with anorexia nervosa. In bulimia nervosa, gastric, oesophageal and bowel abnormalities, hypokalaemia and potassium depletion are common, the latter causing muscle weakness, cardiac arrhythmias and hypotension (Cochrane, 2001)</p> <p><b>Dementia</b> (see also Chapter 12)</p> <p>A cluster of symptoms that provide a label for a range of specific behavioural, psychological, physical and social deficits. The incidence increases dramatically with age but tends to be rare in the under 55 age group (Longmore <i>et al.</i>, 2002). The commonest form of dementia is Alzheimer's disease, which accounts for 50–70% of all cases. The onset is insidious and irreversible. The disease progresses gradually but continuously and survival is approximately 8–11 years from the time of onset of symptoms</p> <p>Other primary causes of dementias include:</p> <ul style="list-style-type: none"> <li>Huntington's chorea (hereditary disease caused by a defect in a single gene)</li> </ul>	<p>Ongoing assessment can be provided by the mental health team and it may be beneficial to have a registered mental health nurse with the patient continuously if she or he is deemed to be high risk</p>	<p>Person-centred nursing is key to the care and treatment of patients with dementia (Morton, 1999).</p> <p>Pharmacological treatments with anticholinesterases are also now being used – see Chapter 12 for more detailed information</p>

Pick's disease (rare form of dementia affecting the frontal and temporal lobes of the brain)

Creutzfeldt-Jakob disease

There are many other causes of dementia of a secondary nature:

Brain tumours (primary and metastatic brain tumours)

Korsakoff's disease (alcohol dementia)

Trauma (head injury)

Drugs

Infection (e.g. HIV/AIDS)

Hydrocephalus

**Delirium** (see also Chapter 12)

Characterised by a transient and fluctuating mental state. It is a reversible medical condition of organic cause although it has neuro-psychiatric aspects which may require specialist psychiatric advice in terms of management of associated behaviours

Delirium is more common after 60 years of age, and it is detected in at least 10% of those admitted to hospital with acute illness (Lipowski, 1987)

Causes of delirium include:

Infection

Drugs (sedatives, anticonvulsants, opiates, etc.)

Stroke

Myocardial Infarction

Hypoxia

Hypoglycaemia

Liver failure

Thiamine or B<sub>12</sub> deficiency

Alcohol withdrawal

Trauma

Epilepsy

Pain

Encephalitis/meningitis

Impaired consciousness, which can occur over hours or days

Disorientation to time, place and person

Erratic behaviour

Thinking can be slow and muddled

Paranoia is also common

Perception is usually disturbed, with illusions and visual or tactile hallucinations common

Mood is often labile, ranging through anxiety, depression and agitation

Memory is impaired. After the episode of delirium is over, the person often cannot remember it

The cause of the delirium should be treated (e.g. any infection) and, while nurses can address the affect associated with it (e.g. anxiety, fear, etc.), in extreme cases, where the patient is at risk, psychotropic medication can be used – see Chapter 12 for more detailed information

## Mental health assessment

Assessment has four overall objectives (Barker, 1997):

- Measurement – gaining information on the scale or size of a problem.
- Clarification – understanding the context or conditions of the problem.
- Explanation – exploring the possible cause, purpose or function of the problem.
- Variation – exploring how the problem varies over time, its seriousness and how it affects the individual.

Mental health screening and assessment tools are available to assist in assessment, and commonly used instruments include the Hospital Anxiety and Depression Rating Scale (Zigmond & Snaith, 1983), devised to determine the patient's levels of anxiety and depression in non-psychiatric hospital clinics, while the General Health Questionnaire (Goldberg, 1972) can be used to identify individuals suffering from non-psychotic mental health problems in general populations.

Neither aims to provide a diagnosis but rather to identify those in need of further assessment. Once the information has been gathered, and a problem identified, then it has to be used and appropriate action taken, which may include referral on to mental health services for a full mental health assessment. However, in most cases, it is appropriate that the ward team undertake a fuller assessment of its own before considering referral. First, any mental health problems identified might be within the competence and experience of the team to address. Second, this will allow a clearer discussion with the mental health liaison team if a referral is to be made (see Chapter 6).

There is obviously a difference between an assessment that a mental health nurse would undertake and that which might be expected of a nurse without any formal mental health training. The purpose of a more complete assessment is to comprehend the way in which a person functions as a result of their condition, the way in which their current problems affect them and ways in which they usually solve the problems, and adapt and employ their psychological strengths. Exploring the relationships between the person's thoughts, feelings and behaviour is a diagnostic process that nurses can, and do, perform well (Ryrie & Norman, 2004). It will also enable the nurse to help the patient make sense of his relationship with the external world and, in this case, the clinical team on the ward, as well as help the nurse determine whether or not the patient has the capacity to make informed decisions. Key components that constitute a baseline mental state assessment are outlined in Table 1.4.

A biographical history should, routinely, have been gathered at the time of admission, either by the doctor or by a nurse. This provides an opportunity to give an account of his personal and family history and how the current events fit within this. However, this is often not done. Not only is it unacceptable in the twenty-first century that people are under the care of clinical teams whose members know very little about them as individuals rather than a set

**Table 1.4** Factors to consider when undertaking an assessment of the patient's mental health in a general hospital setting.

Factors to consider before assessment	<p>Has a physical cause for the problem(s) been ruled out?</p> <p>Has drug and/or alcohol intoxication, or withdrawal, been ruled out as a cause?</p> <p>Is the person physically well enough (e.g. not sedated, intoxicated, vomiting or in pain) to interview?</p> <p>Does the person have a known mental health history? If so, is his mental health team involved in his care while he is in hospital?</p>
History of presenting complaint, or what has prompted the assessment at this time	<p>What recent event(s) precipitated or triggered this presentation or made you think assessment was necessary now?</p> <p>Does the person pose an immediate (i.e. within the next few minutes or hours) risk with specific plans to self-harm or aggression/violence towards you or others?</p> <p>Is there any suggestion, or does it appear likely, that the person may try to abscond?</p>
Appearance and behaviour	<p>Is the person obviously distressed, markedly anxious or highly aroused?</p> <p>Is the person quiet and withdrawn?</p> <p>Is the person behaving inappropriately to the situation?</p> <p>Is the person attentive and engaged with the assessment process?</p> <p>How does the patient look? This is best done as a photo shot description, e.g. clean shaven, dishevelled, make up worn, colour of hair, smiling</p> <p>How does the patient respond to and interact with the assessor?</p> <p>Does he make eye contact?</p>
Biographical history	<p>This comprises a personal, family and social history of the person, allowing him to tell his 'story' and placing his illness and current psychological/mental health problems in context</p> <p>It can include details about his financial and social situation, employment, social and sexual relationships<sup>6</sup></p>
Past psychiatric history	<p>Does he have a history of violence?</p> <p>Has the person got a history of self-harm?</p> <p>Does the person have a history of mental health problems or psychiatric illness?</p>
Speech	<p>Is the speech slow, rapid, loud or very soft, disjointed, vague and lacking any meaningful content?</p> <p>Is the individual skipping from one subject to another?</p> <p>Is the speech 'pressured' (a rush of words that is difficult to stop)?</p>

<sup>6</sup> A relevant issue many nurses find difficult to ask about is whether or not the individual has ever felt they have been abused, physically, emotionally or sexually. It may be that you do not feel confident to ask this but it is a valid and important line of enquiry.

**Table 1.4** (Cont'd)

Thought content	<p>What are the themes emerging from the patient's thoughts throughout the interview?</p> <p>Does the patient experience negative, obsessive or unwanted, intrusive thoughts?</p> <p>Delusional thoughts may also be present or other psychotic ideas (see Chapter 10)</p> <p>What does he think about his illness, treatment and prognosis?</p>
Mood	<p>How does the patient describe his mood?</p> <p>How do you see the patient's mood? The descriptions can be different, i.e. the patient may say that his mood is 'fine' or 'okay' (subjective) but the assessor may observe in the interview that the patient's mood is 'low' 'depressed' 'high' etc. (objective)</p>
Perceptions	<p>Does the person appear to be experiencing any delusions or hallucinations (see Chapter 10)?</p> <p>Does the person have any unusual beliefs about his illness that are not congruent with the information given or his situation?</p> <p>Does the person feel controlled or influenced by external forces?</p>
Cognition	<p>Does the person have the capacity to consent, i.e. can the patient understand and retain information, and then make balanced judgements based on an evaluation of his options?</p> <p>What is the patient's level of concentration?</p>
Risk	<p>Is the person at risk of:</p> <ul style="list-style-type: none"> <li>Suicide?</li> <li>Self-harm?</li> <li>Aggression and/or violence to others?</li> </ul> <p>Are there particular risks associated with the person's mental state and physical illness, e.g. hopelessness prompting non-adherence with treatment?</p> <p>Is the person at risk of self neglect?</p> <p>How immediate is the risk?</p> <p>What would be the likely impact of any actions if the person were to act upon his ideas?</p>
Formulation	<p>What is your understanding of the issues the patient has described?</p> <p>What is the level of risk?</p> <p>Is immediate action required?</p> <p>Is a referral to the liaison psychiatry team necessary?</p> <p>How urgent is the referral?</p>

of symptoms and illness, but it is also very poor practice. There is now a large body of evidence that shows the patient's life experience is profoundly important in shaping such things as his health beliefs, attitudes to hospitalisation, social support and psychological strengths.

If there is a recognition that specialist assessment is going to be sought from the mental health liaison team, it may be better to undertake a truncated

assessment, as the mental health nurse will need to go through a more detailed examination of the patient's mental state and related factors. However, as described in Chapter 6, basic information needs to be gathered before making a referral, including:

- the history of the presenting complaint and why the referral is being made at this time
- a summary of the patient's mental state
- any concerns about risk
- the urgency of the referral.

## The nurse–patient relationship

As noted earlier in this chapter, both despite of and because of, the difficulties posed by a variety of organisational, educational and practice issues, there is a greater scope for nurses to utilise simple communications and interpersonal skills with patients experiencing mental health difficulties. The subject of the nurse–patient relationship has been well rehearsed in the literature. It is not the intention here to detail that but to provide the reader with an overview of its fundamental features in meeting the mental health needs of patients. We have looked at how a holistic approach to care involves integrating all aspects of the person's physical care needs with his psychological needs, which concerns his feelings, thoughts, beliefs and attitudes. It is then that the nurse is helping the patient to deal with his physical illness from a psychological and emotional viewpoint. Arnold and Underman-Boggs (1999) suggest that a therapeutic relationship requires a combination of full presence and emotional objectivity and describe it as:

*'A conscious commitment on the part of the professional nurse to understand how an individual client and his/her family perceive, feel and respond to their world.'*

Rogers defined it as a 'helping relationship', characterised as one 'in which at least one of the parties has the intent of promoting the growth, development, maturity, improved functioning and improved coping with life of the other' (Sundeen *et al.*, 1998).

Benner and Wrubel (1989) claim that the presence of the nurse, both physically and psychologically, is significant for sustaining and deepening the relationship. The uniqueness of this, and the nature of the work it enables, is what then gives nursing its intimacy in comparison with the patient's relationships with other health professionals. Nurses are the only health workers actually providing care to – and with – patients around the clock. This is undoubtedly one of the reasons patients can 'connect' to the nurse as the one person in the health care team who can understand them from a 'holistic' perspective and thus communicate more empathically.

Such commitment by the nurse needs, however, to be visibly demonstrated and calls for the use of a range of interpersonal and communication skills, including Arnold and Underman-Boggs' notion of 'full presence' and 'emotional objectivity' (1999), self-awareness, emotional intelligence, reflection, critical thinking, and empathy. Again, it is not easy work and requires emotional labour (Smith, 1992) but, probably more than anything, gives nursing both its credibility and its authority.

## Effective use of interpersonal skills and therapeutic communication

Hyland and Donaldson (1989) stated that the tool of psychological care is communication, as it is a fundamental requirement to understand what patients think and feel, and to develop a therapeutic relationship. McCabe (2004) argues that patient-centred communication is a basic component of nursing and facilitates the development of a positive nurse-patient relationship.

Although national guidance has effectively 'written out' nurses and nursing in the treatment and care of patients with anxiety and depression, or those who have self-harmed (National Institute of Clinical Excellence, 2004), this is more about the continued medical dominance of the policy agenda and a reliance on formal treatments, such as cognitive behavioural therapy, that few patients will access, particularly in the general hospital. Nonetheless, the use of therapeutic communications in nursing, empathy particularly, is what enables therapeutic change (Ryrie & Norman, 2004) and should not be underestimated.

Box 1.3 outlines the overall benefits of good communication, while Table 1.5 summarises particular skills that nurses can employ, although it needs to

### Box 1.3 Overall benefits from positive and effective communications.

- Poor communication and unhelpful attitudes rate second highest in complaints against NHS trusts in DoH statistics ([www.statistics.gov.uk](http://www.statistics.gov.uk))
- Effective communication with patients is related to positive outcomes. Explaining and understanding patient concerns even when they cannot be resolved results in a significant reduction in anxiety (Simpson *et al.*, 1991)
- Breaking difficult news to patients effectively ensures better adjustment and decreases the risk of the patient developing a mental health-related problem such as adjustment disorder or a mood disorder. It facilitates the use of coping strategies appropriately and decreases feelings of helplessness (Fallowfield *et al.*, 1990)
- Recognition of early signs of aggression or impending violence can help defuse angry or aggressive exchanges
- Failure of communication between staff members can put patients at risk and decrease the quality of working life for all disciplines involved

**Table 1.5** Therapeutic communications.

Intervention	Explanation/example
<i>Preparation (this is more for formal meetings)</i>	
Use a quiet, private environment	Promotes confidentiality and minimises interruptions
Agree the agenda if necessary	Keeps the communication focused
Let the patient know how long you have for the interview	Allows both the nurse and patient to gauge the communications according to the time available. It can avoid the patient beginning to talk about very distressing issues just as the nurse has to go and do something else
<i>Non-verbal</i>	
Active listening	Repeating key words, affirming what has been said, making eye contact, helping the person elaborate on what they wish to say
Look for non-verbal cues	The patient may say everything is 'fine' but look depressed or tearful
Use – and tolerate – short silences	Allows both the nurse and patient to reflect on what has been said and its implications
Body language and posture	Physical congruence with what you are saying, making eye contact, and having a relaxed, open posture convey your interest in the person
Empathising with or recognition of <i>what</i> the other is feeling rather than <i>how</i> he or she is feeling	Conveyed by actively, or reflectively, listening and responding in a way that indicates an understanding of the patient's emotion and perspective, whether stated or not
Genuineness	Acting congruently to the situation, not over-emphasising the caring role. It is supported by being open and spontaneous, and not defensive
<i>Verbal</i>	
Use simple language with as little jargon as possible	Makes the communication process as straightforward as possible
Use open questions to encourage elaboration; also allows the patient to direct the interaction	'How do you feel about what's happened?'
Clarification	'I'm not sure what you mean. Could you tell me a bit more?'
Re-stating	'So you're saying that you find that difficult?'

Table 1.5 (Cont'd)

Intervention	Explanation/example
Engaging with the patient's agenda, or aligning	Finding out what the patient wants and why, e.g. how he wants to be cared for or treated
Set clear boundaries	Clarifying for the patient what are acceptable behaviours (as opposed to acceptable emotional responses)
Know how to close down the interview if you feel out of your depth or are not sure how to respond	'I can see this is distressing for you and I think it best that we pause at this time. It's not that I'm ignoring you, but my colleague, who is more skilled in this area, will talk some more with you about it.'
Summarising	Towards the end of the discussion, go over the key points again, and check whether or not the person wants further information, or to discuss anything in more detail
Confrontation	'Getting angry and shouting at the nurses doesn't help us understand how to help you. Can you say what you are actually concerned about?'
Problem solving	'I know this is very distressing for you but I wonder what might help or has helped you in similar situations?'
<i>After the interview or discussion</i>	
Use diagrams	These can illustrate difficult technical concepts or anatomical information if the patient has difficulty understanding
Visual aids	These can be considered for people with a learning disability
The use of interpreters	Vital for anyone for whom English is their second language or who has a hearing disability when important communications are planned
Provide other sources of information, e.g. the internet, self-help organisations and leaflets	This might be a written record of the key points of the discussion, or even a tape. Leaflets from self-help or voluntary groups might be made available, as well as website addresses and anything else that might help the patient
Document, in detail, what has been discussed	Can be used as part of the feedback (also important to be done verbally) to the rest of the multi-disciplinary team

(Maynard, 1989; Buckman, 1992; Barker, 1997; Sundeen et al., 1998; Russell, 2002; Rylie & Norman, 2004)

be remembered that the use of therapeutic communication techniques does not automatically guarantee therapeutic communication and, because of the many factors involved in human relationships, it is not possible to state that any particular skill, method or pattern of application guarantees success (Sundeen *et al.*, 1998). There are times when, for various reasons, a person cannot assimilate what is being said. This will often be displayed by the person not acknowledging or remembering the information given. Most important in such circumstances is for the nurse not to be deterred, but to look at how better communication can be facilitated, especially if what is required is to give the patient some space and time to reflect on what has been communicated.

These skills can obviously be utilised in more formal meetings with patients, for example, during an assessment or when preparing to impart or share bad news. However, most of them are highly applicable in any communication with the patient, even – indeed, especially – while the nurse is providing physical care. Other key characteristics the nurse can cultivate and exploit in communicating with patients, carers and relatives include altruism, courtesy, kindness, honesty and respect for others. Unconditional acceptance is communicated through accepting patients as people with needs entitled to care and respect (Russell, 2002). It is not to suggest that nurses do not make judgements or feel alienated from the behaviour or attitudes of some patients, but the act of caring comes, in part, from not revealing them.

Reflection and self-awareness can help the nurse consider her actions, their impact, or why care is being provided in the way it is, even questioning its necessity. Unnecessary care, like unnecessary tasks or 'being busy', takes valuable time away from qualitative interventions, such as those of therapeutic communication. Reflection and self-awareness also help the nurse understand why a particular intervention was selected and can help nurses avoid presumptive and ritualised practice (Jarvis, 1992). Equally, reflection can help guard against the widely advocated but ill-informed practice of giving 'reassurance', which conflicts with forms of care such as empathising and is often more about the nurse trying to assuage her own distress and uncomfortable feelings.

In reality, no one could demonstrate the above skills to patients at all times. As has been emphasised, it will always present a challenge to nurses, who will often have conflicting demands placed upon them, not only at work but also in their personal lives. Tiredness and stress affect the nurse's ability to communicate therapeutically and care effectively. Once more, self-awareness can enable the nurse to recognise this and take appropriate steps to adapt to it, possibly resolving the cause of the stress, possibly seeking the support of colleagues in not taking a lead in particularly difficult interactions or with patients she is finding challenging at that time. This necessarily requires good teamwork and a milieu where nurses can openly express their own vulnerability and concerns. It should be recognised that no nurse can work effectively outside such an environment (see Chapter 4).

## Communication and recording of patient-related information

An essential part of communication concerns documentation. It is particularly important to avoid vague or potentially misleading terminology, labelling or jargon, all of which can create significant communication problems with the patient (see Chapter 4). Well written care plans, developed in negotiation with the patient wherever possible, will reflect the course of the patient's contact with nursing staff (Sundeen *et al.*, 1998), as well as the quality of that contact. Hackneyed phrases such as 'offer reassurance' or 'develop a therapeutic relationship' should be avoided. Specific interventions about communications and/or the patient's mental health needs or problems should be used, with interventions and objectives designed to address the problem or need identified.

It can take longer to document an interaction that explores an individual's mental health needs, but the key task is to convey what was communicated, from *both* sides, and should separate out a factual account of what occurred and the clinician's impression (although the latter may be important in itself). Documentation should include detailed information regarding the patient's presentation, identified mental health needs, results from the use of any screening or assessment tools, and a clear management plan. This should include a risk management plan describing who is responsible for each action (see Chapter 8).

## Support mechanisms for nursing staff and other clinicians

A variety of mechanisms at different levels of the hospital organisation are required to enable nurses to perform the work outlined in this and other chapters. Organisational, educational and policy issues have already been touched upon. At ward level, a range of initiatives can be helpful. Ongoing training and education for the ward team on issues relevant to mental health and risk assessment can be provided, and many mental health liaison teams undertake this as a core element of their work (see Chapter 6).

Clinical supervision is a staff development process that aims to safeguard standards of care, facilitate personal and professional development and promote excellence in health care (Bishop, 1998). Research shows it has a beneficial impact on both patient care and staff health (Butterworth *et al.*, 1997), facilitates reflective practice and professional learning, and should be kept separate from managerial supervision – although it is important this is provided as well (Bond & Holland, 1998; Johns & Freshwater, 1998). Clinical supervision can be provided on a one-to-one basis or in groups, formally or informally. Whole-team training and supervision promote better quality decision-making, treatment and democratisation of work practices.

Another structural mechanism key to effective team working is shared governance. This is achieved through 'councils' made up of managers and

clinicians from all backgrounds, all with equal authority, taking a solution focused approach to *all* aspects of the team's working, identifying its agenda from the staff affected by particular issues and where information is shared openly. This allows the team to address stressors that may be patient related or, more likely, to do with organisational issues, either within the team or wider hospital. Even if the whole team is not happy with the resolution of the issue, exerting influence and involvement in the process is still beneficial (DoH, 2001b).

Involving nurses in decisions around the admission of patients, discharge planning, treatment and care, rather than viewing this as the province of the medical team, also promotes the provision of holistic care in the most essential way. This can be achieved by regular clinical reviews involving clinicians from all disciplines rather than the traditional ward round.

## Conclusions

This chapter has covered a lot of ground in outlining the elements of holistic care and the nursing approaches that can enable this. It is complex, difficult and often hampered by a range of external influences. It demands a lot of the individual nurse, the nursing team and others involved with the patient's care, in particular the multi-professional team, managers and educationalists. Paradoxically, it also makes demands of the patient. It requires managers and medical staff to relinquish some of their power and influence while nurses have to be prepared to develop their knowledge and skills, as well as expand the range of their nursing role. This is not achieved through picking up specific tasks that consume their time at the expense of core elements of their nursing role. As shall be seen throughout the remainder of this book, however, it is essential if the nurse is to be able to pro-actively meet the mental health needs of the patient.

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