The Psychiatric Nurse as Therapist 2

The Nurse Therapist in Child Psychiatry

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A major issue over the last five years is whether the nursing profession is the most appropriate to care for psychiatrically disturbed children[1]. A recent review[2] suggests that there exist serious psychiatric problems of childhood which patently call for nursing assessment, decision and action and further, that successful clinical nursing practice is dependent on a perceptive assessment of psychological, social and physical needs of such children supported by a sound theoretical rationale.

Many units, from expedience, must rely on the intuition, experience or in-service training of their staff, but intuitive gifts have no general value unless they can be conceptualized into principles which can then be made generally available[2]. Even worse, many units have staff with no previous child experience, who on a rotation basis accept a care-taking or custodial rôle. Ackral *et al.*[3] point out that the acquisition of therapeutic nursing skills through trial and error management of patients appears foolhardy and retrogressive when an increasing body of knowledge about the theory and practice of modern methods of management and therapy is being developed. They consider that the solution lies in providing comprehensive practical and theoretical further training.

Qualities of Child Psychiatric Nurses

A fundamental question which must be posed concerns the most appropriate personal characteristics of child psychiatric nurses. Wardle[4], who undertook a survey of child psychiatric departments, comments on the remarkable uniformity of unit directors' views concerning qualities required in nursing staff. Those most frequently mentioned were: adequate intelligence, adaptability and versatility, consistency and stability, a liking for children, patience and tolerance, warm-heartedness and motherliness, an ability to relate with sensitivity, empathy and skills in child care. The multi-disciplinary Joint Board Panel[5] lay stress on the capacity for warmth and affection while being aware of the dangers of over-possessiveness, the need for staff to understand and take into account the individual differences of patients and the need for toleration of parents. On the other hand, senior nurses in the United States[6] offered the view that child psychiatric nurses tended, after training, to differ from other nurses in their greater awareness of dynamic and social factors and of the need for direct intervention in child and family disturbances. Brown *et al.*[2] describe three essential characteristics 'which are seldom acknowledged, but which we recognize from our practical experience are an ability to tolerate anxiety, a sense of humour and a greater degree of physical fitness than is necessary in adult work'. Some authorities[7] actually list undesirable qualities, which are mainly extremes of attitudes or traits.

Valuable as these informed opinions may be, what is necessary is some research by vocational psychologists to ascertain the features most predictive of the successful nurse. For instance, in another context[8] research has indicated that important features for psychotherapeutic success consists of non-possessive warmth, correct empathy and genuineness. These divergent views suggest that techniques of student selection may be a particularly fruitful area for research.

Two of the most important tasks in the immediate future are to delineate the salient characteristics of the successful child psychiatric nurse and the seeking of objective ways of uncovering such characteristics in potential candidates[2]. Haldane *et al.*[7] point out that there is no ideal stereotype—that within a pool of trained staff not all individuals will possess the same capacities and skills, nor will one individual respond most appropriately to all situations. Within the total staff the range of qualities and therapeutic skills needed should be available for all clinical contingencies. A question of particular importance is whether different personal qualities and personalities are necessary for the dynamic and behaviour therapist.

Roles and Skills with Particular Emphasis on Therapeutic Skills

John *et al.*[9] describe seven main skills which the psychiatric nurse should possess—skills in the area of basic nursing, technical nursing, occupational and recreational activities, communication both with patients and co-workers, human relationships, organization and observation. The Joint Board[5] describe skills related to maintaining the physical well-being of children (including child care and specific technical nursing skills), emotional well-being, social well-being, the application of individual and group socio-therapeutic techniques, co-ordination, co-operation and communication skills, management, administrative and teaching skills. These different views from the adult and the child field appreciably overlap.

The omission by John and colleagues of child care and parent surrogate skills is understandable as they were writing about general psychiatry, but there is no obvious explanation for the lack of reference to therapeutic skills. Perhaps it was because the previous therapeutic tradition tended to be a benevolent and custodial one. Over the last 10 years the psychiatric nursing literature has increasingly described the use of therapeutic skills, both in the hospital and in the home. To quote the Ministry publication, *Psychiatric Nursing: Today and Tomorrow*[10], 'Much psychiatric treatment today sees the patient as an active participant in treatment—not as a passive object for the exercise of medical skills. This means that the nurse—who is often beside the patient all day—is the key therapeutic figure'. This document advocates the introduction of the nurse to a variety of therapeutic ventures such as behaviour therapy, group therapy and therapeutic communities. Others, too, have underlined this point—'We have no evidence to suggest that experienced nurses are

less able to help patients who need continuing care than psychiatric social workers or doctors and they are sometimes helpful when other members of the staff have achieved nothing. They only are available through the 24 hours'[11].

Brown *et al.*[2] report that in child psychiatry parallel developments have been described in the nursing literature. Over a brief span of time the writings of a single author present evidence of a changing rôle. In 1944 Szurek[12] wrote that he viewed the nurse as a daily supervisor with child care functions, but in 1956 he reported that he then recognized an important therapeutic rôle—'Such a rôle was facilitated by the greater number of therapeutic encounters between the nurse and the child patient during the day and the fact that the nurse acted as a collaborative therapist on the team'. In fact a whole range of opinions from scepticism to approval regarding the value and appropriateness of the nurse as a therapist has appeared in the Anglo-American literature. For instance, in 1966, in an American Nursing Association publication there is an account of a debate of the appropriateness of the psychiatric nurse specialist functioning as a therapist, but this concept has not had universal approval[13 14].

Brown *et al.* see the question as being 'not whether psychotherapy is a suitable undertaking for child psychiatric nurses, but rather which nurses are suitable for psychotherapeutic training. Such training must inevitably evolve, otherwise highly trained nurses become dissatisfied with their limited rôle in the multidisciplinary team'.

What Kind of Therapy

The kind of therapy and the depth of therapy utilized by the nurse will depend on her training, her therapeutic potential, her clinical judgement, her ability to work co-operatively in a team and the therapeutic philosophy of the department in which he or she is based —for instance, it might mainly be individual therapy, group therapy, family therapy or even behaviour therapy. However, basic to all of these are the principles of a day-to-day management of different types of behaviours or disorders, which have been so clearly adumbrated by Rogers[15]. The activities of such nurses have been described by Churchill[14]—who emphasizes that they should be free to move in or out of the rôle of the therapist according to the needs of the patient and her expert analysis and evaluation of presenting situations. This suggests that the therapist has absolute freedom but it is generally accepted that all freedom is relative and the operative factors consist of the therapeutic atmosphere and the views of multiple disciplines which can sanction modification of the environment as far as is possible to satisfy the needs of each individual child more effectively. A further word needs to be said about intensity of therapy. Bruno Bettelheim[16] has sketched his concept of intensive therapy and the rôle of the child care worker as a psychotherapist. He sees treatment as total treatment and refutes the suggestion that there are pertinent questions about hierarchy or professional training. He sees the key factor not as the professional discipline of the worker but rather his/her commitment to engage in the process of self-understanding (Ex Middleton and Pothier—Working Paper). Such a principle in a modified form has relevance for behaviour modification as well.

Little if any time needs to be devoted to the traditional therapies as their principles and objectives have so often been outlined. Instead I would like to expand on the subject of nurse intervention in a crisis or any other situation where nurse/child interaction is necessary to cope with, or modify behaviour. Previously, the most frequent techniques used by residential staff were either absolute permissiveness with or without depth interpretation of behaviour by the individual therapist in an individual session, or repression and custodial care. Such methods of management sometimes worked, sometimes did not and sometimes led to an explosive escalation of the disturbed behaviour.

Redl[17] has conceptualized the special type of interviewing techniques which are needed to deal sensitively with such life events in any institutional setting. The objectives are to help the child gain control of himself and deal actively with his life situation. He calls his technique 'life space interviewing'. Life space interviewing is conducted within a therapeutic atmosphere by a therapist who has empathic and therapeutic potential. Redl asserts that such interviewing though undertaken 'with the child by somebody not his therapist, in the stricter interpretation of the term, involves as subtle and important issues and strategy of technique as the decisions the psychoanalyst has to make during the course of a therapeutic hour.'

Furthermore, he asserts that any kind of therapy with children in such settings 'will stand or fall with the wisdom and skill which the day-to-day therapist' in the children's lives carry out their life space interviewing tasks.

Life Space Interviewing

Some of the characteristics, goals and tasks of life space interviewing are:

1. It is closely built around the child's direct life experience which becomes the focus of the interview.
2. It is undertaken by a person who is a part of the child's 'natural habitat or life space' with a clear-cut rôle and responsibility in the child's daily living.
3. Two major types of goals and tasks in this technique are:
   (a) Emotional first aid on the spot: to deal with the situation at a very superficial here and now level, so that the child can be got back into his previous equable or happy mood.
   (b) Clinical exploitation of life events: occasionally such life events may provide an opportunity of bringing to the child's awareness a significant life issue and the relevant interpretation of it.
4. The event which gives rise to life space interviewing is called the *issue*, but the difference between the above two types is not dependent on the issue.

Why has so much time been devoted to life space interviewing? Two excellent reasons are outlined by Redl. First, if we are to tackle children's problems more effectively in the future than in the past we need to develop new types of treatment closer to real life situations. Secondly, there is a grave manpower shortage and it would be foolhardy to continue to underutilize and undervalue the wealth of potential talent which is within our grasp in our hospitals.

Behaviour Modification Techniques

Similar considerations apply to behaviour modification techniques which provide nurses with opportunities for making a major contribution to improving the mental health of children with serious psychiatric disorders. Some might even consider such techniques more appropriate for nurse use than any others as nurses are not members of the child psychiatric team who are focusing on causes but have to make immediate decisions about how to manage behaviour in here and now situations; nor are they in the position of being able to manipulate causes[18]. And finally, we know that even when we have successfully dealt with the presumed causes the disturbed behaviour may persist; further, disturbed behaviour can bring in its wake superadded emotional disturbance which is a kind of vicious circle type of phenomenon.

I think it is helpful to point out that most trained nurses already use the behaviour modification techniques described by Clarizio and Yellon in relation to classroom management.

(i) Simple withdrawal of reinforcers to reduce troublesome tantrums in childhood.
(ii) *Positive* reinforcement in that they materially or socially reward desired responses.
(iii) Try to help the child to acquire social skills through the emulation or imitation of socially acceptable patterns of behaviour manifested by models.
(iv) Labelling certain behaviours as being specific within a given environmental context.
(v) Help the child to relax within the proximity of a previously anxiety-provoking stimulus.

In the use of such methods, these nurses, without realizing it, are intuitively but inconsistently using the techniques of extinction, operant conditioning, modelling, discriminative learning and desensitization.

The next view which is going to be offered is not a popular one. It consists of the author not regarding the above two variants of dynamic and behaviour therapy as incompatible bedfellows. Strange—yes. But incompatible—no. Even if the presumed earlier causes of current behaviour are ignored, can we really ignore the meaning of here and now life events for the child[19]. Nor can we ignore motivation or our endeavours are in danger of becoming gross, non-cognitive or mindless mechanical manipulations. A judicious combination of the two based on clinical judgement adds a humanizing dimension to the whole exercise.

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The Psychiatric Nurse as Therapist 3

Operant Treatment of the Long-Term Patient 1. A Psychologist's View

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The treatment of the long-term patient is becoming of increasing importance as, with the decline in numbers of patients in our psychiatric hospitals, it emerges as one of the most intractable problems in contemporary psychiatry. The difficulties in treating these patients are due to at least three different sets of problems.

The Basic Problems

First, the patients themselves. Chronic psychiatric patients are characterized primarily by their apathy and loss of initiative. They are withdrawn, preoccupied with their own internal problems, and avoid social contact with other patients about them. They are uncommunicative, often not speaking unless spoken to. They may, for example, pass every meal without saying a word to the adjacent patient, who has been sitting next to them for 10 to 20 years.

Apart from this general lack of activity, many of these patients display in addition some idiosyncratic behaviour pattern. This pattern may consist of a highly stereotyped repetitious sequence of finger movements, or of a particular sequence of words said in response to any social approach made by a nurse. Occasionally a patient may have a spontaneous outburst of violence, such as a spate of window smashing, or may show a sudden refusal to carry out some activity normally carried out, such as eating meals.

In English and Welsh psychiatric hospitals alone there are some 75,000 patients who have been in hospital over 2 years: after this time, patients tend to lose interest in the outside world, tend to conform to the hospital routine, and so slip gradually into institutionalization.

In general then, these patients are a real problem: there are many of them, they are difficult to motivate; it is difficult to find out exactly what