Caring: The Essence of Mental Health Nursing

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Chapter 4

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Learning Outcomes

After reading this chapter you should be better able to:

1. Consider the concept of caring in terms of the language of caring and its ethical underpinnings.

2. Demonstrate an awareness of the relevance of caring to contemporary mental health nursing practice when working with people in a recovery-focussed way.

3. Display the interpersonal and intra-personal skills required to adopt a caring approach to practice.

4. Transfer these skills into your nursing practice.

Abstract

This chapter explores the concept of caring in mental health nursing and locates the art of caring in twenty first century practice. You will be introduced to the ethics of caring and be asked to reflect on your own values, choices and actions when caring. Throughout the chapter you will be provided with opportunities to consider the some of the core skills involved in mental health nursing, including using reflection and how to communicate a caring approach.

Keywords

Caring, Communication Skills, Mental Health Nursing, Ethics

Introduction

The chapter is divided into two parts. Part one examines the language of "caring" in health care settings and identifies the core ethical principles and values that underpin the concept of care. The origins of mental health nursing will be considered by locating emotional and psychological caring in a historical context. The relationship between caring and treatment is examined considering contemporary policy and models of practice.

Part two describes the skills associated with a caring approach to mental health practice. The skills are informed by the recognition that human relationships are intrinsically complicated, and caring cannot be separated from the quality of both interpersonal and intrapersonal communication. In this part we also provide an outline of some basic

skills you can practice which will help you to learn how to listen attentively whilst caring. This aims to ensure caring remains the essence of mental health nursing practice.

Part 1: The concept of caring in mental health nursing practice

Evidence supports the healing power of caring and argues that nurses develop this healing approach by mobilising hope, confidence and trust between themselves and the person they are working with (Benner, 1984). The following section will provide the historical and theoretical justification for caring to remain the essence of mental health nursing practice whilst helping people toward recovery.

The Ethics of Caring

A caring practitioner will acknowledge the need to be physically present and offer solidarity, consolation, and support (Prince-Paul & Kelley, 2017). Such practical expressions of care are at the heart of mental health nursing practice. Caring for another can be seen as the nurse making informed, altruistic decisions which empower the person with whom you are working (Santangelo et al., 2018).

A caring approach requires the mental health nurse to make moral choices and justify their actions in the context of wider questions such as: *How does the action taken agree or conflict with my own moral values? How has the action taken enhanced the choice and well-being of the person I am working with?* What are considered reasonable actions will vary by person or situation. Caring must be underpinned by common

principles, supported by the Nursing and Midwifery Council's Code of Practice (NMC, 2018).

(1) Non-maleficence: To do no harm physically or psychologically.

(2) Benevolence or beneficence, and compassion: To give positive help to people wherever necessary.

(3) Justice: To treat people fairly or equally.

(4) Autonomy: Accepting that everyone has the right to make their own decision based on their own values

(Haddad & Geiger, 2021).

These principles encourage you to base your actions on duty and obligation. Such obligations need to be understood, interpreted and applied by you. They are inseparable from your character and the moral qualities and values you possess. Considering caring as a moral quality or individual value allows you to consider caring towards another as a complex situation in which the moral character, the role of emotion, and the significance of the relationship between you and the person with whom you are working is fully acknowledged.

The language of care: "caretakers" or caring nurses?

The word "care" is perhaps one of the most over-used words in mental health practice.

"Care plans"

"Care co-ordinator"

"Care Programme Approach"

"Care managers"

"Health care assistant"

Not only does the word show up in health settings but it appears in other contexts too, for example, we tell people to "take care" when we leave them; we sometimes ask, "would you care for a cup of tea?". The building where you work or study may have a "caretaker", someone who takes care of the premises. As with any word, when it is used so much in so many contexts, it can easily lose its meaning. For example, is there much difference between caring for a building and caring for a person? We would argue that there is a huge difference and unless we understand the meaning of "care" and put that

meaning into practice, we may as well become caretakers of buildings rather than people.

The good caretaker takes pride in the building and protects it from harm. However, the personal needs of vulnerable people are much greater than the physical demands of the caretaker of buildings. As a mental health nurse (the "caretaker" of vulnerable people) you are inevitably caught up in the tricky business of human relationships. We discuss the complexities of this kind of work in practice later in the chapter. We also argue that you need skills to implement care to complement your moral values and character.

Historical Context

In 1952 psychiatric nurse Hildegard Peplau wrote "*Interpersonal Relations in Nursing"* in which she identified a relational model for mental health nursing, placing emphasis upon the nurse/client relationship. As psychologist, Carl Rogers (1951, 1963), had done much to introduce a "scientific" approach to the realm of "client-centred therapy", so Peplau gave mental health nursing a theoretical base from which mental health nurses could give a meaningful rationale for caring. Mental health nursing subsequently developed as a profession with a theoretical cornerstone of caring through interpersonal relating and caring by way of the therapeutic relationship, and the deliberate use of self "within" this relationship, became core to the mental health nursing role. The idea that caring occurs "within" the therapeutic relationship has generally been maintained throughout the mental health nursing literature; notably through Peplau (1952), Altschul (1985), Watkins (2001), Barker (2003).

Contemporary Context of Caring

The current context of caring is one of transformation, reflecting a movement towards understanding mental health as occurring on a continuum (Johnstone, 2019). This directs thinking toward a "recovery-focussed" approach. The recovery approach is centered around several principles that emphasise the importance of working in partnership with patients and carers to identify realistic life goals and enabling them their achievement. Recovery is an individual journey, accepting that the person is the "expert" in their life. Care should therefore be guided by the person. Those you work with might not always make decisions you agree with, or you might not necessarily approve of peoples' preferred recovery strategies. Co-creating care **with** people and deciding together what works best for **them** is where you need to stop and think carefully about how your own values might influence care. It is this inherently relational nature of caring which makes mental health nursing complex.

The principles of recovery are crucial for maximising choice and autonomy in the care people receive. These principles have been reflected in policy reforms (Department of Health and Social Care, 2019; NHS England, 2019); changes to the Mental Health Code of Practice (Mental Health Act, 2007; Sustere & Tarpey, 2019); and the mental health nursing competency framework (Health Education England, 2020). We recommended that you familiarise yourself with the following: the tidal model (Barker & Buchanan-Barker 2004); the wellness recovery action plan (WRAP®) (Copeland 1997); and strengths perspective (Ibrahim et al., 2014). These models form the basis of recovery

principles. A caring approach therefore represents the foundation for the therapeutic relationship which can act as a vehicle towards recovery.

However, you may be frequently faced with dilemmas which involve striking a balance between promoting recovery through adopting a caring approach and the necessity to protect individuals and communities from harm. Mental health nurses are expected to be able to predict and develop measures to manage the behaviour of individuals experiencing mental health difficulties. In some environments, managing risk can often dominate the decision-making process (Felton et al., 2018), hence a more controlling than caring line of practice is justified.

Studies have shown that patients feel that professionals prioritise medication management and symptom monitoring to manage risk. This is at the expense of providing space and time for individual work, in which the person can raise issues that are important to them and feel heard and cared for (Eldal et al., 2019). It is suggested that this dissonance of priorities can be explained by the continued dominance of a medicalised understanding of mental distress within mental health services. The consequence of this is a conflict of values and understandings which ultimately prevents shared decision making and the promotion of autonomy which are essential to recovery (Waldemar et al., 2016). The primary objective of mental health nursing should always be to form therapeutic human relationships.

Part 2: Skills for caring in mental health nursing practice

Caring in the context of mental health nursing is complicated. It is far easier on human skills and emotions to be a caretaker of buildings than it is to become a caregiver of vulnerable people. There are, however, skills that can be developed to enable "care in action". The historical and theoretical foundations of mental health nursing emphasise the importance of interpersonal and intra-personal skills which are essential for building therapeutic relationships. At the heart of these relationships is a caring approach which can be communicated to the people you work with using basic interpersonal and intra-personal communication skills.

Interpersonal Skills for Caring

The basic interpersonal skills which communicate a caring approach are listed below. Each of these skills will be described and explained. Exercises are given for you to practise each of these skills. We suggest that you conduct these practical tasks with your fellow students and take turns to adopt the various roles outlined in the tasks. This will give you an opportunity to experience the skill in a safe environment where it is ok to make mistakes before practicing in your placements. We also suggest you take the opportunity to reflect upon adopting each of the roles as a way of enhancing your understanding of how it feels to be placed in the varied positions within the interaction.

- Nonverbal communication
- Open questioning

- Clarifying
- Reflecting content
- Reflecting feeling
- Using silence

When all the skills are being used together the proper, respectful conditions for personal growth to take place are provided. The kind of environment and space that is created is caring and therapeutic. By employing these skills in your individual work, you may be able to provide an effective way of truly listening and in doing so communicate genuine care. Not only does the person benefit from being offered these conditions, but the nurse can also learn to develop empathic understanding in the process of exercising the skills.

We cannot emphasise enough the need to practise these skills and one of the best ways to do this is to create role play scenarios. In box 4.1 we have included several such scenarios that might be useful.

Box 4.1 Interpersonal Skills Practice Scenarios

A Client

You are Amanda aged 28. Having experienced many abusive relationships, you went into prostitution and began to use drugs and alcohol regularly. You were admitted to an

acute ward after getting drunk one night. You have been detained under the Mental Health Act and you do not know why you are there and feel very angry that your freedom has been curtailed.

A Nurse

You have been asked to talk with Amanda who is 28. She has been detained under Section 2 of the Mental Health Act. You know nothing about her past, other than she has a history of drink and drugs. She was admitted to an acute ward after claiming to be the virgin Mary and running around a local park with few clothes on.

B Client

You are Bev aged 22. You have been admitted to the acute ward after a serious attempt on your life. You have now been an inpatient for 6 weeks. It is totally impractical for you to go back to your parents as you have a very destructive relationship with them. You have got no ideas for your future. Everything seems hopeless.

B Nurse

You have been asked to spend time with Bev who is 22. She was admitted to the acute ward after a serious attempt on her life. She has now been an inpatient for 6 weeks. You are under a great deal of pressure to discharge her into a women's hostel.

To practise skills for caring using these scenarios it is useful for three people to work together: a client, a helper, and an observer. The observer's role is to sit to one side and silently make notes about the skills the worker is using. The observer should give the worker feedback at the end of the session. Usually when these scenarios are being used 10 minutes should be allowed for practise.

The six skills for listening and communicating care

1. Nonverbal communication

In establishing a caring relationship, nonverbal communication is of the upmost importance. Much of all the communication that takes place between people is nonverbal. When we meet someone for the first time, we automatically make judgments about people, and this is invariable communicated nonverbally. It is important that we are always aware of our nonverbal communication.

Sadly, there are many stories of people being admitted to hospital for the first time and are then left alone. At this critical moment it is imperative that a person is warmly greeted, and a member of staff dedicated to sitting with the person, creating a therapeutic space from the outset.

We have developed an acronym (SURETY) to help facilitate this therapeutic space.

S - Sit at an angle to the client

U - Uncross legs and arms

R - Relax

E - Eye contact

T - Touch

Y - Your intuition

Figure 4.1: Comparisons of ineffective and effective non-verbal communication

Compare the photographs in Fig 4.1. Assuming this sort of positioning may seem common sense, but it is not. You need to practise awareness of body language when working therapeutically.

- Sit at an angle to the client

If we sit directly opposite somebody who is feeling in any way vulnerable, this may be interpreted as confrontational. Sitting exactly next to a person (as in a waiting room), is impersonal. If, however, we sit at a slight angle, it creates a non-confrontational, comfortable seating arrangement, ideal for one-to-one work.

- Uncross legs and arms

Research into nonverbal communication (Lee, 2019) has shown that crossed arms and legs communicate defensiveness. Depending on the whole-body position, crossed arms and legs may also communicate that we are not interested. Purposefully uncrossing arms and legs, communicates openness and that we are receptive to the person.

- Relax

Despite the prescriptive nature of this method of deliberate nonverbal communication, it is most important that the listener learns to relax in the assumed position. It may feel awkward at first, but it is worth it, and furthermore, it works!

- Eye Contact

Maintaining appropriate eye contact is a powerful way of communicating respect and that you are paying attention. Eyes that wander to windows or the clock are sure to be read as lack of interest or attention.

"Appropriate" eye contact is different to staring. Appropriate eye contact breaks on occasions. It is always important to have eye contact at the ready if a client is distressed and perhaps looking down. If they momentarily look up and your eyes are not waiting for them, they may lose trust.

- Touch

The appropriate use of touch is not universal and cultural sensitivity is essential. Hugs or kisses are not appropriate in mental health care although respectful use of touch can communicate compassion, empathy and understanding. Always seek informed consent from the person first.

- Your Intuition

Our final point here is the need for workers to trust their intuition. There are no set guidelines for every situation but as the practitioner grows in confidence so they should learn to trust their intuition.

2. Asking Open Questions

A closed question is a question that elicits a yes or no answer. An open question invites the client to think, explore and talk freely.

Examples of open and closed questions are in Table 4.1

A woman has been admitted to a word having taken a large overdose. The worker is conducting an assessment.

Closed	Open
• Did you really want to die? • Do you live alone? • Do you work? • Are you feeling suicidal?	• How were you feeling when you over-dosed? • Tell me about you home life? • What do you do for a living? • How are you feeling now?

Look again at Table 4.1 and you will see that closed questions usually begin with: Do, did or are. Open questions usually begin with: How, when, what and tell. Can you think of more?

We advise against using the word “why”. Often, when people are in distress, being asked “why” can be infuriating. People often do not know “why”.

3. Clarifying

When clarifying some factual information, it is fine to ask closed questions: “Did you say your husband was George?”

Unfortunately, however, assessments often sound like a tick list of information giving and receiving and little time is given to open exploration.

Clarifying is essential if we are muddled about factual information. People are generally happy to clarify if we have misheard or made a wrong assumption.

4. Reflecting Content

Reflecting to the person the content what they are saying:

- Demonstrates you are listening
- Ensures accuracy
- Communicates empathetic understanding
- Creates dialogue

Here are two examples (Box 4.2 and Box 4.3):

Box 4.2 Examples of Reflecting Content

Example 1

Service user: I don't know why I've been sent here to talk to you

Student nurse: You don't know why you are here

Example 2

Client: I don't know what's the matter with me, the doctor says one thing, my son says something else, and I don't know what to do.

Nurse: You're getting conflicting advice and you are unsure what to do.

These responses may not be perfect and there is no absolute right or wrong. What you are attempting is to avoid judgement and focus on being reflective.

5. Reflecting Feeling

Reflecting feeling is the same as reflecting content but there needs to be a focus on the person's feelings. These may be communicated verbally or nonverbally.

Box 4.3 Examples of Reflecting Feelings

"You had tears in your eyes when you said that"

"You sounded angry when you said that"

"You sound sad"

"You look very tense"

"I can see your fists clenched"

"You look afraid"

"You look pleased about that"

Examples of reflecting feelings communicated verbally:

For this use the same expressions as before but this time we add the reflection of feelings:

"…and you sound confused"

" … and you sound sad"

" … and you sound worried"

" … and you look angry"

" … and you look frightened"

Once again, we stress the need to practice these skills. They are quite straightforward in principle but take a long time to develop. Do not underestimate the effectiveness of using skills of reflection. As people feel listened to and empathically understood, trust will inevitably develop, and the person will feel able to engage.

6. Silence

The use of silence in attentive listening and communicating care is essential. Whilst silence is common between people who are intimate, it is often considered uncomfortable in normal conversation. We have provided some questions for you to consider in Box 4.4. Working therapeutically needs to be more than normal conversation and the use of silence has to be practised (see Box 4.5).

Box 4.4 Pause for Thought

How often do you experience silence?

How do you feel?

Why not sit in silence now for 10 minutes?

This is often very difficult to achieve, have you noticed?

The world was a much quieter place years ago. Before technology brought us recorded music and mobile phones!

In using attentive listening skills for individual work, it is necessary to allow adequate pauses between the client speaking and your next response/intervention.

Box 4.5 Using Silence

Example without a pause:

Client: I don't know why I've been sent to talk to you

Nurse: You don't know why you are here?

Now with a pause the dialogue changes

Client: I don't know why I've been sent to talk to you

[Pause]

Client: Maybe it's for my own good

[Pause]

Nurse: You don’t know why you are here but maybe it’s for your own good

The first pause allows the client to think for themselves. The second pause allows you to reflect. We recommend a pause of five seconds.

Now when you practise your skills, count to five in your mind before making your next intervention. If you can introduce this very simple skill into your work, it will have an immediate impact on the style and tone of the interaction. From the outset we have argued for the significance of respect in the caring relationship. The use of silence is a way of communicating that respect. Silence conveys several messages:

- The person is important to you
- You have time for them
- This is more than a normal conversation
- Interventions are considered
- It is OK to be with someone without feeling the need to **do** something.

Using the Skills in Practice

Whenever you are given the opportunity to work with someone, we believe that it is necessary to employ interpersonal skills such as those presented in this chapter. It is not enough to just rely on personality or charm. The work of building, sustaining, and ending therapeutic relationships is complex and if it is to be therapeutic then relationship building takes time, patience and skill. Our critics may accuse us of oversimplifying the skills needed for working in caring relationships. What we assert is that if the practitioner masters the skills in this chapter their work will be greatly enhanced. It may be helpful to access the "transferring skills into your practice" self-assessment provided on the website to help you to prepare, plan, implement, and evaluate the use of these skills in your placement.

Intra-personal skills for caring

There is much emotional and psychological distress all around us and we are not immune to mental health difficulties. At times, we all need somebody who will offer us the human qualities to provide a caring relationship. In clinical practice, this support should come from your supervisor who themselves has experience in mental health work and supervisory training. On occasions, it may be necessary for mental health nurses to receive counselling or psychotherapy. It is perfectly understandable that people who are regularly exposed to the distress of others may be affected in some way.

Conclusion

Communicating care towards another is part of a wider human experience. It requires both emotional and thoughtful response, but often leads to tension. The values of the nurse are not always in line with those of the patient or those of the healthcare institution or system they are working within. Therefore, caring often requires making decisions which are justified by conveying a compassionate response to the person with whom you work (Straughair, 2019). Caring is more than a principle or ingredient of mental health nursing practice, but part of the core which underlies every therapeutic interaction.

Tips from service users

- Show me that you are listening to me and at least 'trying' to understand me as a person (not just a diagnosis).
- Think about '*what is right for this person?',* knowing that that might change as things change as my condition fluctuates.
- Validating my feelings and experiences is a huge thing for me and a very important aspect of my care.

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Research into Recovery

www.researchintorecovery.com

Recovery and the Conspiracy of Hope

http://www.patdeegan.com/

National Empowerment Centre

http://www.power2u.org/index.html

- Strengths Based Approach

Ibrahim, N., Michail, M. & Callaghan, P. (2014). The strengths based approach as a service delivery model for severe mental illness: a meta-analysis of clinical trials. BMC Psychiatry 14, 243.

- Tidal Model

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- WRAP

Wellness and recovery action planning

http://www.mentalhealthrecovery.com/