

Principles and practice of mental health nursing

[Health & Medicine](#), [Mental Health](#)



Introduction

This essay will discuss the development of Cognitive Behavioural Therapy (CBT) and its role in mental health nursing. A brief definition of CBT will be given, and treatment modalities used before the advent of CBT for the treatment of anxiety will be explored. The essay will evaluate the principles and practice of CBT, and equate this with the recovery process. The essay will also explore two CBT approaches that can be used to work with anxiety. The limitations of CBT will be discussed, likewise the relevance of CBT to mental health nursing. The essay will be concluded by highlighting the learning I derived by writing this essay.

CBT is an umbrella classification of the different approaches in psychotherapy treatment which helps patients to understand how their thoughts and feelings influence their behaviour. CBT is evidenced based, collaborative, structured, time limited, and empirical in approach (Westbrook et al, 2007). According to the National Institute for Health and Clinical Excellence (NICE) guideline, (2010) it should be recommended to patients and carers for the management of major mental health problems. The CBT process normalises recovery which is important in therapeutic alliance as opposed to the medical model of care which pathologises recovery. The socialization process fits with that of the recovery model both of which are patient centred, giving hope and optimism to the patient, and using a set of outcomes set by the patients (Till, U. 2007).

According to Hersen, M (2008), the earliest origin of CBT can be traced back to the times of Siddhartha Gautama (563-483 BC) and Epictetus (A. D. 50-

138) both of whose work reflected the concept of CBT in their teaching. CBT was developed from two parts way: ' Behaviourism' and ' Psychoanalysis'

Behavioural therapy was developed from the principles of animal learning to humans from two main principles called classical and operant conditioning (Shawe-Taylor & Rigby, 1999). Classical conditioning theory was based on the work of Pavlov (1927) while " Operant Conditioning" theory was based on the work of Skinner (1938). Psychoanalysis was developed by Sigmund Freud and looks at the functioning and behaviour of human. BT arose as a response to the psychodynamic image, when Freudian psychoanalysis was questioned for its lack of a scientific base.

The application of behavioural science resulted in merging CT & BT approaches, resulting to the treatment of anxiety disorder and inappropriate behaviours, and little progress in depression and psychosis (Shawe-Taylor and Rigby, 1999). However, the failure and criticism following the use of strict behavioural concept to explain complex behaviour brought about the emergence of the cognitive behavioural therapy. The major difference between the two approaches is the inclusion of the meditational approach in CT. (Hersen, M and Gross, A. 2008). Rational emotive behavioural therapy (REBT), developed by Albert Ellis (1913-2007) was one of the treatment approach used during this period.

CT was developed in the 1960's by Aaron Beck, and this approach became popular for its effective treatment of depression. The significant result from the merge of BT & CT was the outcome of treatment for panic disorder by both Clark and Barlow in the UK and US respectively. Their combination in

the 80's and 90's has resulted in CBT being a sort after therapy for mental health disorders.

Anxiety is an example of a mental health problem. Anxiety is a common and treatable mental health disorders which manifest as feelings of uneasiness such as worry or fear which could be mild or severe, and a normal part of human condition Barker (2009). The feelings of fear and worry are sometimes helpful in psychologically preparing us to face the problem and physically triggering the flight and flight response. This affects 1 in every 10 people (RCPSYCH, 2010).

The major types of anxiety disorder are: generalised anxiety disorder, panic disorder, obsessive compulsive disorder (OCD), post traumatic stress disorder and social phobia or social anxiety disorder. The symptoms of anxiety manifest through the mind via frequent worries, lacking concentration, feeling irritable, feeling tired and sleeping badly. While in the body symptoms include palpitations, sweating, muscle tension, fast breathing and faintness (RCPSYCH, 2010). Social anxiety disorder is use for discussion in this essay.

Treatment modalities before the coming of CBT include those from psychoanalysis and Behaviourism. Anxiety treatments available before CBT include: refraining people from excess exercise in other not to increase the strain on the nervous system, administering Strychnine, arsenic and quinine and applying a white hot iron along the spine in severe cases. Exposure treatment which is still being use till date, use of Radionics by attaching patients to various devices with the belief that healthy energy is vibrated to

unhealthy parts of the body, Use of Rational emotive behaviour therapy (REBT), and the use of Gamma-amino-butyric acid (GABA) facilitating drugs. Insulin shock therapy was also used (Marlowe, J 2011)

Cognitive approaches use in working with social anxiety is: cognitive restructuring and exposure therapy. Cognitive restructuring according to Heimberg and Becker (2002) is the identification and challenging of irrational thoughts, which include beliefs, assumptions and expectations and replacing them with those that are rational, realistic and adaptive. The principle is not only challenging the negative thinking pattern that contribute to the anxiety, it also helps to replace them with more positive and realistic thought pattern by suggesting alternatives and by reinforcing the client belief in the alternative interpretations and ideas suggested (Norman and Rylie, 2009).

For a person having a fear of public speaking in social anxiety disorder, the way he or she feels is not determined by the situation but by his or her perception of the situation, thus the thought, emotion and behaviour is important in therapy. The therapist, in collaboration with the client uses the situation-emotion-thought-behaviour (SETB) to structure how the treatment will go. Cognitive restructuring is done in three steps, with full collaboration between the client and the therapist after building up a working therapeutic relationship. The first step is identifying the content and occurrence of the unhelpful thought. The therapist will ask the client to write down his or her thoughts, using thought monitoring records. Client may come up with thought like: I am not good at preparing speeches; I will make a fool of myself, or what will people think if I say the wrong thing. The therapist

starting question could be, “ If we could make one thought go away, which one will you choose to make a difference in the way you feel”, or “ what is the worst thing that could happen?” Such questions are asked to uncover underlying fear. (Norman and Rylie, 2009, Padesky and Greenberger, 1995). The second step is challenging the negative thoughts. Here, the therapist will help to dispel the irrational thoughts and beliefs to loose much of its power over the patient at this stage. The third step is replacing the negative thoughts with realistic thoughts which are more accurate and positive, with the therapist teaching the client about realistic calming statements he/ she can say when such anxious situation comes up.

Systematic desensitization is a type of behavioural therapy use to treat social anxiety. It was developed by Joseph Wolpe, a South African psychiatrist. Systematic desensitization also called graded exposure, is the process of facing the anxiety or fear producing triggers from the less feared to the most dreaded ones, and the pre - planned grading of the triggers for exposure is referred to as “ hierarchy” while habituation is “ the reduction of anxiety over time when a person encounters an anxiety or fear - provoking trigger without the use of safety behaviours” (Norman and Rylie, 2009). Systematic desensitization helps a client to gradually challenge his or her fears or anxiety, build confidence over time and master skills for controlling his or her anxiety. The process involves the therapist first teaching the client some relaxation techniques like deep muscle relaxation and assesses their ability to utilise this. For example, a person who is anxious of facing the public and due to give a lecture, the step is to create a hierarchy of the anxiety or fear experience. The questions the therapist can ask to evoke

triggers are: “ What places, thing or people make you uncomfortable“ What brings your fear/anxiety/worry on(Norman and Ryrice, 2009). Then the therapist ask the client to set an exposure task according to his hierarchy of triggers, which should be graded, focused, repeated, and prolonged using the daily exposure diary. The client then work through the list with the guardian of the therapist, and the goal is to stay in each situation until the anxiety or fear subsides. The whole process is carried out with both parties collaborating together to achieve the goal, first through “ in vivo exposure, such as imagining giving a speech and when the situation become easier, then the client progresses to the situation in the real world. The use of home work is also use.

Despite all the good attributes associated with CBT, it is not without its own limitations. CBT is very complex to implement having a poor outcome with substance users who have a higher level of cognitive impairment (Patient UK). The availability of well trained and experienced qualified therapist is hard to get in the rural communities (Robertson, 2010). CBT does not work for everybody, and requires high commitment from the patient who see the home work as difficult and challenging (Patient UK). Some aspects of CBT therapy cannot be applied on people with learning disability and language is a barrier for those who English is not their first language.

Nurses interact and undertake more roles with patient, and they are the first contact complaints are made to, which could give them an opportunity to offer CBT skills in the nursing process if it was incorporated in their training. (Padesky and Greenberger, 1995) Thus, the teaching of basic CBT skills is

now being incorporated into the curriculum of the Mental Health Nursing pre/post registration programme. According to Gournay, K (2005), mental health nurses are now taking up challenging roles in management and nurse prescribing, giving advantage of freeing up the psychiatrist to undertake the more complex cases. The case for a nurse cognitive-behavioural therapist has been made glaring by the shortage of qualified therapist as a result of the widening evidence base for the approach and the recommendation by the NICE guidance for the provision of CBT for the treatment of hallucination and delusions (National Institute for Clinical Excellence, 2002). As recovery is all about inspiring hope to the patients, the mental health nurses will be better equipped to offer a person centred care required for patient recovery. The incorporation of CBT to mental health nurses curriculum will prepare nurses to be more collaborative in approach, and allow patients to have more input in their care which will improve the therapeutic relationship between the nurse and the patient and make nurses more approachable. With the advent of computer based CBT, the need for patients to meet with the therapist on a one on one basis is reduced, thus addressing the shortages of therapist and opening a new window for the people who are depressed or withdrawn to use the approach. (Robertson, 2010). There is prospect for mental health nursing considering the boost in career prospect this will bring to the profession and their position in the multidisciplinary team.

This assignment has been an eye opener for me as a mental health student. It has exposed me to various issues in mental health, past & present. And given me the opportunity to plan ahead of the future in shaping my direction

in the profession. The essay has also given me the opportunity to know about the history of CBT and the various treatment approaches used before its era. It has given me the opportunity to see the interrelationship between CBT and recovery in care practice and also shown me that CBT skills will greatly enhance the quality of care provided by the mental health nurse. CBT should be made mandatory for all mental health nurses as a matter of necessity.

REFERENCES

Barker, P. (Ed) (2009) *Psychiatric and Mental Health Nursing: The craft of caring* 2nd edn. London: Hodder Arnold.

Gournay, k. (2005) 'The changing face of psychiatric nursing: revisiting mental health nursing', *Advances in psychiatry treatment*, 11, pp. 6-11
RCPSYCH (Online). Available at: <http://www.apr.rcpsych.org/cgi/c>

Hersen, M. and Gross, A. (2008) *Handbook of Clinical Psychology. Volume 1*. John Wiley & Sons.

Heimberg, R. and Becker, R. (2002) *Cognitive-behavioural group therapy for social phobia: basic mechanisms and clinical strategies*. 1st edn. New York: Guilford Press.

Marlowe, J. (2011) 'Historical treatments for anxiety' (Online). Available at: http://www.ehow.com/facts_5681571_hist.

Norman, I. and Ryrie, I. (2009) *The Art and Science of Mental Health Nursing*. 2nd edn. Milton Keynes: Open University Press.

<https://assignbuster.com/principles-and-practice-of-mental-health-nursing/>

National Institute for health and clinical excellence (2010) Summary of cognitive behavioural therapy interventions recommended by NICE.

Available at: <http://www.nice.org.uk/usingguidance/com>

Padesky, C. and Greenberger, D. (1995) Clinicians Guide to Mind Over Mood. London. Guilford Press.

Patient UK (2011) what is cognitive-behavioural therapy Available at: <http://www.patient.co.uk/health/cognitive->

RCPSYCH (2010) ' Anxiety, Panic and Phobias'. Available at: <http://www.rcpsych.ac.uk/mentalhealthinfo> (Assessed: 4 March 2011).

Robertson, D. (2010) The Philosophy of cognitive Behavioural Therapy: Stoicism as rational and cognitive psychotherapy. London: Karmac.

Shawe-Taylor, M. and Rigby, J. (1999) ' Cognitive behaviour therapy: its evolution and basic principles', The Journal of The Royal Society for the Promotion of Health, 199(4), pp. 244-246.

Till, R. (2007) ' The values of recovery within mental health nursing', Mental health practice, 11(3), pp. 32-36.

Westbrook, D. Kennerley, H. And Kirk, J. (2007) An Introduction to Cognitive Behaviour Therapy- skills and applications. London: Sage.