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PSYCHIATRIC MENTAL HEALTH NURSING

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Psychiatric Mental Health Nursing

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Psychiatric Mental Health Nursing

Psychiatric mental health nursing is an integral aspect of all nursing as well as an area of clinical specialization. It has been variously defined by leaders in the profession. It is generally agreed, however, that psychiatric nursing is an interpersonal process and that it is concerned with the promotion of mental health and the prevention of mental illness as well as with the assessment of and intervention with people who are evidencing problems in living and in relating with other people. Volume 2 of the first edition of this *Handbook* includes a chapter by H. Peplau, "Principles of Psychiatric Nursing," which very adequately describes the field of psychiatric nursing up to 1959. This present chapter is intended to be supplemental to that work.

In this paper the term "generalist" refers to a nurse with basic preparation. The terms "specialist" and "psychiatric nurse" refer to nurses with a master's degree in the clinical specialty area of psychiatric mental health nursing.

Trends and Issues in Psychiatric Nursing

Many developments since World War II led to modifications in the practice of psychiatric nursing. Such events include social legislation, particularly the legislation that led to the community mental-health

movement; the development of new technologies in psychology and psychiatry; and changes within the health care delivery system and the profession of nursing. Some implications of these events are discussed below. Changes in the practice of psychiatric mental health nursing include those made in the settings for practice; the addition of new roles, skills, and techniques; and the increase in responsibility and accountability for one's own practice.

Impact of the Community Mental-Health Movement

Psychiatric care has moved from the narrow focus of hospital psychiatry to the more inclusive concept of community mental health services. This major shift in emphasis, which has affected all the mental health professions, was ushered in by the report of the Joint Commission on Mental Illness and Health. Congress, through the Mental Health Study Act of 1955, had directed the commission (as chosen by the National Institute of Mental Health) to analyze and evaluate the needs and resources of the mentally ill in the United States and to make recommendations for a mental health program. The report, after being submitted to Congress, the Surgeon General of the Public Health Service, and the governors of the fifty states, was published in 1961 under the title *Action for Mental Health* (Joint Commissions on Mental Illness and Health, 1969).

This landmark report on the history of mental health in the United States noted that progress depends on the solution of problems in three areas: (1) manpower, (2) facilities, and (3) cost. While recognizing that certain kinds of medical, psychiatric, and neurological examinations and treatments must be carried out under the immediate direction of physicians specifically trained in these procedures, the report stated that nonmedical mental health workers with aptitude, sound training, practical experience, and demonstrable competence should be permitted to do general short-term psychotherapy. This helped pave the way for nurses to become primary therapists, taking full responsibility for their therapeutic work with clients. The report also recommended the establishment of additional clinics, psychiatric units in general hospitals; the development of regional state hospitals of not more than 1000 beds; the creation of aftercare and rehabilitation services; and a public education program.

President Kennedy, in a message to Congress in 1963, had stated: "We need a new type of health facility, one which will return mental health care to the mainstream of American medicine and at the same time upgrade mental health services." Congress enacted the "Mental Retardation Facilities and Community Mental Health Centers Construction Act" in October of that year. This legislation authorized federal funds for use by the states in constructing comprehensive community mental health centers. The 1963 act covered only the construction of community mental health centers, but in 1965 the

measure was considerably strengthened by legislation that provided substantial funding for staffing of the centers for the next five years (Adelson, 1967).

The Narcotic Addicts Rehabilitation Act of 1966 took a major step in revising society's attitude toward addiction by establishing the narcotics addict, within federal law, as a sick person to be treated rather than punished. Through its administration of this act and of the Narcotic Addict Rehabilitation Amendment to the Community Mental Health Centers Act, the National Institute of Mental Health actively carried out the congressional mandate to treat and rehabilitate drug addicts. Nurses have become more involved in dealing with drug abuse and the management of drug-dependent individuals since this legislation was enacted. Subsequent legislation defining public drunkenness as an evidence of sickness rather than as a crime is also altering treatment methods for alcoholics, which will probably produce further changes in the practice of psychiatric nursing.

By the mid-1960s the community mental health movement was well under way. Since that time it has drastically influenced the practice of psychiatric nursing, which might now more appropriately be called community mental health-psychiatric nursing. The changes that have occurred largely as a result of this movement include the following:

1. A shift from hospital-based to community-based practice.

2. A shift from an individual-patient focus to a family orientation.

3. An emphasis on the competencies and coping abilities of people as well as on their problems and psychopathology.

4. An emphasis on prevention as well as on treatment and rehabilitation.

5. A greater number and diversity of settings of practice.

6. A greater number and diversity of roles for psychiatric nursing.

7. An increased involvement of generalist-level nurses (particularly public health nurses) in mental health work.

8. An increase in the responsibility and accountability of nurses for their own practice.

9. A greater use of group leadership skills and techniques.

10. A greater awareness and conscious use of social systems and human relationship systems.

Innovations in the Treatment of Psychiatric Patients

Changes in the hospital practice of psychiatry have also had an impact on psychiatric nursing practice. In settings where the prevailing philosophy of treatment has been the traditional one-to-one psychotherapy or psychoanalysis, the role of nursing tended in the past to be custodial—the

"other twenty-three hours." Within this framework in the mid-twentieth century, nurses struggled to be recognized as more than just caretakers. They tried to do this by becoming more or less traditional one-to-one therapists, following the medical model.

"Milieu therapy" also had its beginnings within the framework of psychoanalytically-oriented inpatient psychiatry. The importance of the interaction with the nursing staff became obvious in treatment programs that recognized the importance of the impact of the total milieu on the individual patient. Nursing personnel are the conveyors of the culture; in very large part, they constitute the milieu of the patients. In milieu-conscious programs, nursing came to be recognized for the significant roles it plays in providing therapeutic care.

The "therapeutic community" concept (Jones, 1953) opened further doors to the development and recognition of therapeutic nursing roles in hospital psychiatric treatment. The development of psychiatric nursing in therapeutic communities was described by Holmes and Werner (1966). Concerning psychiatric nursing in a therapeutic community, they said that it is "an exciting adventure, marked by loss of traditional nursing roles, blurring of roles of all disciplines, increased responsibility for therapy on the part of both patients and staff, more intense staff-patient relationships, and a whole complex of problems for nursing that we are just beginning to explore."

(Holmes, 1966, p. iii) The development of the therapeutic community concept did a great deal for the development of psychiatric nursing, by providing a framework in which nurses could participate more actively and utilize their skills in many more ways. The distinctive features of the therapeutic community are: (1) patients are included in practically all information-sharing processes on the ward; (2) patients' opinions are included in decisions about other patients' readiness for such things as passes and discharges; and (3) such inclusion of patients in a democratic community process is considered treatment (Holmes, 1966). One can readily see that such a framework fosters open communication and responsibility. In such a setting nurses as well as patients become more responsible members of the society. Psychiatric nursing, while still interpersonally oriented and concerned primarily with relationships, is extended beyond the one-to-one or formal group setting to the total milieu. The therapeutic-community framework applies to part-time treatment situations such as day or evening care programs as well as to full-time inpatient units. In many situations where the concept has been implemented, such as therapeutic communities for drug addicts and alcoholics, nurses are involved and are active contributors to the total treatment program.

The application of social learning theory has had a considerable influence on psychiatric nursing. Although it may have been most influential in hospital settings, the use of behavior-modification techniques, like the use

of therapeutic-community concepts, has also received wide application in outpatient settings. Social learning programs have perhaps been most widely used for chronic schizophrenic patients, mentally retarded people, and children. When behavior modification is utilized in hospital settings, nurses are generally involved in implementing the program; in some instances they are the initiators (Cockrill, 1968; Bourgeois, 1968; Swanson, 1972).

Psychiatric nurses (prepared at the masters' level) generally are familiar with social learning theory and its clinical application. Some, indeed, are expert in the use of behavior-modification techniques. The graduate preparation is not uniform in this regard. Generalist nurses, while they may have some familiarity with theory and techniques, usually need in-service education to supplement their knowledge and enable them to implement behavior-modification programs effectively.

The incorporation of approaches based on learning theory was evident in the papers presented at a 1969 conference called "The New Hospital Psychiatry." This conference brought together a large group of professionals engaged in the hospital treatment of psychiatric patients. The papers at this conference "reflect the newly vitalized eclectic spirit of modern hospital psychiatry. They document the shift from the narrowness of the exclusively medical model to the more inclusive "education and social learning" points of view, which make possible both a theoretical and a technical pluralism in

approaching mental disorder" (Abroms, 1971, p. ix). A great many new techniques for and approaches to the treatment of patients were described in relation to a variety of treatment programs. These include: action group processes, including psychodrama; group-treatment situations of many kinds; family approaches; a great many behavioral approaches, including token-economy systems; special sessions using role playing; and sessions using mirrors, tape recorders, and video tape for feedback. Also described were special sessions designed to help the patient with particular kinds of behaviors (expressing anger, being assertive, and so forth), representing opportunities for the patient to practice behaving in certain ways and to assume roles that are foreign to him or difficult for him. The treatment program worked out with and for each patient presented an impressive variety of therapeutic activities. And in many if not most of these activities, nurses were key personnel.

The paper presented on psychiatric nursing at the 1969 conference analyzed the influences of these myriad new techniques on the practice of psychiatric nursing. The functions of the psychiatric nurse were described as follows. She does all the ordinary things such as observing the patient and becoming aware of all the things that are affecting his life: how he is eating and sleeping, what is happening between him and his family, how he is feeling and behaving, how he is getting along in the unit, and what he is doing in his treatment program. The nurse is responsible for learning all these things

every day about every patient, recording the information and reporting it to the appropriate people, and participating in making and revising the program for each patient. Other than that, "all" she does is work with the patients, get to know them, eat with them, play with them, and participate with them in all the activities that are part of the patients' treatment programs (Holmes, 1971, p. 90).

Psychiatric nursing consists of the experiential aspects of living with the patients— observing, caring, sharing, nurturing, sustaining, and communicating for the simple purpose of understanding a patient's meaning as opposed to changing his thinking or behavior. But it also consists of strategic maneuvers —carefully thought out and planned ways of responding to a patient that are designed to have an impact on a particular aspect of his behavior. There is more to nursing than the use of verbal skills. If nursing is unique in anything, it is in the totality of the view of the patient and in the experiential aspects of living with the patient. In nursing there is an opportunity for genuine encounters between human beings (Holmes, 1971, p. 90).

Psychiatric Nursing in the General Hospital

An increasingly important role for psychiatric nurses exists in the general hospital setting. Bulbulyan (1969) has described the development of

the role of the psychiatric nurse as a member of the psychiatric consultation service, within a general hospital, that provided emergency consultation to the entire hospital. Gradually the nurse assumed the task of evaluating the status of patients referred for psychiatric consultation and preparing the patients for that consultation. The psychiatric nurse also set up her own mental health consultation program with the nursing personnel in the general hospital. These were weekly conferences in which patients and patient situations were discussed with the nursing personnel of the units. The main focus was on nursing care. In these conferences, every attempt was made to integrate mental health concepts with the physical care and social needs of patients.

Progressive hospitals throughout the country seek the services of such clinical specialists to function in the general hospital setting. In some situations a psychiatric nurse is employed full-time to work as a clinical specialist in the general hospital. She may not be attached to any particular nursing unit but may develop a consulting relationship with the nursing staff on any or all of the units in the hospital. In other situations the psychiatric nurse is a member of the psychiatric consultation service within the general hospital. In still other instances the psychiatric nurse is employed as a consultant by the department of nursing to provide consultation to nursing services.

The functions of the psychiatric nurse fall into two main areas: (1) directly intervening with patients and families, and (2) teaching and consulting with the nursing staff. The kinds of patients with whom psychiatric nursing intervention is useful include: (1) patients who are experiencing acute psychological disturbances while in the hospital; (2) certain high-risk groups of patients; and (3) patients who cause the nurses acute psychological distress (the well-known problem patients). But although the psychiatric nurse in a general hospital setting does do crisis intervention with patients who become acutely upset by some aspect of their illness or experience with hospitalization, her work might best be considered primarily as preventive mental health work. Much of it deals with patients and families who, because of the physical health problems they have, are very prone to emotional problems. (Some examples are discussed below.) Working with children and their families in regard to surgery, serious disease, or hospitalization can do a great deal to prevent later serious emotional disturbances. Patients undergoing extreme kinds of surgery (particularly life-and-death operations such as open-heart surgery and mutilating operations such as amputations of breasts, legs, or other body parts) are a high-risk population. Patients who go on chronic kidney dialysis are also prime candidates for mental health consultation. These patients have to live from day to day depending on a machine to sustain their life; generally, too, they suffer from chronically poor health and a lack of vitality. Thus the psychological and social problems of

kidney dialysis patients are very great, but in many instances they can be worked with effectively through psychiatric nursing intervention.

Patients and families of patients with longterm, progressively debilitating, or fatal diseases or with crippling injuries can also be helped by psychiatric nursing intervention. The time of diagnosis of such a disease is likely to be a time of crisis for the patient and his immediate family. A psychiatric nurse who understands loss and the processes of grief can often be helpful to the family in facing this situation. These are but some of the high-risk patients and families in the general hospital setting who might profit from mental health consultation provided by a psychiatric nurse. As previously stated, this consultation includes both working directly with the patient and his family, and consulting with the nursing staff to help them develop attitudes and behaviors which will be useful in sustaining these patients and families through their experience.

An example of nursing intervention with a dying patient illustrates the potential usefulness of a psychiatric nursing consultant to a medical-surgical nursing unit (Holmes, 1971). The problem concerned a newly admitted patient with near-terminal cancer. She was extremely anxious, extremely demanding, and never satisfied by anything that was done for her. The staff members were very upset with this patient, refusing to work with her, and some were even requesting transfer to other units. The coordinator, being

sensitive to the experiences of both the patient and the staff, recognized that this situation could easily develop into a disaster for all concerned. She requested a consultation from the psychiatric nurse, who in this situation worked directly with the patient and with the nurse who was coordinator of the unit in which the patient was hospitalized. The coordinator, then, worked with the nursing staff on the unit and with members of the patient's family. The consultation began with an interview with the patient, in which the coordinator participated. The interview was introduced by asking the patient to let the two nurses know her better, so that together they might plan the best possible nursing care. The patient responded well to this invitation and began to discuss more and more openly and with less denial the progression of her cancer, her despair, her concern for her family, and the wall of silence that separated her from them. Following this interview, the coordinator was able to talk with the nursing staff from a different orientation. She was able to help them change their perspective on the patient, no longer seeing her as a demanding, irritable, and irritating patient but as a needful, dying person who was experiencing the greatest difficulty of her life. The remainder of the consultation consisted of brief weekly interviews with the patient and discussions with the coordinator about the nursing care.

In this situation (and in many like it), a relatively brief intervention with the patient and with key members of the nursing staff was helpful in enabling the patient to face her own death and take care of the unfinished business

between her and her family. It also helped the nursing staff to appreciate the struggle the patient was having and to sustain her throughout the experience.

The psychiatric nurse may or may not elect to work with the patient directly. If she does choose to do so, it is often useful for her to do it in a manner that makes her intervention directly available to at least some members of the nursing staff. In the above case the interview with the patient was done in conjunction with the coordinator, so that the coordinator might learn more directly how such an interview can be helpful to a patient. The coordinator could then use this information in helping the nursing staff to understand the patient and her experience better, to understand something about their own reactions to the patient and their participation in the problem, and to refocus their efforts so that they could work effectively with the patient and gain satisfaction in doing so. The psychiatric nurse is likely to be better able to provide this kind of consultation to nursing personnel than are other mental health professionals. She has been down this route herself, and she knows very well the frustrations and trials of attempting to provide good nursing care on a busy, hectic unit. She knows the strains nurses bear when they work daily with patients who are in pain, grieving, or dying. She understands the kinds of defenses that nurses inevitably erect against these experiences. And because she understands so well what the nurses might be going through, she can often help them set their own needs aside in order to respond to the patient in terms of his needs and his experiences.

Psychiatric Aides and Mental Health Technicians

In 1953 the American Nurses Association-National League for Nursing Coordinating Council accepted the recommendation that, in meeting the need of the mentally ill, the nursing profession should assume the leadership and the responsibility for the training of all those nursing personnel who take care of psychiatric patients. This was to include registered nurses, licensed practical nurses, and psychiatric aides.

The nursing profession stated the principle that all who give nursing care to psychiatric patients are in fact nursing personnel. In an effort to improve the care given by nonprofessional nursing personnel, the National League for Nursing, in conjunction with the American Psychiatric Association, cosponsored the Seminar Project for Teachers of Psychiatric Aides. This was a demonstration project conducted in four southern states between the years of 1958 and 1960. The project was supported by a grant from the National Institute of Mental Health. It developed a method of upgrading psychiatric care by improving the teaching and supervision of psychiatric aides. This was accomplished by providing an intensive learning experience for the nurses—primarily head nurses and supervisors—who in effect were the teachers of aides. It is not known how far-reaching the effects were of this demonstration project, but several states subsequently set up similar programs aimed at improving the teaching and supervision of aides (Lewis, 1961).

The career mental-health worker has lately come into his own. Florida was the first state to develop a two-year mental-health technician training program within a junior college setting (Atty, 1972). Now there are a variety of training programs for mental-health workers and technicians (the terminology varies). In some instances nurses have set up and operated these programs, but the mental health workers who are the products of the program are not necessarily considered part of the nursing discipline. The preparation may be at several academic levels. In some instances these workers are employed by the nursing staff and considered to be nursing personnel; in other instances they form their own discipline. Workers employed in mental health centers, where departmental ties are generally considered obsolete, usually constitute their own discipline and generally are not considered sub-professional members of the nursing staff.

Thus this is a changing scene, with both conceptual and political implications. The political aspects have to do with such issues as power, money, status, and recognition. The conceptual aspects have to do with the fact that roles are emerging rather than static. Perhaps in hospital situations, nursing care is a sufficiently clear entity for all to agree on what constitutes nursing care and who gives it (although even there the situation may get cloudy at times). In mental health centers the situation is less clear. There are large areas of overlap in the functions of all the mental health disciplines. In many instances, people from different disciplines do very much the same

thing. Probably roles will stabilize and solidify as it becomes clearer what each discipline can best contribute in the field of mental health. In the meantime, roles are not rigidly defined in this fluid, emerging field.

Some Changes within the Nursing Profession

Nursing is unusual among the health professions because of the wide range of levels of preparation found there. This variety is both a problem and a source of continuing change and development. Increasing numbers of nurses have achieved doctorates, for the most part in the sciences related to nursing. Nurses with doctorates in nursing and related sciences are prepared to do independent research, to teach others research methods, to contribute directly and indirectly to the development of theory in nursing, and to provide leadership for the further development of nursing practice and nursing education.

Certification is an area in which several developments have occurred simultaneously, which results in considerable confusion. Some states established certification of nurses as a requirement for licensure, which usually means that the nurse must give evidence of continuing education in order to renew her license to practice. On the national level, the American Nurses Association (ANA) provides certification of practitioners at the general-nursing level in recognition of excellence of practice in the clinical

area of psychiatric mental-health nursing. In addition, there is a movement among clinical specialists in psychiatric nursing (prepared at the master's level or above) to obtain board certification as specialists in their field; this certification would be a formal recognition of advanced preparation, experience, and excellence in practice. The term "certification" is used to indicate all three of these movements, which are quite different from one another. But when the issues and problems involved are all resolved, "certification" in nursing should have a consensual meaning.

One additional development of considerable general importance is the expanding role of nurses. A plethora of terms is being utilized to describe the changing roles of nurses, including "expanded role," "extended role," "primary care agent," and many others (Atty, 1972). Nursing practice has been defined as including acute care, long-term care, and primary care, with nurses having extended responsibility in any of these areas. There is an increased emphasis on having nurses function in areas of health assessment, health maintenance, health promotion, and the prevention of illness and disability. The general trend is for qualified nursing specialists to participate actively in health care programs that reach out into the communities.

The Generalist in Psychiatric Nursing

Preparation: Settings for Practice

Psychiatric nursing is an integral aspect of all nursing. The generalist in psychiatric nursing is any nurse with basic (as opposed to graduate) preparation who works in a psychiatric setting. The settings for psychiatric nursing services vary widely. They include hospitals (both general and psychiatric), public health agencies, clinics, day- and night-care centers, offices, homes, schools, camps, industrial centers, and probably others as well. Insofar as psychiatric nursing is an aspect of all nursing, in fact, any setting in which nursing is practiced might be considered a setting for the practice of psychiatric nursing. Community agencies such as public health agencies, schools, and mental health centers have become increasingly important settings for practice.

The basic preparation for nurses is gained through any one of three routes: (1) an associate degree from a two-year junior college program; (2) a diploma from a three-year hospital program; and (3) a baccalaureate degree from a college or university. Graduates from all three kinds of programs are eligible to take state board examinations to become registered nurses, which gives them the legal authority to practice. Nurses graduating from all these programs have had basic psychiatric -mental health nursing, which usually includes an emphasis on communication skills and on relating therapeutically with psychiatric patients. Some programs also include the study of family relationships and group dynamics. The nurses study theories and methods of treatment of psychiatric illness, the expected effects of treatment on patient

behavior, and patient care. The theoretical approach varies from school to school, but it is often based on psychoanalytic or interpersonal theories.

Graduates from baccalaureate programs generally have more theoretical preparation, which may include some familiarity with learning-theory-based approaches as well as more traditional psychiatric orientations. The course of study in the baccalaureate programs combines special education in the theory and the practice of nursing with general education in the humanities and the behavioral, biological, and physical sciences.

Graduates of collegiate programs in professional nursing accredited by the National League for Nursing (NLN)—the national accrediting agency for nursing education, recognized by the National Commission on Accrediting and by the nursing profession itself—are prepared to give high-quality nursing care to patients and their families and to direct the nursing care given by other nursing team members working with them. They are qualified for employment in general nursing practice in any setting where professional nursing care is given: hospitals, public health agencies of all kinds, the military and other federal nursing services, nursing homes, and so forth. These nurses have the educational background necessary for graduate study in nursing at the master's degree level (National League for Nursing, 1972).

In the mid-1970s there were more than 200 baccalaureate programs

accredited by the NLN. These programs all included theory and practice in both public health and psychiatric mental health nursing. In some of the newer programs (or those with revised curricula) the mental health concepts were integrated throughout the curriculum. Such programs also stress independent study, mastery of content, and self-determined rate of progress.

Roles and Functions

Some aspects of the practice of the generalist in psychiatric nursing are described below.

They are summarized from the ANA *Statement on Psychiatric Nursing Practice* (American Nurses, Association, 1967).

1. *Clinical nursing care*. Such care includes a variety of activities designed to obtain data for the formulation and implementation of the clinical nursing care plan. The nurse observes and assesses patient behavior (including group behavior), interprets and implements physicians orders, reviews information from other disciplines, holds individual and group conferences with nursing and non-nursing personnel, and participates in investigative activities.

2. *Providing a therapeutic milieu*. The nurse makes use of such concepts as authority, power, dependence, independence, responsibility, and decision-making in the development and maintenance of a sociopsychological milieu conducive to

recovery. The patient's strengths and potential for helping others are utilized as active forces in the therapeutic milieu.

3. *Counseling*. The nurse is concerned with helping the patient understand what is happening to him in the present situation, so that he can integrate this knowledge with his other experiences in life. The focus is on experiential learning. The aim of counseling is to work specifically on the problem or behavior pattern that is presenting difficulties. Counseling by the nurse can include regularly scheduled interviews (as well as unscheduled sessions) with patients, their families, and others.

4. *Being a symbolic parent*. Experiences of daily living form the basis for nursing interventions that aim at encouraging constructive changes in a patient's behavior. Nursing care activities that are utilized for this purpose include bathing, feeding, and dressing. By suggesting and persuading, comforting, guiding, and setting limits, the nurse supplies supportive, emotional-care elements of "parent-like" supervision.

5. *Teaching health*. The teaching of proper health practices is a responsibility of all nurses. Subjects include the usual good personal practices, but the nurse is also concerned with behavioral patterns such as aggression, personal problems such as anxiety, and group problems such as adolescent drug addiction. Such teaching involves serving as a good model of health, and it requires the formal or informal teaching of patients, families, and community groups.

6. *Serving as a social agent*. Nurses provide leadership in individual and group activities designed to assist patients in gaining the social skills that are basic to improved relationships with others and good adaptation to cultural norms. Nurses promote and help to improve the patients' recreational, social, and occupational competence.

7. *Providing clinical assistance to personnel*. Nurses provide leadership and support for one another through formal and informal conferences with nursing personnel. Nursing conferences are used to discuss, review, and evaluate nursing-care planning and intervention.

8. *Technical activities*. The technical aspects of nursing in psychiatric settings are essentially the same technical activities involved in nursing in any setting. Included are preparing and dispensing medications, observing effects and complications, collecting data for clinical trials of new drugs, preparing patients for specific therapies, and preparing for and supervising varied treatments and procedures. Nurses performing such nursing procedures have an essential concern for the quality and purposiveness of their interactions with patients.

9. *Joint planning*. Joint planning with other professional workers is essential to providing total patient care. In interdisciplinary conferences, nurses discuss the nature of and rationale for nursing care and coordinate it with the approaches taken by other professional workers.

Writings on the development of nursing in community mental health indicate some new emphases in psychiatric nursing by the generalist nurse. One important aspect of the community mental health movement is the increasing use of public health nurses to work with psychiatric patients. This is particularly true in programs for follow-up of patients— especially chronic schizophrenic patients— who have been hospitalized. There are numerous community care programs for the mentally ill in which public health nurses play the principal roles. Many of these programs came into being when mental hospitals joined forces with public health nursing agencies in an endeavor to provide continuity in total service to the mentally ill and their families. The public health nurse plays a key role in these operations and may function as liaison between the public health agencies and hospitals (Amendt, 1965; Scarpitti, 1965).

The role of public health nurses in community mental health nursing is of increasing significance. One important contribution that nurses with public health preparation bring to the mental health team is their community orientation. Public health nurses have found themselves in many places. They have traditionally been welcomed by families as persons who have something to offer and who care. They are interested in the prevention of disease and chronic illness and therefore consider not only the individual but the family as well. Home visiting by a public health nurse is a valuable tool in dealing with crisis situations. In any home visit the nurse assesses the kind of

neighborhood and house in which the family lives, the family's interactions, their strengths as well as their weaknesses, and their material and emotional needs. Thus the orientation of public health nurses leads them to consider the total health needs of the entire family (DeYoung, 1968).

In inpatient treatment settings, nurses are usually involved in and may carry major responsibilities for a host of treatment modalities. Staff nurses often carry responsibilities for patient-staff meetings and are active in all programs for hospitalized patients. They may be leaders or co-leaders of patient activity groups and therapy groups. They are involved in such community activities as visiting patients and their families in conjunction with the patients' therapy.

Nurses are also working in methadone maintenance centers, in halfway houses for drug addicts, and with drug-dependent individuals in general community mental health centers. School nurses are increasingly involved with drug abusers. By virtue of their professional preparation and interest in the health and welfare of children, school nurses can work effectively in the areas of drug abuse prevention and the rehabilitation of addicts (Foreman, 1971).

In community mental health centers, nurses are moving into many additional roles. Generally they spend most of their time seeing clients.

Among the activities of nurses in mental health centers are individual, family, and marital crisis therapy; evaluation and disposition of patients; and short-term and longer-term work with clients in many different ways, including specialized kinds of group therapies. Nurses are also used in medication follow-up. They are particularly apt to work well with patients and families who have a combination of physical, psychological, and social problems. They make home visits, often working with the whole family as well as the identified patient. In addition, the role of liaison between nursing staffs in hospitals (or in community agencies such as the visiting nurse services) and the mental health center seems to be carried out best by nurses. Those nurses with a background in mental health bring to consultation with other nurses not only their knowledge of the mental health problems involved but also an understanding of ward management problems that may influence a staff's reaction to a particular patient (Brockmeier, 1968).

The Specialist in Psychiatric Nursing

Preparation: Settings for Practice

Clinical specialization in psychiatric nursing is based upon the knowledge and skills obtained through completion of a program of graduate study in a university with clinical specialization in psychiatric-mental health nursing. The master's degree is currently the basis of clinical specialization.

Theoretical bases, concepts, and principles from which therapeutic skills are developed are acquired through academically supervised study and clinical practice. The skills developed during this educational experience are further refined to a high degree of expertness through continuing education, clinical practice, and competent supervision. It is recognized that additional education at the graduate level is required to provide for competent practice in subspecialties such as child psychiatric nursing (American Nurses Association, 1967, p. 14).

Graduate education in nursing prepares for specialization. Most graduate study is offered at the master's level, although graduate education in nursing also increasingly includes doctoral programs. The masters program builds on the foundation of an undergraduate college education with a nursing major. The purpose of this program is to prepare professional nursing leaders. It is distinguished by a concentrated study of a specific area of nursing (such as psychiatric mental health nursing), an introduction to research methods, and an independent study of a nursing problem using research techniques. Many \LN-accredited master's programs combine study of a clinical area, such as psychiatric nursing, with study of a functional activity, such as teaching, supervision, administration, or consultation. Although nursing is the major focus of the program, a master's education also includes advanced courses in the natural and social sciences relevant to the area of specialization. Other subjects appropriate to graduate education may

also be required (National League for Nursing, 1972).

In the mid-1970s there were over seventy NLN-accredited master's degree programs in psychiatric mental health nursing. This number included programs in all areas of psychiatric mental health nursing: adult and child programs; community programs; and programs related to teaching, administration, supervision, and clinical specialization in psychiatric mental health nursing. Within this number were more than forty master's programs (in nearly as many universities) that specifically prepared nurses to function as clinical specialists in psychiatric mental health nursing.

The term "clinical specialist" in psychiatric nursing has come to be accepted as indicating the nurse with a master's-level preparation in the clinical specialty area of psychiatric nursing. Other terms such as "nurse clinician," "nurse practitioner," and "psychiatric nurse" are also sometimes used to mean approximately the same thing. Because of existing variations in the use of these terms, it is well to clarify what meaning is intended.

The clinical content of the various psychiatric nursing master's programs varies somewhat, although all include both theory and supervised practice in psychiatric mental health nursing. Theoretical approaches to the study of psychopathology and treatment include psychoanalytic, interpersonal, family-systems, biophysical, behavioral, and phenomenological

approaches. Some programs include an overview of all of these; others are more limited in scope. Most programs emphasize interpersonal approaches because of their usefulness in psychiatric nursing intervention. Clinical practice emphasizes community settings as well as hospitals. Group and family interaction processes are studied, and master's students generally have some clinical experience in both these areas. Preventive aspects of mental-health consultation are receiving greater emphasis in many programs.

Leininger defined some of the content that should be included in the new psychiatric nursing instruction. She urged that this content be integrated with the older content, particularly that related to individual, group, and family therapy. (Some programs do encompass much of this content, and others can be expected to move in this direction.) The newer content she identified includes:

> theoretical concepts about the nature and definitions of a community; community and social organization theories; ecology and mental health; demographic aspects of mental illness; culture and mental illness; social systems theory and its application in both institutional and community social systems; social structure concepts; the dynamics of family social structure; role theory (sick and well role behavior); the culture of poverty and mental health; ethnological aspects of cultural groups; psychocultural and sociological research findings about 'normal' and 'abnormal' mental behavior; cross-cultural viewpoints about mental illness; human and physical community resources supporting optimal mental health; preventive aspects of mental illness; and criteria for the assessment of mental illness in different communities. (Leininger, 1969, p. 19).

The settings for practice for the clinical specialist in psychiatric nursing are many and varied. Hospitals, both general and psychiatric, are the traditional arenas for practice. Community agencies of many kinds are becoming more important as settings, however, particularly comprehensive community mental health centers. All the settings previously listed are available to the psychiatric nurse. In addition, some nurses are going into the private practice of counseling and therapy, generally with other mental health professionals.

Roles and Functions

The primary role of the clinical specialist is that of the expert practitioner giving direct care to patients who present the most complex nursing problems. Today's clinical specialist in nursing may also function in such roles as teacher, consultant, director, or coordinator. The ANA *Statement* (American Nurses Association, 1967) categorizes these as *direct-* and *indirect-*care functions. The direct-care functions are inherent in the therapy of psychiatric patients. The scope of the functions of these clinical nursing specialists depends upon a variety of factors, including educational preparation and clinical experience, personal aptitude and preference, opportunities for clinical practice in specific psychiatric settings, and the availability of competent supervision.

The direct-care functions, as defined by the ANA, are summarized below.

1. *Individual psychotherapy*. The clinical specialist in psychiatric nursing is prepared to practice individual psychotherapy under supervision. The purpose of individual psychotherapy is to develop and assess the meaning of the experience with the patient so that he is increasingly able to use these insights in further problem-solving and in improving his relationships with others.

2. *Group psychotherapy*. The psychiatric nurse is qualified to conduct group psychotherapy, either as therapist or as cotherapist, with supervision. Some psychiatric nurses have adequate training and experience to function as teacher, supervisor, and consultant to other mental health professionals who are learning to conduct group therapy.

3. *Family therapy*. The psychiatric nurse may assume the role of a family therapist directly involved in attempting to influence family groups in the maintenance of mental health and the resolution of their mental health problems. The nurse may function either alone or as cotherapist with other mental health professionals.

4. *Sociotherapy*. The key concept of sociotherapy is the provision of a therapeutic environment that promotes mental health through corrective or remedial experiences, fosters healthy coping abilities, and corrects maladaptive coping patterns. Sociotherapy encourages the development of interpersonal

> skills that help people to manage their environment and strengthen or correct their coping abilities. The psychiatric nurse practicing sociotherapy is responsible for providing a therapeutic environment and coordinating the collaborative efforts of others who are involved in the treatment and care of the individual. In the practice of sociotherapy, the psychiatric nurse has the opportunity to contribute to the development of community programs and the solution of community mental health problems.

The indirect nursing care roles described in the ANA *Statement* include: administrator, clinical supervisor, director of staff development and training, consultant or resource person, and researcher.

Community Mental Health Work

These are the more or less well-established roles of the psychiatric nurse. In addition, primarily under the impact of the community mental health movement, psychiatric nursing is extending out into the community. In making this move, nurses have pioneered new roles. Some of these roles are already becoming stabilized, but many are still very much in the developmental stages.

The roles and activities performed by an individual nurse are influenced by many variables unique to the individual center and the individual nurse. These variables include the interest and talents of the nurse, her academic

preparation, and her prior experience in community mental health and other kinds of nursing. They also include the requirements and interests of the larger social system of which she is a part—namely, the staff of the community mental health center in which she works, and the community that the center serves. "Among the variables that influence the role of the nurse are the type of services performed by the center in which she is working, the composition, preparation, and organization of the staff rendering the services, the population served, the community's needs as viewed by the community and as viewed by the center, and finally the nurse's own beliefs as to what her role or roles can be within that setting" (Stokes, 1970, p. 645).

Another variable that influences the way in which nurses (as well as other professionals) function in community mental health centers is the model under which the center operates. These models, as identified and described by Schulberg and Baker (1970), are as follows.

1. *The medical model*. Here the doctor-patient relationship is important. The patient is considered sick, and community resources are mobilized by the doctor for his patient. The focus is on the individual. Under this model one can predict that the services that are offered tend to focus on the provision of therapy.

2. *The public health practice model*. This model is concerned primarily with the community population as a whole. The focus is on the prevention of mental disorders. Here one can predict

that there will be more interaction between the community and the center.

3. *The ecological systems model*. Here the individual is viewed as functioning within a succession of open systems, and mental disorder is considered a manifestation of intolerable strain in some or all of the systems. Here again, one can predict considerable interaction between the center and the community, and therapy would probably focus primarily on groups rather than on individuals.

Several studies in the 1960s and 1970s described the role, functions, and activities of nurses in various community mental health centers (DeYoung, 1971; Hess, 1969; Stokes, 1969; Zahourek, 1971). The results of some of these studies are presented to show the range and diversity of activities of the psychiatric nurse in the mental health centers.

Zahourek (1971) studied the activities of twenty-one nurses in the mental health center of the Denver General Hospital. This included generalist nurses as well as clinical specialists. In the emergency service (with on-call psychiatric back-up) they evaluated and made disposition of all psychiatric patients seen in the emergency room. As members of the generic outpatient teams, they received cases on a random basis from the neighborhood served by the teams, evaluating these patients and developing and implementing treatment plans for them. They also provided indirect services to patients through consultation with and education of other providers of community

care. Nurses held both top and middle management positions within the center, including those of outpatient team leader and director of psychiatric nursing. These nurses had diversified functions, serving as therapists, educators, administrators, community liaison, consultants, and research assistants. Nurses working in the emergency room and outpatient situations had many contacts with the community. These included community health nursing agencies; police; juvenile and adult legal agencies; hospitals; schools; churches, welfare, vocational and rehabilitation services; educational programs in nursing and other health care disciplines; community action centers; charities; specialized agencies caring for alcoholics and drug addicts; and businesses. The nurses provided consultation to other emergency room personnel, medical-surgical unit personnel, schools, psychiatric hospitals, local visiting nurse services, and welfare agencies.

Hess (1969) studied a group of ten nurses at a community mental health center in Illinois. These nurses saw their roles as follows: therapists, in-take workers (assessing, evaluating, and assigning patients to teams), and workers in a variety of informal situations such as the home.

Over a five-year period, Stokes (1969) and three colleagues participated in the activities of a newly developed mental health center. They developed an outline of their roles, functions, and activities within the framework of a model of primary, secondary, and tertiary prevention. The roles that Stokes

and her colleagues considered a psychiatric nurse to be able to perform included the following: psychotherapist, with individuals and families; cotherapist, with families or groups; consultant to other professionals and community groups; teacher; liaison to general hospital departments; and collaborator—for instance, between professional and community groups.

Bulbulyan (1969) felt that the main goal of the mental health center in relation to the community at large was to develop a collaborative relationship with members of the community in order to accomplish the gigantic task of maintaining and promoting mental health. This involves working with groups and organizing coordinating committees of agencies in the community, which means working with people in the neighborhoods and schools, churches, and social and civic agencies. It involves organization of self-help movements among the client population, aimed at changing the factors and social stresses that tend to influence mental health. Bulbulyan stated that she did not believe that the therapist role is the most important role for the psychiatric nurse. Other nursing roles are equally important, particularly those that involve the sum total of the nurse's unique background *as* a nurse, and her ability to integrate mental health concepts in other areas and to assist all members of the team to function effectively.

Nurses, by virtue of their medical and social science background, are well prepared to function in community psychiatry. It is the particular

combination of skills that nurses have that makes them unique and valuable members of the team. Because they are rooted in the biological and sociological disciplines, they are in an unique position to assess a client's problems, to interpret them to the appropriate specialist, and to intervene constructively themselves (Ujhely, 1969).

Concluding Remarks

It is evident that, in a few short years, nurses have established their usefulness in community mental health work. As members of the health professions, nurses are interested primarily in fostering the physical and emotional welfare of individuals. The generality of their orientation is useful. They are oriented toward the whole person, in the context of his family and community. Because of their generally pragmatic approach, they are able to help people deal more effectively with some of the realistic problems of life, such as poverty, illness, child-rearing problems, and family-life problems. They are comfortable in making home visits, and are usually well accepted into the clients' homes. Because they are skilled at working collaboratively with other health professionals in the community, such as public health nurses, they make excellent liaison people and mental health consultants.

Nurses have been active in defining the theoretical basis for practice. In crisis intervention and suicide prevention programs, nurses have delineated

the theoretical framework on which crisis intervention is based (Aguilera, 1970).

The additional concepts and skills needed by psychiatric nurses to enable them to move into community mental health work are being identified and integrated into graduate programs. These include such things as knowledge of community organization techniques, of mental health consultation, of social systems, of group processes, and of the epidemiology of mental illness. Among the trends that are most obvious in the practice of psychiatric nursing are broadened scope of practice, greater diversity of roles, greater responsibility, and greater extension into the community. One prediction I can safely make for the future is that there will be even more change.

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