

The Role Of Mental Health Nurses in the United States

A Literature Review

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<p>Mental health services in the United States are increasingly facing shortages in the availability of qualified health-care providers such as psychologists, psychiatrists, and general medicine physicians. Graduating physicians are increasingly choosing to become specialists rather than practice as general medicine providers. This places strain on rural areas, where psychiatric specialists are in short supply, and most patients rely on generalized medical providers to meet their mental health care needs.</p> <p>Thus, it appeared prudent to examine the roles and responsibilities of the psychiatric nurse in the United States, as the World Health Organization has increasingly emphasized the importance of undergraduate health care professionals in meeting mental health care demand on a primary level. A preliminary search of the literature revealed that a definition of the role of mental health nurses is difficult to articulate and has no broad consensus.</p> <p>A review of the literature clarified the role of the mental health nurse in the United States. Information about the qualifications of MHN's were sought, and the scope narrowed to MHN-RNs. Findings indicated that registered nurses in mental health practice: utilize the nursing process in the planning, implementation, and evaluation of psychiatric care; use the fundamental basics of the psychiatric interviewing process to collect vital information; and practice the artful use of self in the therapeutic relationship in order to promote positive patients outcomes through the usage of therapeutic communication.</p>		
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1 Introduction

In developed countries, 35-50 percent of patients with severe mental health disorders have not received treatment in a 12-month period. The figures in less wealthy countries are even more worrying, at 76-85 percent. With common conditions such as bipolar disorder, depression, and anxiety disorders, over 50 percent of people have not received treatment. Bridging this treatment gap is a priority in the global response to mental illnesses. (WHO, 2004).

One of many reasons for the treatment gap in mental health care is the lack of qualified mental health professionals and other human resources, especially in poorer countries. The WHO thus recommends the inclusion and training of undergraduate professionals in mental health care, in order to increase the number of health care professionals who can treat patients with mental health and substance abuse problems. (WHO, *op cit*). As nurses represent a significant portion of undergraduate health care professionals, it seems prudent to examine their current and potential role in meeting mental health care demand.

However, even amongst mental health professionals, there is lack of a conclusive definition as to what role mental health nurses should take. This is largely due to the varying standards across different countries. The aim of this paper is to describe the work of mental health nurses in the United States. Its purpose is to provide a concise, inclusive source of information, as the question of what a mental health nurse's work entails is a challenging topic to define definitively, even in the professional literature.

2 Mental Health

The World Health Organization (2014) defines **mental health** as “a state of wellbeing in which every individual recognizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”. This positive philosophy of mental health is bolstered by the WHO’s definition of overall health, which states that health is about well-being, not simply the lack of disease. Mental health and mental illness are separated entities, in the same manner that physical health and physical disease are differing concepts in that one is a *positive* perspective on health, whilst the other is negative. (WHO 2014).

According to the CDC (2011), **mental illnesses** are “health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.” Although treatment of mental illnesses is a global priority, relatively little attention has been paid to promotion of mental health in people *free of illness*. As previously discussed, mental health is an optimized concept which stresses the importance of coping and well-being in most areas of life. Given that absence of mental illness does not in of itself imply good mental health, it is thus estimated that only 17% of adults in the United States do not meet the WHO definition of optimum mental health. (CDC, 2011).

Mental illness and disability

Mental illnesses are an ever-increasing public health concern around the globe. As the leading cause of disability, mental and substance abuse disorders represent 23 percent of years lost to disability. Years Lived with Disability (YLDs)

and Disability Adjusted Life Years (DALYs) are measures of disease burden which represent the number of years that a person lives with a disability, and the number of years lost to premature death and impaired function, respectively. Measured by DALYs, mental and neurological conditions totaled 13 percent of all disease burden; it is estimated to reach 15 percent by the year 2020. A significant portion of the adult population will suffer from a mental illness within their lifetime; approximately 8.4 to 29.1 percent of adults will be affected over a 12-month period. These figures increase to 12.2 to 48.6 percent over a lifetime, totaling about 450 million people globally. (WHO, 2004, *op cit*).

The statistics for the United States are reflective of these global trends, with an estimated 18.6 percent of adults and about 13 percent of children aged 8-15 years having suffered from any mental illness within the past 12 months. The national disease burden of mental illness, measured by DALYs, is 13.6 – slightly higher than the WHO average. (NIMH, 2012).

2.1 Barriers to treatment

Part of the reason for the high number of years lived with disability is the fact that these disorders have a relatively early-age onset. Further, only a small number of people receive treatment within either specialized or primary health care; initial contact with health services, if it occurs at all, is often delayed by many years. (WHO, 2004, *op cit*).

People with mental illness often have a myriad of personal, situational, and financial barriers that reduce the likelihood of seeking and adhering to treatment. Mojtabai *et al* refer to these barriers as attitudinal/evaluative barriers, structural barriers, and financial barriers. Attitudinal barriers may refer to such attitudes as

the patient's own opinions about the mental health care system and their own perceived need for care, while structural barriers might include matters such as the ease of making an appointment with a provider or transportation to the clinic. (2011).

According to a study of a US population with recent mental illness by Kessler *et al*, 55 percent of respondents did not believe that their problem necessitated treatment. Of the respondents who accepted that they could use help, 72.1 percent wanted to handle their own problems, and 60.6 percent believed that the problem would go away by itself. Lack of faith in treatment or the health care system were also significant, with 38.1 percent believing that psychiatric care is not effective or cannot help, 11.2 percent reporting dissatisfaction with currently available mental health services, and 14.2 percent reporting that they sought treatment in the past and it did not help. Overall, these **attitudinal barriers** accounted for the majority of the treatment gap in this population. (2001).

Situational barriers to care consisted of 40.8 percent of patients who reported not knowing where to go for help, while 27.7 percent thought obtaining treatment would take too much effort and time. **Financial barriers** were reported at 45.6 percent altogether, with patients reporting that their insurance would either not cover mental health care treatment at all, or would not provide enough coverage to defer the cost ("underinsurance"). Some respondents simply had a general perception that treatment would be too expensive without regard to matters of insurance coverage. (Kessler, *op cit*).

It is interesting to consider that making mental health care more affordable and accessible only addresses part of the treatment gap, despite a wide-spread focus – both in the literature and in politics -- on citizens' access to and ability to afford health care in the United States. Although sufferers in the USA are more likely

than those in countries with universal healthcare to report financial barriers to treatment, patients' own evaluations – perceived need for care, usefulness of mental health care, and trust in the health care system -- are by far the most influential factors in the decision to obtain treatment. (Sareens, 2007).

3 The American Mental Health Care System

Overview of the healthcare system

In contrast to many other developed Western countries, the United States lacks a central, national health insurance scheme which entitles all citizens to basic health care services. Though advances have been made in order to attempt to make universal access a reality, the delivery system of health services remains fragmented and marked by the presence of *sub-systems* of health care delivery, which are formed by either the response to market forces, or as a response to the need of certain vulnerable groups. Where a patient receives care largely depends on the paying entity. This fragmentation of health care delivery is considered by many to be the defining feature of the American system. (Shi and Singh, 2015).

Managed care is, by far, the most prevalent sub-system of health care delivery.

The core aims of a managed care system can be summarized thus:

- to integrate the basic functions of health care delivery
- to employ mechanisms to control and moderate usage of health services
- to oversee pricing and, by extension, how much participating health care providers are paid

Under this system, patients are provided with the services of a managed care organization through their place of employment, or through the government, in lieu of purchasing health insurance. These managed care organizations provide a “health plan” to these patients, and organize health care services in accordance with the contract with the employer/government. (Shi and Singh, *op cit.*)

The most common type of managed care system is the **Health Maintenance Organization**, or HMO. Typically patients are assigned a primary-care physician (PCP) who acts as a de-facto gatekeeper: specialist visits and pre-approval for hospital care are only covered under the health plan if specifically handled by the PCP. In addition, patients may only access providers that are members of the HMO network for every need except crisis and emergency care. Financing through HMOs and similar employment-based schemes accounts for 55 percent of total health care spending in the United States. (Shi & Singh, *op. cit.*)

Typically, patients covered by a managed-care health plan must pay a **premium**, or cost for the amount of insurance provided, which may be subtracted from their monthly pay under an employer-contracted health plan. Further, health plans often require the patient to meet a **deductible**, or a set amount that must be paid out-of-pocket before the insurer will cover additional health care. High deductible health plans are popular with those looking to save on monthly premiums, yet in return may cause them to delay or avoid necessary health care due to the higher amount they must pay themselves before insurance will cover treatment. Interestingly, this trend seems to be affecting mostly middle-income individuals and families, rather than vulnerable populations. (USA Today, 2015).

Other sub-systems of health care delivery include the military health service, Medicare and Medicaid programs, and the State Children’s Health Insurance

Program. These programs are designed to serve the more vulnerable populations that do not have access to employer-based health plans.

The major differences between the US health care system and other major Western countries can be summarized with eight items (see Table 1).

<ul style="list-style-type: none"> • No central governing agency and little integration and coordination • Technology-driven delivery system focusing on acute care • High in cost, unequal in access, average in outcome • Delivery of health care under imperfect market conditions 	<ul style="list-style-type: none"> • Legal risks influence practice behaviors • Government as subsidiary to private sector • Multiple players and balance of power • Access to health care selectively based on insurance coverage
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Table 1 Defining feature of the US health care system

Shi and Singh. "Essentials of the US Health Care System", 2015.

3.1 Mental health providers and points of contact

According to the Congressional Research Service report on mental health care, mental health providers may be separated into four general categories: specialists, generalists, social service providers, and volunteers. (Sundararaman, 2009).

Specialist mental health providers include psychiatrists, psychologists, and psychiatric nurses. These professionals are licensed and accredited by their own associations, and receive regular training and education in mental health as a condition of keeping their license. Of note, they are the only mental health professionals who possess the authority to refer a patient for involuntary

treatment. Specialized mental health care is typically provided in a clinic, hospital, or other venue specifically designated for it: the majority of care is on an out-patient basis, with in-patient treatment being preferentially spared for patients who pose a risk to themselves or others. (ibid, p.6).

Generalized mental health providers are those in the primary care settings: general practitioners, pediatricians, and nurse practitioners. While they receive continuing education in health-related matters as a condition of keeping their licenses, this education may not necessarily include mental health issues. General medical care providers are often the first point of contact for mentally ill patients, and may act as the solely responsible provider in areas in which there is limited access to specialized mental health care. Pediatricians, in general, manage mental health problems in children and adolescents, with the exception of the most severe cases (who may then be referred to specialist care). They meet patients in outpatient medical clinics and emergency departments of local hospitals. (ibid, pp. 6-7).

Social service providers, such as student counselors and correctional counselors, have corresponding degrees in social work and continuing education in their chosen fields. However, they are not required to undergo any mental health care training. They often operate in non-medical establishments such as schools and prisons. In addition, some may work with the community in the form of support groups, in which case services may be provided through community centers and similar public spaces. (ibid, p. 7).

Finally, **volunteers** include entities like support groups, peer counselors, and clergy members. These providers do not require formal training of any kind, and may operate phone hotlines and internet pages, as well as meet with clients in churches, private homes, *et cetera*. (ibid, p. 7).

3.2 Fragmentation of health care delivery

According to Stange (2009), fragmentation in the context of healthcare may be said to be, at its root, “focusing and acting on the parts without adequately appreciating their relation to the evolving whole”. In a system whereby insurance coverage (or lack thereof) controls *who* accesses *what* health care providers, *where*, and *when*, it only compounds the problem of a lack of whole-person, comprehensive care. (Stange, 2009, a.)

Indeed, an increasing numbers of physicians are choosing to specialize rather than begin their careers as general medicine providers. While impressively innovative achievements in specialized health care have been emerging as a result, patients are decreasingly cared for as a whole due to a shortage of primary care physicians. For instance, a patient may see several specialists -- instead of one primary doctor -- for each individual health concern. In this way, the focus is first on the disease, and secondly on the patient experiencing the disease. A primary care system which encompasses first-contact access, coordination of care, a comprehensive approach, and personalization of care is thus vital in addressing fragmentation. (Stange, 2009, b).

3.3 Complicating factors in the fragmentation of mental health care

Emergency room utilization

While the United States spends more than any other developed country on health care (13 percent of GDP), many Americans, as previously discussed, have

difficulties accessing the most basic of health services. The un/under-insured citizens typically do not see a primary health care provider for routine, preventative care unless they can pay the doctor's visit fee. (Shi and Singh, *op cit.*). However, there is an important loophole which allows the acutely sick to receive the care that they need.

The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law which requires that patients presenting with an acute and urgent physical or mental health problem be treated and stabilized, regardless of their insurance status or whether they can pay for treatment. The EMTALA is considered to be the nation's one, true nationalized health care program; patients who cannot pay for primary care visits wait for their chronic conditions to become acute, after which they can obtain treatment through emergency services. (American College of Emergency Physicians, 2014).

The episodic nature of emergency department services results in little coordination between health services. Few patients understand the emergency care that they received nor their discharge instructions, and typically are not referred to any provider for follow-up care, or cannot afford follow-up care at all. (NEHI, pp. 7, 2010). The result appears to be that patients receive no health care until their health condition once again becomes acute, and the pattern of fragmented care begins again.

This is especially problematic considering that a significant portion of homeless people rely on emergency medical services to treat acute phases of mental illness. Hospitals have undertaken the practice of "patient dumping" – discharging a patient to a place other than his or her permanent residence – often far away from the hospital, in order to avoid the costs associated with stabilizing the patient's condition under the requirements of EMTALA, and to discourage them from

returning. As a result, the vulnerable homeless people suffering from mental illness do not receive the care that they need. (Kahntroff & Watson, 2009).

People with mental illnesses underserved or pushed out of managed care

The widespread nature of the managed care model has led to people with relatively minor mental illnesses obtaining treatment at increasing rates, especially at the primary care level. Conversely, those with severe mental illnesses are increasingly underserved due to the allocation of funds over a broader and larger group of people under the managed care model. This is thought to prioritize spending on patients whose treatment is less resource-intensive, thus undertreating those with severe illness. (American Psychological Association, 2009).

Even further, according to MACPAC, those with mental illnesses, especially of the severe variety, are more likely to be fired from their jobs and to lose their ability to work. In this way, they are removed from their source of health insurance, and the burden of treating severely mentally ill people then falls on public clinics and government insurance programs. This is supported by the fact that the government Medicaid plan is the single largest payer in the nation for behavioral and mental health services, accounting for 26 percent of total spending for such services in 2009. (MACPAC, 2015).

Government insurance programs severely lacking in mental health providers

To further complicate matters, there exists a severe shortage of mental health professionals who accept government insurance like Medicaid, due to the very low payments for services rendered. This leads to difficulty accessing needed mental health care amongst the vulnerable disabled, senior, and low-income populations. Professionals such as psychologists may be blocked from

government insurance reimbursement altogether, leaving a significant pool of providers who would like to treat the most vulnerable and severely ill, but find themselves locked out of the government insurance system. (Dickson, 2015).

4 Summary of the United States Mental Health System

Background research into the topic has brought to light the fact that there is significant mental health care need in the US population. In particular, the literature presented thus far highlights the need for health care professionals who can manage patients with psychiatric illness. The need for primary care management of mental illness is due to multiple causes:

- the shortage of specialist mental health providers;
- the separation of mental and physical health care, which is accessed through widely varying channels;
- the payment problems presented by the current system for reimbursing specialist care for patients relying on government insurance.

It is therefore increasingly clear that primary health care should also include comprehensive mental health care, instead of focusing primarily on physical health.

One significant barrier brought to light during the background research has been the shortage of primary care providers, due to many graduating medical doctors choosing to specialize rather than practice as generalists. Considering that nurses and their advanced-practice counterparts have been increasingly filling gaps in basic healthcare coverage at the primary-care level (NACNEP, 2012), it appears

prudent to examine how mental health nurses might lend their expertise to address the provider shortage.

5 Mental Health Nursing

According to the American Nurses Association, psychiatric-mental health nursing is:

“...a specialized area of nursing which is committed to promoting mental health through the assessment, diagnosis, and treatment of behavioral problems, mental disorders, and comorbid conditions across the lifespan.”

Mental health nursing is best described as both an art, and as a science: the purposeful use of self as an art-form, and an array of neurobiological, nursing, and psychosocial theories and concepts as a science. (ANA, 2014, p. 19).

5.1 Levels of mental health nursing practice and roles

The title of a mental health nurse in the United States is PMH-RN, which is short for “Psychiatric-Mental Health Registered Nurse”. While any registered nurse may practice as a PMH-RN, due to the complexity of care required, the preferred level of education is at the bachelor level, with accreditation by the American Nurses Credentialing Center. (ANA, 2007, p. 131).

Their more advanced counterparts, the PMH-APRN (Psychiatric-Mental Health Advanced Practice Registered Nurse), have additional education at the master or doctorate level which provide them with more autonomy in their role, as well as

the ability to practice formal psychotherapy and prescribe psychopharmacological interventions. (ANA, 2007, p. 134-136).

Psychiatric-mental health registered nursing is described as the usage of the **nursing process** to treat people with either existing or potential mental health problems, psychiatric disorders, and comorbid mental health problems and substance abuse disorders. The nursing process, in the context of mental health nursing practice, is intended to promote health and safety; assess dysfunction and individual areas of strength; improve coping abilities in order to assist clients in meeting their own recovery goals; promote life skills, teach symptom management, and prevent further disability. (ANA, 2013, p. 25).

Data collection upon intake is based upon the nurse's knowledge of human behavior, and the principles of the **psychiatric interviewing process**. The work of mental health nursing is accomplished through the interpersonal relationship, therapeutic intervention skills, and professional attributes. Such attributes might include self-awareness, empathy, and moral integrity, which enable a PMH-RN to practice the **artful use of self** in the **therapeutic relationship**. (ANA, 2013, p. 27).

6 Aim and Purpose

The aim of this paper is to describe the work of mental health nurses in the United States. Its purpose is to provide a concise, inclusive source of information, as the question of what a mental health nurse's work entails is a challenging topic to define definitively, even in the professional literature. This is largely due to the varying standards across different countries. Therefore the focus has been narrowed to focus on the United States.

The research question for this work is:

1. What are the important methods and concepts integral to mental health nursing in the United States?

7 Research Methodology

Literature review

The selected research questions have been deemed best investigated by way of qualitative research; namely, literature review. According to Creswell (2014), a review of the literature means, in simple terms, “locating and summarizing the studies about a topic”. It serves several purposes: It shares the results of other studies in relation to the proposed study with the audience; relates the proposed study to ongoing dialogue in the literature, filling in gaps and extending existing studies; and provides a point of reference for both establishing the importance of the proposed study, as well as comparison of results. (Creswell, 2014).

The literature may be strategically placed either towards the beginning of the study, in a separate section, or at the end. Typically, theoretically-based studies introduce the literature early in the study in order to provide a foundation for further expansion. In quantitative research, especially, inclusion of large amounts of literature in the introduction to the study serves to guide the author in formulating research questions or hypotheses. It can also serve to describe a problem, relay existing literature, or introduce a theory. (Creswell, 2014). The

author has thus provided abundant information about the US health care system and the problems therein to provide necessary context for the basis of the study.

7.1 Literature search process

The literature search began on 29.9.2016. Databases searched included CINAHL, Academic Search Elite, and Pubmed. In addition, one library database was searched for books and printed journals: the JAMK University of Applied Sciences network.

Each concept was submitted to its own literature search thusly: “the nursing process”, “psychiatric interview process”, “artful use of self”, “the therapeutic relationship”. Combination of the keywords and manual searching were conducted in order to clarify available literature and allow for the refinement of search parameters in an attempt to yield more relevant, specific results.

The following inclusion and exclusion criteria were decided upon:

Inclusion	Exclusion
Peer-reviewed publication	Not peer-reviewed
Full text available	Full text unavailable
English-language	Language other than English

Table 2 Inclusion and Exclusion Criteria

7.2 Literature selection process

The process of the database search and selection will be demonstrated through the following tables, ordered by keywords used.

Table 3 Database results. Keywords: "the nursing process"

Database	Total hits	Full text available	Selected
EBSCO Academic Search Elite	566	351	0
CINAHL	7659	1,736	3
PUBMED	7718	278	0
JAMK library database	122	122	1
Total	16065	2487	8

Table 4 Database results. Keywords: "the psychiatric interview"

Database	Total hits	Full text available	Selected
EBSCO Academic Search Elite	627	111	0
CINAHL	145	38	0
PUBMED	1413	313	0
JAMK library database	1	1	1
Total	2186	463	1

Table 5 Database results. Keywords: "therapeutic relationship"

Database	Total hits	Full text available	Selected
EBSCO Academic Search Elite	4716	1372	2
CINAHL	877	344	2
PUBMED	1882	232	0
JAMK library database	7	7	1
Total	7482	1955	5

Table 6 Database results. Keywords: “artful use of self”

Database	Total hits	Full text available	Selected
EBSCO Academic Search Elite	161	54	0
CINAHL	2	1	1
PUBMED	10	2	0
JAMK university library	0	0	0
Total	173	57	1

Literature was carefully selected not only based on the aforementioned inclusion/exclusion criteria, but also on the basis of utilization and relevance. For instance, although many keywords yielded hundreds of full-text articles, it was necessary to ensure that they addressed the research question. Many otherwise selected articles were not limited to the nursing point of view, were from a theoretical/ethical versus factual perspective, or were too narrow or specific in scope to be useful in a broad examination of the topic.

7.3 Data Analysis

Creswell (2014, *op cit.*) also suggests usage of a literature map to assist in organizing the literature. A researcher sorts through selected results, critically examining whether the source can be useful in the study (analysis). Then, a literature map may be created as a list of preliminary sources as well as a record of analysis.

The literature was carefully selected for relevance and contribution to a concise view of the chosen topics. It was limited to a nursing viewpoint whenever possible, although some concepts required a broader, medicalized definition to provide context for further expansion. A list of selected literature and the concepts covered by the authors was created to assist in the reporting process and to provide a basis for the conclusion. Refer to Figure 1, next page.

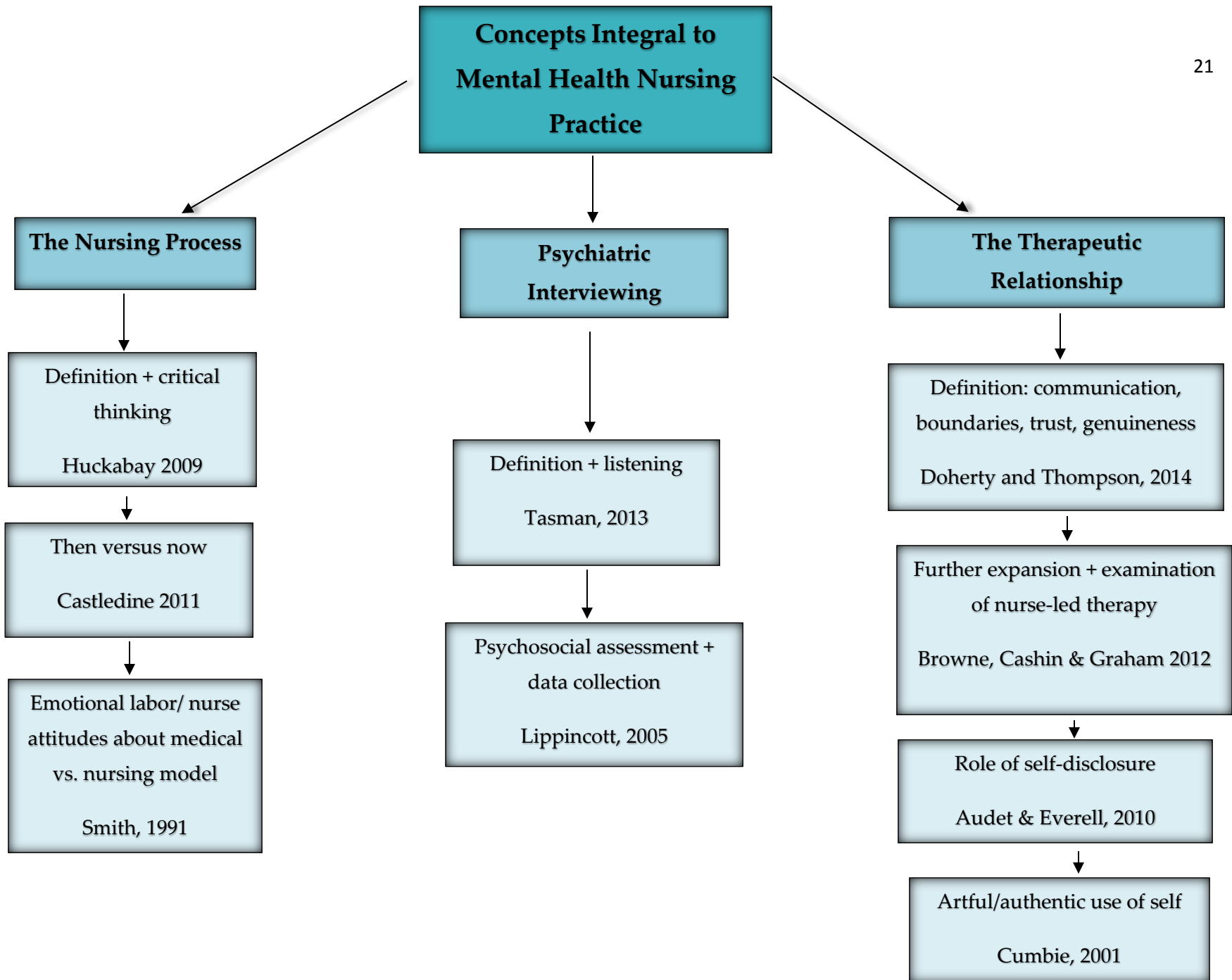


Figure 1 Literature Map

Results

The Nursing Process

The nursing process is a systematic approach to gathering and processing information about the patient. It is a six-part process which allows the nurse to: gather both subjective and objective care for the patient; reach a nursing diagnosis based on the data; make a care plan; implement the planned care; evaluate the effectiveness of the care, and finally; to revise care as necessary based on the evaluation. (Huckabay, 2009).

Each step of the process demands critical thinking skills on the part of the nurse. The universal standards of critical thinking include clarity, accuracy, precision, depth, relevance, breadth, and logic. When considering a problem to be solved, or a patient situation, application of the standards of critical thinking enable the nurse to be certain that their reasoning is sound when reaching a conclusion. (*ibid.*)

According to Castledine (2011), the nursing process has evolved over the years to place less importance on nurses as organizers and implementers of care planning, recognizing that it has become more of an interdisciplinary process, involving, for example, other professionals like social workers. Additionally, in modern times, there is increasing focus on planning care according to evidence-based guidelines and information, which makes evidence-based medicine an essential part of the planning process. While evaluation remains an equally important part of the nursing process, today the preferred term is "outcomes", in order to describe more accurately what has happened to the patient in the context of

his/her care. In this way, the nursing process has been increasingly resembling the medical model. (131).

The Psychiatric Interview

The psychiatric perspective

According to Tasman, the psychiatric interview has its' roots in the father of psychotherapy, Sigmund Freud. Under his influence, listening on a deep level became an integral part of psychiatric practice, whereas before, a psychiatric patient's treatment could be expressed through the metaphor of auscultating and percussing the patient with his/her shirt on – so much remained covered, unseen, and deemed unworthy of further consideration. (1-2).

Additionally, Tasman states that although different schools of psychotherapeutic thought have their own methodology, effective, deep listening is considered indispensable in the therapeutic relationship. Patients may be thought of as storytellers who speak with the hope of being heard and understood. It is the listener's responsibility to respond with sensitivity, and to uncover what the problem is and attempt to name it. Listening is a journey of discovery of who the patient is, with the patient acting as an informant. It requires time, concentration, imagination, humor, and placing the patient in the role of the "hero" of his/her own life story. (ibid.)

Key listening skills include:

- **Hearing** – Inference of meanings of words; figures of speech which tell a different story; tone of voice and affect, and the order/stream of thoughts.

- **Seeing** – Patient's posture, gestures, facial expressions, and overt affect.
- **Comparing** – Noticing what is *not* said, disparities between different expressions of emotion, using intuition.
- **Reflecting** – Being aware of one's own internal reactions, taking time to reflect despite pressure to respond immediately.

(ibid. , 2)

The psychiatric interview can be said to be similar to the taking of history and physical examination by a medical doctor. They both assess and survey objective and subjective symptoms of illness, create a differential diagnosis, and implement further evaluation and treatment. (ibid. , 65-66).

The nursing perspective

Lippencott (2005) provides an alternate term more suitable for nursing in the form of the **psychosocial assessment**. Such an assessment begins by conveying to the patient that the nurse can be trusted and cares about his/her thoughts and behaviors through both non-verbal and verbal communication. This is the foundation of the therapeutic relationship, to be addressed in its own chapter. A friendly but professional attitude should be used, as well as a calm tone of voice. It is important not to be in a hurry, as building trust and rapport takes time. (4).

Patient history is the mainstay of the psychosocial assessment in nursing.

Lippencott proposes the following concepts and methods as part of a comprehensive patient history:

- **Primary complaint** – It is important to be aware that the patient may not voice this him/herself, and instead may have been referred to care by a concerned family member or healthcare provider. If this is the case, the nurse should conclude whether or not the patient is aware of the problem, documenting the response in exact quotations.

- **Symptoms** – Clarify the symptoms, their onset, the severity, and length of time. Did they occur abruptly, or gradually over time? How do the symptoms compare to the patient’s baseline level of functioning?
- **Psychiatric history** – Inquire about and document past incidence of mental health problems, including hallucinations/delusions, violence, substance abuse, suicide attempts, depression, and previous psychiatric treatment, if any.
- **Demographic data** – Discover the patient’s age, ethnic origin, mother tongue, place of birth, relationship status, and religion. This will be used to check the patient’s record and provide a context for further treatment.
- **Socioeconomic data** – Patients who are experiencing economic or personal hurdles are more likely to have a flare in symptoms. Inquire about the patient’s personal life and economic situation, and determine whether or not it could contribute to the current symptoms. In addition, information about the patient’s employment status, educational level, income, housing conditions, and family may provide important information in the context of the problem.
- **Cultural/religious beliefs** – These will provide information about how well the patient might react to hospital/psychiatric mental health treatment, or how they think of their illness.

(ibid.)

The Therapeutic Relationship

Definition

Of note, Lippencott’s basis for an effective psychosocial assessment rests on the initiation of a therapeutic relationship with the client. (*op cit.*) This is substantiated by Doherty and Thompson (2014), who maintain that a therapeutic relationship is essential in an effective assessment, comprehension of patient needs, and the delivery of quality, person-centered care (502).

In its essence, a therapeutic nursing relationship can be defined as “one in which the patient feels comfortable being honest with the nurse”. The focus of therapeutic communication is warmth and empathy, which make the patient feel at ease and secure. This leads to an effective working relationship and positive patient outcomes. Rather than focusing on the disease, the care is patient-focused, and is carried out by employing listening and questioning techniques, providing support, and minimizing a task-oriented approach to giving care. (ibid.).

Patients pass judgment on their mental health care providers from the very first meeting. Therefore, it is crucial that the therapeutic relationship is initiated with the uniqueness of the patient in mind, and that the patient immediately can draw the conclusion that their health care provider can be trusted. It is also of great importance to implement professional boundaries from the start; the nurse and the patient must know their role at all times, and it is the responsibility of the nurse to maintain professional boundaries, thus ensuring ethical care, and that the line between professional and personal boundaries is not transgressed. (ibid. , 504).

Artful/authentic use of self

According to Cumbie, the holistic perspective of nursing necessitates that each nurse must bring an authentic self into the moment of therapeutic interaction. This is achieved by reflection, self-awareness, and striving for harmony through mind, body, and soul. A nurse must know their own self and portray congruence in the way that they relate to the world and to their different roles. In so doing, this harmony is brought into the therapeutic interaction, and enables the undertaking of a caring, healing relationship. When this relationship is as it should be, it feels “effortless and correct, as though the communication is in keeping with a larger order”, and the nurse has the capacity to act as a human

being who is receiving the feelings of another human being for themselves. (2001).

Self-disclosure

Audet and Everall introduce the concept of self-disclosure in the therapeutic relationship, noting that it is a point of contention in the research. Immediate disclosure, which focuses on the present moment and the client – eg. “I’m sensing some anger right now.” – is considered acceptable due to its function in the therapeutic relationship; to clarify the therapist’s interpretation of the client’s interactions with others. Non-immediate disclosure involves elaboration on the therapist’s life outside of work; for example, life experiences, values, and emotional hardships – eg. “I remember when I had a panic attack during a speech”. This is considered the more controversial type of disclosure, as it carries the risk of boundary confusion and crossing. (2010, 327-328).

However, disclosure plays a central role in many different disciplines and schools of psychotherapy, as Audet and Everall expand. Proponents believe that disclosure assists in establishing rapport, conveying genuineness, showing empathy, and displaying positive regard for the client. Cognitive behavioral therapists maintain that disclosure encourages the patient to develop more effective coping methods through modelling and reinforcement. Disclosure is also perceived by feministic therapists as a method of shifting the power dynamics towards a more positive, equalized relationship, in which the therapist is viewed as more human. This is in contrast to the traditional therapeutic relationship, wherein the context of “professional-to-patient” interaction can make the patient feel objectified. (ibid., 328).

Studies on the effectiveness of therapist self-disclosure reveal that appropriate, moderate levels of disclosure support, reinforce, or validate the client's perspective. Patients also express greater positive regard when the nature of the disclosure immediately follows up on what the patient has just shared, and which conveys similarity to their experience. Consequently, therapists who properly use self-disclosure are perceived as more involved in the therapeutic process, more trusting, and more understanding. (ibid., 329)

The therapeutic relationship as it relates to nurses – difficult to articulate

Browne, Cashin & Graham (2012) note that there is a confusion over the roles of mental health nurses, even today. Although the therapeutic relationship is considered vital in patient outcomes in mental health, the concept is difficult to concretely define especially in the context of mental health nursing. Browne *et al* refer to a study performed by Dziopa & Ahern (2009) in which the elusiveness of the therapeutic relationship construct was addressed. In their research, they defined nine concepts that embody the therapeutic relationship: conveying understanding and empathy; accepting individuality; providing support; being there or available; genuineness; promotion of equality; demonstration of respect; maintenance of clear boundaries; and self-awareness on the part of the nurse. (Browne *et al*, 2012).

Conclusion

The nursing process and emotional labor

As Castledine (*op cit.*) noted, the nursing process is increasingly inching towards the medicalized perspective of care, with the introduction of multi-disciplinary, evidence-based-medicine care planning. However, nurses have long struggled to apply the nursing process to practice.

Indeed, earlier research by Smith (1991) already examined nurses' tendencies to prefer a more medicalized or task-oriented concept of the nursing process. Students and practicing nurses tended to view **emotional labor** – the production or suppression of feelings in order to maintain an outward appearance that gives patients a feeling of being cared for and safe – as very important to their work and to the nursing process. However, very few derived satisfaction from their work except if it were in the context of tasks completed. (75-76)

Practicing students began their training believing that caring and emotional labor were extremely important for the patient, but over time they focused more on technical, medical, and scientific aspects of nursing. (Smith *op cit* , 77-81).

The nurses interviewed by Smith gave insight into the tolls of emotional labor and compassion burnout, with older nurses growing more exhausted from caring work over time, and relying on new nurses to carry the emotional labor elements of the job. In addition, stereotyping played a role in the nurse-students' perception of the importance of the nursing process – common stereotypes being that nurses are “angels” and “beautiful”. In addition, there were interview requirements necessitating that prospective nurses have excellent people and customer service skills. (Smith *op cit.* 78-79).

Students developed the belief that being a nurse in of itself means “caring” and that emotional labor is simply an integral part of the type of person who chooses nursing as a career. Stereotyping and screening for people/customer service skills for their job reinforced this viewpoint. Thus, students tended to de-prioritize the nursing process and focus more on “hard facts” based on the medical model. (Smith, *op cit*, 78-79).

It would be worth considering implications of the attitude towards the nursing process in the context of mental health nursing practice. As the foundation of the work seems to be the emotional aspects of the nursing process and caring-healing relationships.

The elusiveness of the role of mental health nurses and future outlook

The difficulty locating concrete, definitive descriptions of the work of mental health nurses proved a considerable barrier during the research process. It proved impossible to use literature exclusive to the nursing viewpoint, while at the same time providing enough insight into the various topics.

A possible explanation lies in the history of psychiatric nursing, as reported by Browne *et al* (*op cit*, 2012). In their paper, they note the difficulties of defining the therapeutic relationship as it relates to nursing practice. They point to the history of psychiatric nursing as a possible explanation.

Hildegard Peplau, the pioneer of the concept of the nurse-client relationship, described considerable hardships as she introduced the concept to the field of mental health nursing. She reported that she had to be extremely careful in her teaching of psychiatric nursing – doctors and psychiatrists objected strongly to

the suggestion that nurses could give psychotherapy, preferring instead to refer to it as “talking with the patients”, and much later, “counselling”. (Browne *et al*, *op cit*.)

Another leader in psychiatric nursing work reported that he “tactfully” described psychotherapeutic interventions when asked about the nature of psychiatric nurses’ work, in order to avoid being perceived as a “threat” by other professionals. The therapeutic relationship has long been considered the mainstay of the psychotherapist-patient dynamic, and there was considerable reluctance to extend this role beyond those trained in formal psychotherapy. (Browne *et al*, *op cit*.)

Indeed, much of the literature found during the research process only provided a definitive viewpoint from the context of psychiatric doctors and licensed psychotherapists, who have traditionally been the standard-bearers of the therapeutic relationship as it relates to mental health.

Browne *et al* expand that the identified nine concepts comprising the therapeutic relationship in nursing are equally difficult to articulate as the therapeutic relationship itself, and is therefore of limited usefulness. Additionally they cite a report by Barker (2002), which found that mental health nurses are extremely proud of what they do, but when pressed to define it, the nurses struggled to articulate what exactly the work that they are so proud of actually *is*. (*ibid*.)

They argue that nurses have been side-tracked by trying to define the therapeutic relationship, where the focus needs to be on what nurses contribute *within* this relationship. As the concept of the therapeutic relationship is shared in common amongst almost all healthcare professionals, nurses will not receive proper

recognition and funding until they are able to articulate what nursing as a discipline contributes to such relationships. (Browne *et al*, *op cit.*).

Contrasting viewpoint on the topic of self-disclosure

Audet and Everall's paper (*op cit*, 2010) explained the role of self-disclosure in the therapeutic relationship. Their subsequent study illuminated on the benefits and drawbacks of self-disclosure in depth.

In accordance with Audet and Everall's preliminary research previously discussed, their study indicated that patients felt self-disclosure in the form of small-talk helped them to settle in, feel comfortable, and provided a respite from feeling like they were "being interviewed". In particular, they felt that self-disclosure was necessary to keep the conversation flowing smoothly, as it is awkward for conversations to only go one way, and that the therapy lacked direction without the symmetry that self-disclosure provided. (*ibid.*, 334).

However, a significant minority of patients also felt that self-disclosure was strange, surprising, or that it led to confusion about the reason the personal information was disclosed. One participant even felt that there was a role reversal of sorts; it was described as almost a parent-child dynamic, whereby they was responsible for listening to the therapist's woes, and fought the urge to comfort their own care provider. Other patients felt that self-disclosure revealed personal information which diminished their respect for the therapist, due to unmasking of imperfections that were difficult to dissociate from their concept of the therapist as a professional. (Audet & Everall *op cit* 334-335).

In addition, some patients felt that self-disclosure could back-fire. For instance, a therapist who discloses his struggles with minor social anxiety in response to a patient who is agoraphobic might be perceived as “competing” or minimizing the patient’s problems, and lead to a feeling of being misunderstood. This impacted the sense of trust in the relationship. Feelings of being overwhelmed, burdened, and even bored led to patients’ disengagement from the therapy process due to feeling uncomfortable with the level of intimacy, or due to disillusionment by disclosures which were not in line with what was wanted or expected. Importantly, some patients were reluctant to bring up problems in the therapeutic relationship because they worried about hurting the therapist’s feelings. (ibid., 336-338).

The literature would appear to suggest that the benefits of self-disclosure in the facilitation of a therapeutic relationship must be carefully weighed against the potential risk of confused patient-caregiver boundaries, diminished trust, and placing additional burden on the patient.

Suggestions for development

In light of the findings which indicate that nurses experience less job satisfaction when performing emotional labor, difficulties articulating what they contribute to a therapeutic relationship, and contention as to what role self-disclosure should play, it may be of importance to attempt to create a more robust, inclusive, and official standard for mental health nursing practice. Perhaps if mental health nursing practice and the tasks/work therein were more clearly defined, nurses would find greater satisfaction and recognition for their work in psychiatric settings.

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