The use of psychosocial interventions

It has been recognised that the management of severe mental illness should not only involve medication, but psychosocial interventions (PSI). These interventions draw techniques from cognitive behavioural therapies (CBT) and educational theories. They assume that there is a complex interplay between biological, environmental and sociological factors and that ambient stress together with certain life events may trigger an onset or relapse of mental health problems in some people (Neuchterlein and Dawson, 1984; Zubin and Spring, 1977).

The use of PSI is based on a diagnostic assessment of the patient’s psychopathology. Psychosocial interventions include:

- Engagement and outcome-oriented assessment;
- The family’s assessment of the patient’s needs;
- Psychological management of psychosis – CBT, coping strategy enhancement, self-monitoring approaches and training in problem-solving;
- Medication management, via motivational interviewing techniques.

Research has suggested that CBT, family intervention and medication management are promising interventions for ameliorating a client’s experiences of psychosis (Gould et al, 2001; Kuipers, et al 1997; Kemp et al, 1996; Mari et al, 1996). Nevertheless, a recent meta-analysis highlighted that data supporting the wide use of CBT was far from conclusive (Cormac et al, 2001) and there is a need to be cautious about advertising it as the universal remedy for psychosis (Paley and Shapiro, 2002; Cormac et al 2001).

Despite calls for PSI to be utilised in acute settings, many practitioners perceive PSI to be too mechanical and time consuming. Inflexible shift systems, low staffing levels and a general lack of confidence, skill and experience appear to leave some practitioners feeling unable to tailor PSI to meet the needs of the clients and their families while they are inpatients (Repper and Brooker, 2002). The following case study outlines how staff overcame perceived and actual service obstacles to engage one client and her family using PSI.

**Case study** Andrea was diagnosed with schizophrenia shortly after her 21st birthday. After inpatient treatment she remained in remission for seven years. With family support, she gained a university place but two years into the course her boyfriend left her. She lost interest in studying, began drinking heavily and replaced her prescribed medication with illegal drugs. Andrea returned home but became paranoid, believing the world and her family were against her.

After four months she was persuaded to attend the local community mental health centre but became suspicious of the psychiatrist who offered to increase her medication. Her exhausted mother witnessed Andrea’s distress and pleaded with staff to try a different approach and negotiated Andrea’s referral to a community psychiatric nurse (CPN). While waiting for a CPN appointment Andrea’s mental state deteriorated further and she was sectioned and admitted to an acute ward. On arrival, her parents requested an urgent review. Andrea remained aloof, paranoid and was irritable whenever she was approached. Low staffing levels hampered nurses’ attempts to establish a relationship with her. Andrea said that she hated the manner in which she was being treated and spoken to, and voiced paranoid ideas about her parents. As a consequence, staff were reluctant to offer Andrea’s parents anything other than superficial information.

Events leading up to an admission to an acute psychiatric ward and the admission itself can be daunting for all involved, often precipitating powerful emotions. It is helpful to examine how it is experienced from different perspectives.

In the past Andrea had had negative experiences of psychiatric treatment and inpatient services. On the ward there was limited time to outline her perspectives of her illness, discuss symptoms and/or get to know individual staff members. There was no opportunity to reflect upon Andrea’s strengths and coping strategies that had been learnt between admissions.

The family felt their understanding of the illness, knowledge of stress indicators and detection of early warning signs were undervalued. There was little opportunity to influence the treatment plan and a perception that they had done something wrong.

Staff on the ward felt there was limited time for listening to the experiences of patients and their families. There was also a conflict involved in maintaining client confidentiality and keeping families informed and involved.

**Overcoming the obstacles to PSI** Psychosocial interventions can hold the key to communicating and engaging with clients and families. The difficulty is in balancing the needs of both. The challenge for acute inpatient services is how to develop and sustain working relationships and alliances when the ward is under-staffed, over-stretched and/or confronted by inflexible working systems. Interpersonal skills are key in this respect. In Andrea’s case, it was important to find the time to engender a supportive relationship and let her know that her concerns were being taken seriously.
Her allocated nurse negotiated with the ward manager some flexible ‘off rota’ time and over three, one-hour sessions, they got to know each other. They also used the time to gain a baseline of Andrea’s symptoms and review the efficacy of antipsychotic medication treatment by conducting the Liverpool University neuroleptic side-effect rating scale (Day et al, 1995) and KGV(M) symptom severity scale (Krawiecka et al, 1977).

The results revealed that Andrea was experiencing some side-effects from the medication such as weight gain, dry mouth and an overwhelming feeling of restricted movement. She was also depressed and experiencing some paranoid thoughts – but her paranoid symptoms did not rate as highly as the staff had previously perceived. Through careful questioning Andrea disclosed she had felt vulnerable and frightened by the threat of readmission because a male patient had verbally threatened her during a previous admission. This enabled Andrea’s nurse to present formal data to the ward manager and KGV(M) symptom severity scale (Krawiecka et al, 1977). Splitting of Andrea’s nurse to present formal data to the care team and influence the decision to reduce her medication levels, as well as change staff attitudes.

**Family involvement** Many families are initially very suspicious of mental health professionals when they are asked to offer support, especially if in the past they have experienced a crisis, called for help and not gained an appropriate response. In Andrea’s case her parents had ‘stalled’ her admission, sought a second opinion, did not accept superficial information from staff and subsequently faced negative attitudes and a reputation for being interfering and troublesome.

In Standard 6 of the National Service Framework for Mental Health (Department of Health, 1999), all carers have a right to have their needs assessed and be involved in their relative’s treatment plan. In Andrea’s case it was important to address the negative assumptions that both parties had developed about each other. The team felt constrained by Andrea’s wish not to have her parents involved and were divided about the issue of confidentiality. Utilising ideas generated by Furlong and Leggart (1996) it was deemed important to gain a comprehensive account of the family’s experience.

A meeting was arranged to assess the family’s needs and devise collaborative intervention strategies. These included developing an understanding of Andrea’s early warning signs and crisis planning to pre-empt problems. This provided a structure for giving practical support and information and for communicating the family’s needs to the rest of the multidisciplinary team.

**Stress vulnerability model** The stress vulnerability model (Zubin and Spring, 1977) was explained to Andrea and her family. Stressful events were linked to Andrea’s personal experiences of increased psychosis. Andrea and her family were shown how they could anticipate and manage potentially stressful experiences.

Andrea’s early warning signs were recorded on a chart (see Table 1), incorporating the progression of symptoms and outlining what actions should be taken to prevent an escalation of Andrea’s problems.

**Conclusions** This case study has highlighted how PSI can be incorporated into the routine clinical practice of an acute inpatient ward. Achieving this in busy inpatient wards will never be easy, but as this example has shown, PSI has benefits for patients and their families.

### TABLE 1. CHART RECORDING EARLY WARNING SIGNS OF MENTAL HEALTH PROBLEMS

<table>
<thead>
<tr>
<th>Stage</th>
<th>Signs noted by Andrea (C)</th>
<th>Signs noted by family (F)</th>
<th>Signs noted by staff (S)</th>
<th>Actions to be taken</th>
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| 3 = Extreme symptoms and/or behaviours | Too busy – don’t like to talk to people; no sleep | Very irritating with parents; voice tone changes | Unable to give eye contact; very irritable | C = will try to talk to staff  
F = will contact doctor  
S = will respond, contact CPN and/or visit and assess |
| 2 = Moderate symptoms and/or behaviours | Stops sleeping throughout the night; drinks more coffee and alcohol | Shuts herself away; smokes more | Becoming irritating and suspicious | C = try to avoid coffee, take more relaxing baths, talk to mum  
F = be available  
S = feed back these observations – encourage to take more medication |
| 1 = Mild symptoms and/or behaviours | Stop being so interested in appearance; starts wearing odd clothes | Goes off her food | Slightly distracted | C = try to pay more attention to appearance and talk to mum  
F = listen to Andrea  
S = maintain regular contact |

**REFERENCES**


