Can counselling take place in acute clinical mental health?

ACCORDING to Pirkis et al (2001) counselling is an integral part of the role of the psychiatric nurse. However, from the patient’s perspective, it is an under-utilised tool, and this may adversely affect the nature of patient care (Burnard, 1996; Long, 1996; French, 1994). Ask mental health nurses to articulate the nature and essence of the theory and practice of their counselling provision in the acute clinical mental health setting and many are apparently unable to do so.

Counselling exists in myriad forms, from directive to non-directive, relational to behavioural and existential to deterministic (Corey, 2000; Patterson, 1996; Masson, 1993). So it may be helpful to imagine the range of counselling approaches as a continuum, with the humanistic philosophy of Carl Rogers at one extreme and the deterministic one of Sigmund Freud at the other.

In the context of non-directive therapy, the counsellor can be thought of as a type of therapeutic copilot, as the client is very much in the driving seat. In the context of directive counselling, however, the counsellor is in the driving seat and could be regarded as a type of therapeutic chauffeur. It is, therefore, important to appreciate that to practise counselling without explicit theoretical underpinning is somewhat like flying a plane without instruments and maps (Corey, 2000).

Responsibilities and limitations
Whenever any type of therapy is used, whether in the form of a medical prescription, counselling, or an integration of the two, it must be rigorously underpinned by evidence-based practice (Department of Health, Social Services and Public Safety, 2002). This means that mental health nurses must be fully aware of their professional limitations and clinical responsibilities.

For example, if a patient with a diagnosis of schizophrenia requires intensive support in the form of cognitive behavioural therapy (CBT) while in hospital, and this cannot be provided at ward level, the primary nurse has an obligation to refer that individual to someone who can provide it.

It would be unrealistic to expect nurses to fulfil this function, even if they were CBT trained, due to the intense clinical demands associated with such a ward.

Counselling is a term for a host of approaches, each underpinned by an explicit theoretical rationale. Its overall aim is to encourage the client to make more adaptive choices and to meet life with greater psychological clarity through the provision of a formalised, contractual and structured professional relationship.

For psychiatric nurses to say that they practise a particular form of counselling in the acute clinical environment is no proof that such counselling takes place, or that they understand the philosophy and rationale of the approach they claim to be using.

Difficulty of definition
More than 20 years ago Virginia Henderson defined nursing as primarily assisting the individual, sick or well, with those activities he or she would perform if not experiencing illness, disease or injury.

Subsequent definitions have maintained her paternalistic and anti-egalitarian tenets. Perhaps nurses have superimposed the ‘helping’ essence of their role definition on to their clinical counselling role, so they come to believe that ‘counselling’ and ‘counselling skills practice’ are one and the same, both by definition and in practical terms.

Nurse practitioners must overcome these misconceptions if they are to maximise and improve their counselling skills input in the acute psychiatric environment.

Terms such as ‘treatment’, ‘counselling’, ‘helping’, ‘therapy’, ‘communication skills’, ‘counselling skills’, ‘analysis’, ‘counselling intervention’, ‘counselling techniques’ and ‘psychotherapy’ are used by mental health nurses and other professionals in an ad hoc fashion. This can lead to confusion with regard to their formal definition and subsequent application.

Such confusion raises a number of questions. What is the position of mental health nurses in relation to counselling? How does this translate in terms of their behaviour at acute ward level, if at all?

A number of practitioners based in the acute environment regard themselves as ‘counsellors’, while many others actively reject this label. Why such discord?

How do practitioners define ‘counselling’ and what does it mean to them in daily practice? Do mental health nurses subscribe to a particular school of counselling and if so, which one? Do they feel that certain approaches are more effective with certain individuals? Do they cite any particular factors that may mitigate against effective counselling at ward level? Do practitioners understand the differences between the concepts of ‘counselling’?
and ‘counselling skills practice’? As service providers, practitioners must ascertain what their patients want to achieve from counselling.

More light will only be shed on these issues when further empirical investigation is carried out to ascertain and examine the views of staff and patients. Only then can we encourage mental health nurses to develop their counselling skills with the aim of increasing their patients’ quality of life, maximising optimum recovery and enhancing their own professional practice.

Long and Reid (1996) argue that in order to achieve more effective care at ward level an eclectic model of counselling should be implemented when dealing with suicidal individuals. However, there is an implicit assumption that psychiatric nurses have the abilities and opportunities to implement their recommendations.

Simply because a patient group presents with a variety of difficulties does not necessarily mean that mental health nurses have the interventions to help patients deal with these problems.

Another concern is the feasibility of introducing increased practitioner insight of the ‘counselling process’ into the role of the psychiatric nurse. This raises the question of whether mental health nurses ‘counsel’ or simply practise ‘counselling skills’.

Separate roles

Mental health nurses are involved in a plethora of activities including medicine administration, dealing with aggression and violence, liaising with other disciplines, reporting and recording patient progress, carrying out physical observations, dealing with distressed relatives and handling a multitude of administrative duties.

Strictly speaking, those working in the acute arena should not refer to themselves as ‘counsellors’ as they do not exclusively deal with clients’ psychological problems. They have a counselling role in that they practise counselling skills and some have developed these skills to an advanced level, but this does not mean that as a professional group they can be described as counsellors.

Professional competence and its link with the practice of counselling skills as opposed to counselling was recently highlighted in the Northern Ireland Counselling Review Document (DHSSPS, 2002). A ‘group’ is not a ‘team’ simply because someone chooses to label it so, as Sinclair and Fawcett (1991) remind us. Similarly, the term ‘psychiatric nurse’ should not be thought of as synonymous with ‘counsellor’, ‘specialist’, ‘expert’ or ‘professional’. As Hunt and Wainwright (1995) point out, certification is no reflection of competence; it is simply a licence to practise.

Due to high patient turnover, it is not surprising that psychiatric nurses are concerned with time-saving techniques in relation to therapeutic intervention.

Counselling, however, takes time. Therefore, counselling in acute mental health is perhaps no more likely to be embraced today than it was in the advent of the postmodernist asylum.

The relationship between mental health nurses and patients is complicated when practitioners suffer a violent assault or when practitioners restrain a patient to ensure the safety of everyone involved. Subsequently, therapeutic neutrality and clinical objectivity are damaged and any established trust is destroyed.

Since counselling is impossible without trust, interactions between mental health nurses and their patients in the acute environment should not be viewed in terms of counselling but rather as counselling skills practice. It is unrealistic for nurses to attempt to fuse their role and that of counsellor in the unpredictable environment of an acute admission ward.

Skill expectations

This distinction of roles has considerable implications for those carrying out clinical supervision as well as having a substantial impact upon the process of supervision itself.

Supervisors must ensure that they do not place unrealistic expectations on their staff in relation to counselling. They should give the opportunity to take counselling skills practice to an advanced level rather than reinforcing the myth that counselling can be carried out effectively in the acute clinical arena.

If, for example, during clinical supervision a nurse wishes to refer a patient for CBT, the supervisor should see this request as an indicator of professional maturity and not as a sign of weakness.

The roles of mental health nurse and counsellor are incompatible in an acute mental health environment. Guidance, training and resources should be directed towards encouraging mental health practitioners to take their counselling skills practice to an advanced level rather than focusing on the unrealistic objective of achieving independent counsellor status.

Recognising boundaries

Professional boundaries should be reinforced and maintained. Of course, some practitioners – for example, those treating people with a diagnosis of schizophrenia using the CBT approach – have achieved counsellor status. These individuals can call themselves counsellors because they deal with clients’ psychological problems.

This also applies to practitioners operating within rehabilitation or psychiatric day hospital settings. They are not subject to the same clinical demands and have the time to focus on counselling.

Mental health nurses based in the acute clinical sector do not deal exclusively with the psychological difficulties of their patients. They must be aware of their professional limitations and clinical responsibilities. They must therefore accept that they are not counsellors but counselling skills practitioners.

In conclusion, mental health nurses must collectively express a wish to expand their counselling skills practice in the context of acute psychiatric service provision. This will further refine their professional practice and clinical expertise. The practice of counselling in the acute clinical mental health environment is a fallacy. The practice of counselling skills is a fact.

**REFERENCES**


Pirkis, J. et al (2001) Self-reported needs for care among persons who have suicidal ideation or who have attempted suicide. Psychiatric Services; 52: 3, 381–383.


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