MENTAL HEALTH NURSES KNOWLEDGE AND VIEWS ON TALKING THERAPIES IN CLINICAL PRACTICE

by

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ABSTRACT

Nurses consider that their training, knowledge and skills in evidence-based talking therapy models are essential for competent mental health nursing practice. Using a qualitative descriptive research design this study explored nurses' knowledge and views on their talking therapy training and skills in practice. The study examined the use of talking therapies, or specialised interpersonal processes, embodied within the Te Ao Maramatanga: New Zealand College of Mental Health Nurses Inc (2004) *Standards of Practice for Mental Health Nurses in New Zealand*. A survey questionnaire was sent to 227 registered nurses from a District Health Board (DHB) Mental Health Service and a sample of eight nurses participated in a semi-structured interview. Content analysis based on the headings "knowledge views, skill acquisition and skill transfer" established the major themes from the data collection processes. The findings of this study confirmed that nurses believe their knowledge and skills in evidence-based talking therapies to be vitally important in mental health nursing practice. Nurses identified that talking therapy training courses needed to be clinically relevant and that some learning strategies were advantageous. The identification of some knowledge gaps for, nurses with limited post graduate experience, and for nurses who currently work in inpatient areas suggests that further consideration must be given to ensure that a cohesive, sustainable approach is ensured for progression of workforce development projects relevant to training in talking therapies for mental health nurses in New Zealand.

Key Words

Psychiatric Nursing, Psychotherapy, Mental Health Nursing, Talking Therapies, Qualitative Descriptive

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CHAPTER ONE: INTRODUCTION

Talking therapy skills are essential in mental health nursing practice. Such skills are as important to mental health nursing as the monitoring of vital signs are to medical and surgical nursing. The ability to create a therapeutic interpersonal relationship with people who have mental illness relies on the effective use of talking therapy skills to facilitate assessment, treatment and recovery in a collaborative manner. This study explores nurses' knowledge and views on 'Talking Therapies' in clinical practice. Talking therapies include a wide range of psychological treatment models that in practice "…involve talking, questioning and listening in order to understand, educate and assist with people's problems" (Peters, 2007a, p. 8). Talking therapies may be used in an inpatient or community treatment setting as part of crisis intervention or within a therapeutic treatment programme to resolve or improve the management of mental health difficulties (Peters, 2007a). The term 'talking therapies' was devised by service users and their families in the United Kingdom for inclusion in national strategic documents as the preferred term for describing psychological interventions. Permission was sought by Peters (2007a) to ascribe the term talking therapies to documents published in New Zealand.

Garland (1994) promotes nursing as a collaborative endeavour, working with people to address their mental health needs in a holistic manner. She defines holistic nursing practice as understanding the impact on health of the "physical, biological, social, interpersonal, intrapersonal, environmental and cultural …" (Garland, 1994, p. 134) needs of individuals. Garland also adds, that nursing includes being "…an advocate and an educator promoting autonomy and self-help where possible" (p. 134). The collaborative, interpersonal processes that involve talking, listening, questioning and working holistically in partnership with people are expectations for mental health nursing practice.

Mental Health Nursing: Valuing the New Zealand Context

The objectives for mental health nursing in New Zealand are outlined in the Te Ao Maramatanga: New Zealand College of Mental Health Nurses Inc (2004) *Standards of Practice for Mental Health Nurses in New Zealand*. The standards require mental health nurses to form dynamic, interactive relationships in partnership with people to progress assessment, treatment and recovery.

> Mental health nursing is a specialised expression of nursing which focuses on meeting the health needs of the consumer, in partnership with family/whanau and the community in any setting. It is a specialised interpersonal process embodying a concept of caring which has a therapeutic impact on the consumer, the family or whanau and their cultural context, by:
>
> - Supporting consumers to optimise their health status within the reality of their life situation
> - Encouraging consumers to take an active role in decisions about their care
> - Involving whanau and communities in the care and support of consumers
>
> The mental health nurse recognizes the need for flexibility, adaptability, responsiveness, and sensitivity as they shape their practice to the dynamically changing needs of the consumer, family/whanau and the community (Te Ao Maramatanga: New Zealand College of Mental Health Nurses Inc, 2004, pp. 1-2).

The above definition provides a framework for contemporary mental health nursing practice in New Zealand that is underpinned by relevant theoretical perspectives, for example, interpersonal relations theory. Interpersonal relations theory is a "…theory-based nursing model…" (Howk et al., 1998, p. 336) devised by H.E. Peplau during the 1950's. Discourse pertaining to interpersonal relations theory has been evident in New Zealand nursing literature from the mid 20th century (O' Brien, 2001). Peplau conceptualised her theory of interpersonal relations for nursing from existing theoretical knowledge within behavioral science and psychological models (Howk et al., 1998). The constructs within the interpersonal relations model devised by Peplau are inherent to psychodynamic nursing (Howk et al., 1998; Peplau, 1992) and particularly relevant to mental health nursing. The interrelated constructs formulated within interpersonal relations theory assist in understanding the dynamics within the nurse-patient relationship (Peplau, 1992). The premise that "…what goes on between people can be noticed, studied, understood and if detrimental changed" (Peplau, 1992, p. 14) underpins interpersonal relations theory. Practical application of interpersonal relations theory in nursing includes; using interpersonal techniques such as talking and questioning to assist with understanding,

identification of the patterns and variations of problems, provision of education and suggested strategies to facilitate behaviour change. The theoretical constructs within interpersonal relations theory, the bio-psychosocial health assessment and interventions that are integral to holistic nursing practice are facilitated by the use of talking therapies and are therefore inherent within competencies for mental health nursing standards of practice. For example:

> Standard II, The Mental Health nurse establishes partnerships as the basis for a therapeutic relationship with consumers…
>
> The mental health nurse is familiar with:
>
> I. The theoretical assumptions and principles and processes associated with effective interpersonal communication, therapeutic relationships and partnerships in nursing...
>
> IV. Patterns of interpersonal behaviour…
>
> Standard III, The mental health nurse provides nursing care that reflects contemporary nursing practice and is consistent with the therapeutic plan… (Te Ao Maramatanga: New Zealand College of Mental Health Nurses Inc, 2004, p. 8).

The specialised knowledge and skills required to practice in accord with the standards cannot be underestimated nor assumed. Training is required. The essence of the Te Ao Maramatanga: New Zealand College of Mental Health Nurses (NZCMHN) Inc (2004) *Standards of Practice* is reflected in a statement made by a nurse with training and experience in talking therapies who was interviewed in the course of this study.

> … it [Post Graduate Child Psychotherapy Training] made perfect sense of the nursing practice. It actually put things into [context], it just made sense. I remember once, doing my training, it was about 1978 and I had to go for this assessment. You know, you had to do your assessments and the charge nurse was very cross at me, said to me, you've got to do more than just talk to the patients. Honestly, yeah, that got a remark on my assessment [summative assessment], something about [being] an armchair psychiatric nurse. Spends too much time talking to them, which is a bit

> sad, a bit sad really, wasn't it? I should have been doing the laundry or cleaning lockers. … It's all about talking but it's all about listening as well, isn't it?... and thinking about it…I think it should be called thinking therapies rather than talking because you have to do a lot of thinking before you actually put your mouth into gear.

For this nurse, postgraduate training in Child Psychotherapy validated skills central to her nursing practice. Equally, talking therapy training assured her of the knowledge and skills to nurse in accord with standards of practice. It is hard to imagine that "doing the laundry or cleaning lockers" would have represented holistic nursing practice. Within competencies and standards of practice (eg: Nursing Council of New Zealand, 2007; Te Ao Maramatanga: New Zealand College of Mental Health Nurses Inc, 2004) that underpin mental health nursing there is the opportunity for practical, psychopharmacological and psychotherapeutic interventions to support recovery. The essence of mental health nursing is managing the balance between practical assistance, psychopharmacological relief and psychotherapeutic interventions within a holistic model of nursing care. Psychotherapeutic interventions includes the use of talking therapies.

Nurses in current practice may not been able to access training in talking therapies in either undergraduate or postgraduate training. The lack of access to training in talking therapies was identified in 2006 in a comprehensive review of strategic directions for mental health nursing in New Zealand (Ministry of Health, 2006a). The review included a recommendation that "the Nursing Council of New Zealand in conjunction with mental health nursing professional bodies should review undergraduate mental health education for its relevance to the mental health sector" (Ministry of Health, 2006a, p. xi). The review also identified that mental health workers, including nurses needed training in "specialist skills and cognitive behavioural therapy" (Ministry of Health, 2006a, p. 25). Cognitive Behavioural Therapy (CBT) is one of a range of talking therapies. The recommendations from the 2006 review essentially state that the *Standards of Practice* from Te Ao Maramatanga: (NZCMHN) Inc (2004) have not been implemented consistently across the mental health nursing workforce.

Mental health nursing practice is not reliant on costly equipment but rather on knowledge, therapeutic skills and attitudes that individual nurses need to actively learn and develop to ensure safe and competent nursing practice. The complex multilayered nature of mental health nursing in a changing health care environment in New Zealand is challenging and exciting. There is no room for complacency. O'Brien (1999) identifies a paucity of research into the fundamental knowledge that underpins mental health nursing practice in New Zealand. The paucity of research in New Zealand includes a lack of research into the use of talking therapies in mental health nursing practice. In this study, I have endeavored to contribute to the knowledge base on the use of talking therapy skills in mental health nursing in a District Health Board (DHB). From my literature search there was no comparable study carried out in the DHB or any other mental health nursing setting in New Zealand. Given my assertion that talking therapy skills are an essential component of mental health nursing practice and the paucity of research in this area, in this study I have focused on nurses' knowledge and views in talking therapies in clinical practice. This study therefore adds important research knowledge to mental health nursing practice in New Zealand.

Talking therapies in this study refers to evidence-based psychological therapies used by nurses, including Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT), Motivational Interviewing (MI) Transactional Analysis (TA), Family Therapy, Psychodrama and Psychosocial Interventions. The above cognitive, behavioural and psychological therapies are all theory and evidence-based therapies that require specific steps and processes for their effective use in treatment. To provide context to this study, the above therapies are fully described in Chapter Two.

Background

Global and national perspectives for talking therapies in clinical practice for nurses

Internationally, training in talking therapies has been progressed in the United Kingdom, United States of America, Ireland and Australia, with research publications from the United Kingdom providing a well recognised resource for training and development programmes. More than two decades of nurses being trained in behavioral psychotherapy (Gournay, Denford, Parr, & Newell, 2000), extensive training for all health professionals in

Psychosocial Interventions, including nurses, since 1989 (Brooker & Brabban, 2004; Brooker, Saul, Robinson, King, & Dudley, 2003) and more than fifteen years of Family Therapy training (eg: Bailey, Burbach, & Lea, 2003; Fadden, 1997) provides an indication of the commitment made to training and development in talking therapies in the United Kingdom. Additionally, best practice competencies in undergraduate training in the United Kingdom include the requirement to have knowledge of a range of talking therapy skills. For example; evidence based interpersonal skills, CBT and Psychosocial Interventions (Department of Health UK, 2006). Furthermore, Cognitive Behavioural Therapy (CBT) training initiatives in Ireland and CBT and Family Therapy training initiatives in Australia are reported in research literature, adding to the important body of international literature. Although few studies have been conducted in New Zealand, Crowe and Luty (2005) and Brassington and Krawitz (2006) contribute to the knowledge base for nursing in New Zealand with their research on Interpersonal Therapy (IPT) and Dialectical Behaviour Therapy (DBT) respectively. The experience from international research confirms the value of talking therapy training for nurses and provides relevant information to support the development of training in New Zealand.

A recent document prepared by Peters (2007a) for Te Pou *"We Need To Talk" Talking Therapies – a snapshot of issues and activities across mental health and addiction services in New Zealand* (New Zealand's National Centre of Mental Health Research and Workforce Development) highlights that service users, families and clinicians identified a gap in the access to evidenced based therapies including talking therapies. A gap was also identified in documents pertaining to national strategic directions for service delivery, for example: (Mental Health Commission, 2007; Ministry of Health, 2005a, 2005b, 2006b). Peters' (2007a) document "*We Need To Talk*" identifies training in talking therapies as a priority for New Zealand Workforce Development. Initiatives recommended in the document will be linked to core competencies and skills included in national workforce development projects, in particular the *Let's Get Real: Real skills for people working in mental health and addictions* (Ministry of Health, 2007). A second publication by Peters' (2007b) *We Now Need To Listen: A summary of the key issues from feedback on "We Need To Talk"* states that there has not been a national framework to provide a coordinated and cohesive approach to training in talking therapies for mental health professionals in New Zealand.

During the course of this study I attended an *Acute Nursing Workshop* in Auckland that included a paper entitled *The obstacle is the path: Embracing both the opportunities and challenge when using CBT interventions in acute inpatient mental health nursing* (Garland, 2008). The workshop was followed by a *Forum for Future Practice Initiatives* (2008) facilitated by Anne Garland (Distinguished Visitor, University of Auckland), Anna Schofield (Nursing Leadership Manager, Te Pou) and Helen Hamer (The University of Auckland Faculty of Medical Sciences School of Nursing). The forum was established to facilitate professional discourse about the development of talking therapies in New Zealand. Attendees to the forum collaboratively prepared a report to contribute to the next talking therapies document authored by Janet Peters. The document will inform future workforce development initiatives pertaining to the progression of training in talking therapies for all health professionals, including nurses. My participation in the workshop and forum has served to endorse the value of skills in talking therapies for my own nursing practice and sustained my enthusiasm for this study. Although the utilisation of talking therapies is not limited to nurses, nurses account for a significant proportion of the mental health workforce (Peters, 2007a) which also means that mental health nurses are an important resource. Therefore, it becomes important to establish what it is that nurses already know about talking therapies and to identify potential knowledge gaps.

Personal Nursing Practice Relevant to My Research Project

I registered as a psychopaedic nurse in 1977 and for the first year following my registration worked as a district nurse supporting families with the care of a relative with an intellectual disability. A move to live in Hanmer Springs in 1978 heralded a new direction for me with a different focus in nursing that would continue to influence and support the development of skills that have become integral to my nursing practice in mental health.

My first introduction to formal training in addictions counseling, Transactional Analysis (TA) and Psychodrama, occurred in these formative years of my nursing career and I subsequently spent a number of years working in a variety of drug and alcohol treatment facilities in New Zealand and overseas, including working as a counselor in a therapeutic community in The Hague, Holland. These opportunities and a period of time teacher aiding whilst considering a career change to primary education have allowed me to reflect on and value therapeutic and teaching skills that have since been incorporated into

my nursing practice. I updated my basic nursing training and registered as a comprehensive nurse in 2000. I have maintained an ongoing commitment to academic work, expanding my interest in education to tutoring nursing students, followed by a two year position as an educator for all clinical staff of the mental health service. In my current role as a Clinical Nurse Specialist in an acute inpatient unit, talking therapy training and skills inform my own practice and informs the provision of clinical supervision for staff and leadership roles within the unit and wider mental health service.

Clinically I have spent several years working closely with people who struggle with an eating disorder. As the District Liaison Coordinator between the District Health Board (DHB) and Regional Specialist Eating Disorders Service I am required to manage and triage referrals from Primary and Secondary Health Services, coordinate telemedicine clinical case review and provide supervision for staff in complex case management including their review of treatment and recovery plans. Continuing professional development, including introductory training in Cognitive Behaviour Therapy, is invaluable in my ongoing coordination role and for working with consumers.

Treatment guidelines for an eating disorder refer to cognitive behavioural therapy, interpersonal psychotherapy individual or group psychotherapy and family therapy as being important evidence based psychological treatments for an eating disorder. (American Psychiatric Association, 2000; Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Anorexia Nervosa, 2004). However using talking therapies as part of treatment and recovery is not limited to eating disorders but an important tool effective for a range of mental illnesses.

Research Justification

This study contributes to the fundamental knowledge that underpins mental health nursing practice in New Zealand by exploring nurses' knowledge and views of talking therapies. My justification for this study was based on the following:

- The historical theoretical underpinnings that inform professional standards for mental nursing practice infer that nurses have skills in talking therapies. Mental health nursing "is a specialised expression of nursing" (Te Ao Maramatanga: New Zealand College of Mental Health Nurses Inc, 2004, p. 1) practice. Talking therapy

skills are specialised skills and access to talking therapy training at an undergraduate and postgraduate levels is limited.

- Recent workforce development initiatives that propose to progress talking therapy training for all health professionals, including nurses.
- Influences drawn from my own clinical experience of 30 years during which I have always valued therapeutic talking therapy skills. They are integral to my nursing practice.

Overview of Chapters

In this study, the key terms, knowledge views, skill acquisition and skill transfer provide a framework to explore nurses' knowledge of talking therapies. The key terms confer consistency to the identification of existing knowledge, searching for new knowledge and how that might have been acquired through training and professional development.

Chapter Two and Chapter Three establish the relevance of existing research knowledge that is essential background to this study. Chapter Two discusses the theoretical underpinnings and the practical application of the cognitive, behavioural and other psychological talking therapies. Chapter Three reviews evidence related to nurses' knowledge of talking therapies or training.

Chapter Four describes a quantitative survey questionnaire that sought information pertaining to nurses' knowledge of talking therapies and an outline of the data collection processes in the use of semi-structured interviews. Qualitative content analysis is presented as the most applicable method for analysis of the data derived from the interview process.

Chapter Five presents the findings of the study. The chapter commences with presentation of the results from the quantitative survey questionnaire used to elicit demographic information, details of training and knowledge of talking therapies. The survey results are presented with qualifying statements to provide context and clarity. The results from the qualitative component of this study that involved semi-structured interviews with a sample of nurses are presented in the second part of chapter five. The three key terms, knowledge views, skill acquisition and skill transfer formed an analytic framework for the identification of the themes drawn from participants' transcripts. The results are illustrated by the inclusion of excerpts from the interview transcripts.

Chapter Six presents a discussion of the findings from this study in conjunction with the research reviewed in Chapters Two and Three. The concluding chapter provides recommendations as outcomes from this study and outlines suggestions for further research.

Chapter Summary

Garland (1994) suggests that research is required to explore the distinction between "what a nurse is and what a nurse does" (p. 136)**.** I believe that what a nurse is, or is expected to be is determined through nursing standards of practice. Skills and training in the use of talking therapies in mental health nursing practice provides an important insight into what a nurse does**.** This study identifies what nurses' consider to be important about their knowledge and use of talking therapies in practice. Nurses who had training in talking therapies considered their skills to be vital to their nursing practice. However, nurses who did not have training identified a knowledge gap that they wanted addressed. Identification of what nurses' consider to be important provides valuable information for nurses and future workforce development initiatives. Provision for training at a local level is imperative but I have every reason to believe that this is applicable across the country. Nurses' knowledge views, skill acquisition and skill transfer pertaining to talking therapies and what might help or hinder the integration of their skills into clinical practice, adds perspective to what a nurse is and does in mental health nursing in New Zealand.

CHAPTER TWO: TALKING THERAPIES EXPLAINED

Introduction

The term 'talking therapies' is an inclusive term that refers to an array of psychotherapeutic treatment approaches used by mental health clinicians, including nurses. Talking therapies are based on theoretical models and are used in treatment within a planned and structured therapeutic framework. This chapter provides an overview of the theoretical underpinnings, key concepts and practical application of the therapies relevant to this study.

The first section of this chapter provides a brief overview of the major theorists who provided the foundation for development of the theories that underpin talking therapies. This was to enable me to understand the historical theoretical background to talking therapies and to inform the process of grouping the talking therapies relevant to this study into three broad categories. The categories are; humanistic-experiential-existential therapies, cognitive behavioural-action oriented therapies and systems therapies. Child and family psychotherapy, an eclectic therapeutic approach for children and adolescents is also described. Nurses' training in talking therapies and the use of talking therapies in mental health nursing practice is reviewed in Chapter Three.

Historical Overview

Sigmund Freud (1856-1939) and Alfred Adler (1870-1937) were two prominent theorists who contributed to the development of analytic approaches to therapy (Batemean, Brown, & Pedder, 2000; Corey, 2005; Gilliland & James, 1998). Psychoanalysis, and the work of Sigmund Freud has historical significance because the principles and techniques that inform contemporary psychotherapies were developed either as extensions of psychoanalysis, variations on psychoanalysis, or developed to contrast with psychoanalysis (Bateman et al., 2000; Corey, 2005; Gilliland & James, 1998). Freud's historical theoretical positioning and scientific work focused on internal conflicts, described as " …intrapsychic conflicts pertaining to gratification of needs" (Corey, 2005, p. 75). Contemporary psychoanalytic therapy is focused towards exposing the unconscious, understanding how current behaviour is a repetition of behaviour learnt from early phases of development and how this behaviour effects current relationships (Corey, 2005; Gilliland & James, 1998).

Adlerian therapy, founded by Alfred Adler, developed as an alternative to Freudian theoretical perspectives. It relates an individual's mental health to wider social perspectives of health (Gilliland & James, 1998). Adler's work focused on the continuing influence of the past on the present for individuals. However, in contrast to Freud's beliefs about intra-psychic conflict and sexual urges, Adler argued that people are motivated by social relatedness; that "…behaviour is purposeful and goal-directed; and consciousness more than unconsciousness is the focus of therapy" (Corey, 2005, p. 95). Adler's theories include normalising inferiority to be the driving force for change and that "…what we were born with is not as important as what we choose to do with the abilities and limitations we possess" (Corey, 2005, p. 95). Contemporary Adlerian therapies promote a holistic, social, goal-oriented, systemic, and humanistic approach (Corey, 2005; Gilliland & James, 1998). Most current forms of therapy, particularly in mental health are underpinned by key concepts from Adlerian therapy. For example, individual counselling, family therapy and parent-child counselling, group counselling and brief counselling interventions (Corey, 2005). Humanistic–existential-experiential therapies describes a group of therapies with diverse theoretical and treatment perspectives that evolved parallel to psychoanalysis and behavioural therapies during the early twentieth century (Blyth, 1999; Corey, 2005; Gilliland & James, 1998). The theoretical perspectives that inform cognitive behavioural oriented therapies have been developed from, or in contrast to, the original theoretical perspectives of psychoanalysis.

This historical overview is not intended as an in-depth theoretical discussion or debate about the merits of each theory. Instead, I have attempted to establish that the principles that evolved from Freudian psychoanalysis or contrasting theoretical perspectives underpin contemporary approaches to psychotherapy. I found that most literature categorised psychotherapies predominantly according to their theoretical founder, key characteristics and clinical interventions (eg: Bateman et al., 2000; Corey, 2005; Gilliland & James, 1998) however the overarching headings differed according to the perspective of the author [s]. I found it difficult to establish an exacting consensus position so I elected to follow a format that remained in context with my study and that reinforced practical links from theory to clinical practice. Thus the following section reflects the categories to continue my investigation of the talking therapies relevant to this study. They

are; humanistic–existential–experiential therapies, cognitive behavioural-action oriented therapies, systems therapies and child and family psychotherapy with the understanding that they share certain theoretical principles and characteristics.

Humanistic-Existential–Experiential-Therapies

Gestalt Therapy

Gestalt therapy is an existential-phenomenological model of psychotherapy developed during the 1940s by Fredrick and Laura Perls (Blyth, 1999; Corey, 2005). Phenomenology encompasses an individual's subjective perception of reality and existential encompasses the process of change. 'Gestalt' is a German word which means whole. The Gestalt theory of personality means an integrated view of whole, "…individuals cannot be reduced to discrete psychological parts and still maintain the essence of a whole person" (Gilliland & James, 1998, p. 138). Two of the four key concepts that inform the theory of Gestalt are Holism and Field Theory. Holism means the interrelationship between psychological, physical and environmental dimensions of human functioning. Field theory attends to the interrelationship between the person and their internal and external environment (Corey, 2005; Gilliland & James, 1998).

Gestalt therapy is an action oriented therapy in contrast to therapies that are focused on talking about the problem. Traditionally, Gestalt therapy is practiced in groups where one individual works with the therapist whilst the other group members observe and then provide feedback about their experiences during the group process. This is a form of self-therapy (Blyth, 1999). The goal of therapy is for people to become aware of what they are experiencing in the here-and-now, take responsibility for the associated behaviours, thoughts and feelings, and then experimentally initiate change (Blyth, 1999; Gilliland & James, 1998). In contrast to psychoanalytic therapy which considers the influence of unresolved inner conflicts from early childhood, Gestalt therapy responds to the importance of experiences in the present (Blyth, 1999; Corey, 2005). Past issues, or unfinished business, that manifest as unexpressed feelings such as anger, guilt or anxiety and inhibit fullness in life are resolved by recreation of the experiences in the present (Blyth, 1999; Corey, 2005). Gestalt therapy pays particular attention to non verbal cues and body

language as a valuable means to inform therapy (Blyth, 1999; Gilliland & James, 1998). The client-therapist relationship is central to the therapeutic approach.

The advantages of Gestalt therapy include the experiential nature of the therapeutic approach to treatment. This is in contrast to cognitive therapies that focus on talking about the problem and the use of cognitive processes to change behaviours. Gestalt therapy provides the opportunity for an individual to creatively engage with their own potential to facilitate change (Gilliland & James, 1998). Therapists require extensive training to embed the level of skill and understanding of group dynamics required for the effective use of Gestalt therapy in treatment.

Corey (2005) and Gilliland and James (1998) provide an extensive overview of Gestalt therapy and website addresses for further information. However, I was unable to find empirical literature relevant to Gestalt therapy in New Zealand. I identified that Gestalt Australia and New Zealand (GANZ): Association of Gestalt Therapy and Practitioners, was established in 1997 (Levien, 1997) as a collaborative venture between Australia and New Zealand. The Gestalt Institute of New Zealand (GINZ) is a part of GANZ and provides Gestalt therapy training for health professionals in New Zealand.

Psychodrama

Psychodrama is an experiential form of therapy, developed during the mid 1930s by J, Moreno (1889-1974). A therapeutic approach using psychodrama is focused on what people are experiencing in the moment, a here-and-now approach in contrast to an analytical approach that focuses on psychopathology (Blyth, 1999). Psychodrama is mostly used in group work and integrates imagination, action, verbal expression and self-reflection through the use of dance, music, poetry and art to explore people's problems and concerns (Blatner, 1997). The group therapy process in psychodrama traditionally involves a brief warm-up exercise, selection of a "protagonist", who using an action method explores a problem, followed by group feedback and closure. The scope of psychodrama therapy may also incorporate related psychodynamic techniques that practitioners term "action methods", "experiential techniques", "warm-ups", "role playing or "structured experiences" (Blatner, 1997, p. 24). Psychodrama techniques are termed a praxis as they are not associated with a single theoretical orientation. Blatner asserts that most therapists utilise

psychodrama concurrently with therapies such as cognitive behavioural therapy, family therapy, transactional analysis, Gestalt therapy and others.

Therapy that uses psychodramatic techniques provides an individual with the opportunity to reflect, practice alternative responses to a perceived problem and formulate a more holistic or considered response to a situation. This therapeutic process is in effect a "psychotherapeutic transformative process" (Blatner, 1997, p. 23). Importantly, psychodrama provides for the use of more than a single technique and incorporates a philosophy of treatment using creativity and psychology. Elements of self expression, cathartic expression, playfulness, cognition, physical experience as well as imagery and cognitive insight provide useful tools for a therapeutic treatment approach.

My clinical experience associated with the use of psychodrama stems from working in residential drug and alcohol treatment facilities in New Zealand and the Netherlands during the 1980-1990s. Somov (2008) reviews the use of psychodrama for substance abuse relapse training in the United States and Avarahami (2003) advocates for psychodrama integrated with other therapies, for example Rational Emotive Behavioural Therapy (REBT). Although psychodrama is an effective treatment for substance abuse Somov states that the model is under-utilised. Hug (1997) argues for a more eclectic approach to the use of psychodrama, including the integration of psychodrama with other therapeutic models in treatment for people with chronic mental illness. Psychodrama provides a psychotherapeutic framework for treatment in the adult outpatient mental health service of the DHB used to select participants for this research study.

Transactional Analysis

Transactional analysis (TA) originally developed by Eric Berne during the 1950s, is both a theory of personality and a practical psychotherapeutic treatment that integrates elements of psychoanalytic, humanistic and cognitive therapies to inform personal growth and change (Blyth, 1999; Gilliland & James, 1998; Stewart & Joines, 1997). TA may be used in both individual and group work (Berne, 1961). The basic philosophical assumptions that inform TA are; that people are 'Ok'; psychological disorder is acquired; people have the capacity to think independently; people make life decisions that have consequences; and people are responsible for the choices they make (Blyth, 1999; Stewart & Joines, 1997). From this

philosophical perspective two key principles underpin TA practice. They are; firstly, accepting joint and shared responsibility during therapy for achieving change based on an interactive contractual method and secondly, ensuring that open communication and transparent processes are maintained. Therapists are responsible for the provision of education about the essential concepts of TA for clients (Blyth, 1999; Gilliland & James, 1998; Stewart & Joines, 1997).

The key theoretical perspectives of TA are; the theory of personality, the theory of communicating and the theory of child development which collectively inform the TA theory of psychopathology (Stewart & Joines, 1997). The theory of personality, considered to be the core of TA, is explained by the ego state model, which describes the relationship between behaviours, thoughts and feeling and the way personality traits emerge throughout life. The model portrayed by the three ego states Parent, Adult and Child is always referred to with capital letters to define the theoretical reference as being distinct from casual references to a parent, adult or child (Stewart & Joines, 1997). The Parent ego-state elicits thoughts, feelings or behaviours that unconsciously copy the actions of parents or important parental figures that were of a controlling or nurturing nature. An Adult state emerges with thoughts, feelings and behaviours that reflect informed, considered responses to events in the here-and-now. A return to ways of behaving, thinking and feeling as a child reflects the Child ego-state which might express a sense of fun and frivolity or alternately self depreciating behaviours that might include constantly conforming and compromising to meet perceived expectations (Gilliland & James, 1998; Stewart & Joines, 1997). Exploration to facilitate an awareness of the internal dialogue between ego states is called structural analysis. Transactional analysis involves analysis of communication sequences (Berne, 1961).

The theory of communication in TA can be understood by acknowledging that the transactions that occur during communication, are interactions informed by the Parent, Adult or Child ego-state. The ego-state model provides a format to analyse sequences of communication “transactional analysis proper” (Stewart & Joines, 1997, p. 4) and is considered a distinct process in TA communication theory. For example, transactions may be complimentary where a conversation flows in a consistent manner, or alternatively communication may be considered crossed when the ego state that is addressed does not

elicit the same ego-state response and engenders conflict (Gilliland & James, 1998; Rowe, 1999). Unconscious, repetitive transactions with a familiar pattern and outcome are called games (Berne, 1961). In TA therapy, structural and transactional analysis occur in sequence (Berne, 1961) .

The TA theory of child development is derived from the concept of life-script. Life script illuminates how thought patterns, feelings and behaviours that have originated in childhood, and are often revised during adolescence, have a continuing positive or negative influence during adult years. As adults, we are usually unaware of these early life influences. The TA model includes four life positions or scripts, which determine how individuals see themselves and interactions and behaviours within relationships. The four basic positions are “I’m Ok-You’re Ok”, “I’m Ok-You’re not Ok”, “You’re Ok-I’m not Ok” and “You’re not Ok-I’m not Ok” (Gilliland & James, 1998). Through psychotherapeutic work these life scripts become exposed and through interactive exploration and the analysis of alternative decisions to enable change can be facilitated.

TA is a complex, multilayered theoretical and psychotherapeutic treatment approach. Stewart and Joines (1997) caution against a simplistic interpretation of the model, apparently an error in judgment made by many individuals in earlier years and one that will not be repeated here. In essence, TA provides a therapeutic approach that is appropriate for a wide variety of psychological disorders and used in individual, family and group work. I have found my basic knowledge of the key theoretical principles of TA to be advantageous in my clinical work.

Cognitive Behavioural-Action Oriented Therapies

Although most research dates the development of cognitive theory from the 1950s, cognitive theory can be traced back to the observations and writings of very early Greek philosophers notably the emperor Marcus Aurelius and the slave Epictatus who is thought to have said ‘Men are disturbed not by things, but by the view they take of them’ (Davidson & Stein, 1999; Gilliland & James, 1998; Mahoney, 1993). Historical psychoanalytic theoretical perspectives, in particular those of Alfred Adler have informed the development of cognitive psychotherapies (Froggatt, 2006; Gilliland & James, 1998), that since inception during the 1950s, have differentiated into a wide range of cognitive

psychotherapeutic treatment approaches (Grazebrook & Garland, 2005; Mahoney, 1993). The cognitive psychotherapies relevant to this study, Cognitive Behaviour Therapy (CBT), Rational Emotive Behaviour Therapy (REBT), Dialectical Behavioural Therapy (DBT) and Motivational Interviewing (MI) are discussed in the following section.

Cognitive Behaviour Therapy

Cognitive and behavioural psychotherapies include a range of cognitive and behavioural therapy treatment approaches, from self-help material to structured individual psychotherapy (Grazebrook & Garland, 2005). REBT, developed by Albert Ellis, was the first of the cognitive behavioural psychotherapies. The second, Cognitive therapy (CT) was developed during the 1960s by Aaron Beck in conjunction with his research on depression (Beck, Rush, Shaw, & Emery, 1979; Corey, 2005; Froggatt, 2006). The term CBT was devised during the 1990s, by behavioural therapists initially to describe behaviour therapy with elements of cognitive therapies (Froggatt, 2006). Contemporary use of CBT represents the integration of the concepts and principles from cognitive and behavioural psychological models of human behavior and encompasses the theories of "normal and abnormal development, and theories of emotion and psychopathology" (Grazebrook & Garland, 2005).

Cognitive therapy is defined as "an active, directive, time-limited, structured approach used to treat a variety of psychiatric disorders (for example, depression, anxiety, phobias, pain problems, etc.)" (Beck et al., 1979, p. 3). CBT is based on the premise that an individual's affect and behaviour is determined by attitudes and assumptions based on previous experiences which may or may not be accurate (Beck et al., 1979; Kazantzis, 2006). Therapy is focused towards gaining an understanding of these core beliefs and assumptions and facilitating change. In contrast to psychoanalytic therapies the focus of CBT is on here-and-now practical problem solving (Beck et al., 1979). CBT is differentiated from other behavioural therapies by the overall scientific experimental focus during therapy and the collaborative approach to facilitating change (Beck et al., 1979).

The CBT treatment process involves; formulation of a person's dysfunctional beliefs about themselves, their experiences and perception of their future into a hypothesis; testing the validity of the hypothesis; experimentation with alternative options and

evaluating the outcomes of treatment (Beck et al., 1979; Kazantzis, 2006). CBT includes techniques that encourage people to; monitor negative automatic thoughts or cognitions, to recognise the link between cognitions and affect and behaviour; to examine the evidence for the automatic thought; to reframe cognitions with realistic alternatives; to identify dysfunctional beliefs which negatively influence experiences (Beck et al., 1979). The psycho-educational focus in treatment provides an opportunity to facilitate behaviour change for the client by learning and practicing new skills in their day to day life. Practical homework interventions include tasks such as keeping a diary and goal setting associated with treatment.

The benefits of CBT include the focusing of treatment on problems determined by the consumer, family/whanau, and that treatment involves a planned and structured approach which is based on a clearly defined theoretical model. However as with all forms of treatment, it is crucial to emphasise that the success of treatment is not solely reliant on the scientific method used but more importantly on the therapeutic alliance that allows for new knowledge and skills to be practiced in a progressive and supportive manner.

CBT is one of the most extensively researched cognitive therapies and in a recent meta-analysis conducted by Butler, Chapman, Forman and Beck (2006) identified as an evidence-based treatment approach for a wide range of psychiatric disorders. Most of the research that has evaluated the benefits and efficacy of CBT has been conducted in community mental health treatment or outpatient settings according to Munro, Baker, and Playle (2005) and not in inpatient areas. According to Merrick and Dattillio (2006) the use of cognitive behaviour therapy in New Zealand is also increasing in line with overseas trends. The authors describe a number of factors that have contributed to this. These include an expectation for readily available brief treatments that are cost effective; treatments where professionals can be held accountable to best practice guidelines or protocols; treatments that are empirically supported; treatments that include solution oriented interventions and finally treatments that address people’s cognitive, emotional and behavioural needs.

Rational Emotive Behaviour Therapy

REBT was developed by Albert Ellis, a psychoanalyst, during the 1950s as a reaction to perceived gaps in a psychoanalytic treatment approach (Ellis, 2004). REBT was originally termed Rational Therapy (RT), and with modifications renamed RET and finally REBT (Ellis, 2004). In contrast to medically oriented therapies, REBT was designed to be a comprehensive, form of behaviour therapy that included a range of cognitive, emotional and behavioural methods within a humanistic and educative treatment model (Bendersky Sacks, 2004; Ellis, 2004; Gilliland & James, 1998). Ellis argues that REBT provides a holistic formulation of cognitions, emotions and behaviours because the treatment approach recognises the interrelationships between thinking, feeling and behaving, and that these dimensions act in a circular cause and effect manner (Ellis, 2004). The theoretical, philosophical and psychotherapeutic dimensions that underpin REBT are considered unique to REBT in-spite of similarities to other cognitive therapies (Ellis, 2004; MacInnes, 2004).

In contrast to CBT, where the primary focus is on short-term, practical problem solving, REBT assists the client to identify strategies and behaviour change to effect long term change (Ellis, 2004; Froggatt, 2005; Gilliland & James, 1998). Unconditional self-acceptance is important (Ellis, 2004; Froggatt, 2005). The therapist role includes the use of action-oriented, didactic, directive and confrontational techniques (Ellis, 2004; Gilliland & James, 1998) in contrast to the therapist role in CBT treatment which is considered to be more collaborative (Gilliland & James, 1998).

A treatment approach based on REBT recognizes that an individual's belief system may consist of both rational and irrational beliefs, with the irrational beliefs the origin of emotional disturbance and thus the focus of therapy. The rational and irrational belief systems form the two central principles of REBT. The first principle of REBT is that emotional disturbance is evidenced by four main irrational beliefs and four corresponding rational beliefs that individuals have about themselves, others and the world. The unhealthy irrational psychological beliefs are "…demands, awfulising, low frustration tolerance, and self or other downing…" and in contrast psychological health is represented by four corresponding rational beliefs which are "…anti-awfulising, high frustration tolerance, and self/other acceptance" (Dryden as cited in MacInnes, 2004, p. 685). The second principle states that "… both rational and irrational beliefs consist of a primary and secondary

belief…". For example a self imposed statement relevant to a person with an eating disorder might be "I must control my eating" with the secondary belief represented by "not having control will be intolerable" and thus maintaining the function of the first belief. These beliefs influence the view people have of events and impact on the emotional and behavioural reactions to these events.

The influences of biological tendencies, environmental and social factors and their role in causing ongoing psychological disturbances are considered within the REBT therapeutic treatment approach. Although, the primary focus of REBT treatment is towards uncovering and addressing the irrational beliefs that inhibit recovery (Bendersky Sacks, 2004) a critique conducted by MacInnes (2004) concluded that current research evidence supporting the two central principles to REBT was weak and further research was warranted.

Peters (2007a) does not include REBT in a brief review of the most commonly used talking therapies in New Zealand. REBT is likely to be incorporated under the umbrella of CBT and not specifically identified. During my literature search for this study I was unable to find research in New Zealand pertaining to the use of REBT by nurses. An internet site providing information relevant to training in REBT in New Zealand is available.

Dialectical Behavioural Therapy

Dialectical behavioural therapy (DBT) developed by Dr Marsha Linehan is a cognitive behavioural therapy designed for people who present with a diagnosis of borderline personality disorder, particularly those with chronic self-injurious and suicidal behaviour (Lynch, Trost, Salsman, & Linehan, 2007; Swenson, Torrey, & Koerner, 2002). DBT incorporates principles from "…behavioral science, dialectical philosophy, and Zen practice" (Lynch et al., 2007, p. 183). The dialectical philosophy that underpins DBT is explained by understanding both, the function of self-injurious behaviour (temporary stress reduction) and the dysfunction, created by the negative consequences of self-injurious behaviour on health and interpersonal functioning. Concurrent measures that demonstrate acceptance and validation of the client, and the introduction of strategies that will reduce stress without harmful consequences describes the dialectical tension in DBT between acceptance and change (Salsman & Linehan, 2006). The Zen philosophy in DBT

encourages people to find the balance between an emotional perspective and a rational perspective in response to situations where previously a reactive emotional response resulted in self-injurious behaviour. Heightening objective awareness of surroundings and events, and using this to guide behaviour, describes a therapeutic strategy employed by both client and therapist using DBT (Salsman & Linehan, 2006).

Dr Linehan, proposed a biosocial theory as central to DBT (Lynch et al., 2007; Scheel, 2000). Biosocial theory is explained by the biological and social/environmental influences that underlie the formulation of a diagnosis of borderline personality disorders. According to the biosocial theory, environmental influences related early life experiences inhibit the development of skills to effectively manage often intense emotions. This frequently results in suicidal and self-injurious behaviours that become further complicated by reactive responses from others that reinforce or intensify the behaviours. Treatment is underpinned by this theory. For DBT to be effective, the therapist must demonstrate attitudes such as compassion, acceptance and validation of the client, whilst reinforcing strategies that introduce behaviour change (Lynch et al., 2007; Swenson et al., 2002).

DBT is formulated as an “open-ended” (Scheel, 2000, p. 70), structured programme with provision for a range of interventions including; individual therapy; psychoeducation to enhance interpersonal, cognitive and emotional-regulation skills; strategies to improve motivation; telephone consultation; and specific measures designed to reduce the risk of burnout for therapists when working with people with high risk behaviours (Lynch et al., 2007; Scheel, 2000). Attending to the risk of burnout for therapists is a key characteristic that differentiates DBT from other cognitive behavioral approaches

A hierarchy of goals provides a structure to treatment. The goals are addressed in order; suicidal or para-suicidal behaviours, followed by “therapy-interfering behaviours, quality of life interfering behaviours, and increase of behavioural skills” (Scheel, 2000, p. 70) with the objective of reducing emotional dysregulation and improve adaptive behaviours that will eventually ensure an improved quality of life for the individual. A clear focus of treatment is to ensure that new skills are incorporated into everyday life. Treatment may be provided in a variety of settings and is usually long term in contrast to CBT which has a more immediate short term focus. Scheel (2000) emphasises the need for specialised

training and supervision to ensure that DBT remains in keeping with the research base and the intended model of treatment.

Empirical support for DBT as an effective treatment approach for individuals with borderline personality disorder continues to be the subject of extensive research (eg: Binks et al., 2006; Bohus et al., 2000; Brassington & Krawitz, 2006; Linehan et al., 2006; Lynch et al., 2007; Scheel, 2000; Swenson et al., 2002) with most researchers agreeing that DBT has the most promising efficacy for individuals that experience borderline personality disorder. DBT is included in treatment guideline recommendations (Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Deliberate Self-Harm, 2004) and is referenced as an effective strategy for suicide prevention (Beautrais et al., 2007). Brassington and Krawitz (2006) cite a pilot study undertaken in New Zealand involving ten people with borderline personality disorder treated with DBT. The objective of the study was to determine the clinical applicability for the use of DBT in a standard New Zealand mental health service. The outcome of the study was positive and the authors claim that the routine provision of DBT in Australasian mental health service settings would be achievable. Brassington and Krawitz sought cultural advice for their study which adds value to the research by placing it firmly in the New Zealand context.

Motivational Interviewing

The concept of Motivational Interviewing (MI) was first developed by William Miller in response to his clinical experience in the treatment of alcoholism (Miller, 1983). MI is defined as a "directive, client-centred counselling style for eliciting behavior change by helping clients to explore and resolve ambivalence (Rollnick & Miller, 1995, p. 325). MI was not based on a specific theory but has encompassed principles from a range of psychotherapy models and behaviour change theories (Britt, Blampied, & Hudson, 2003; Chanut, Brown, & Dongier, 2005; Resnicow et al., 2002). The efficacy of motivational interviewing does not rely on the application of a set of techniques, but relies on the strength of the interpersonal relationship to assist people to work through ambivalence and achieve behaviour change (Rollnick & Miller, 1995). The principles that underpin the use of the MI include attributes required by both the therapist and client. For example;

- Expressing empathy and increasing self-esteem: This describes therapist attitudes that demonstrate understanding and use of affirming strategies to improve client self-esteem.
- Develop discrepancy: This requires the therapist to develop discrepancy between the client's current behaviour and their underlying core values.
- Self-efficacy: Describes therapist attitudes that support client self-determination, self-efficacy and optimism to achieve change. The motivation for change is elicited from the client – not imposed.
- Rolling with resistance: This describes a non-confrontational, non-argumentative approach to therapeutic interactions and an acknowledgement that client resistance to change fluctuates. The quality of the therapeutic relationship influences a positive outcome for clients. (Chanut et al., 2005; Miller, 1983; Rollnick & Miller, 1995)

Although initially focused exclusively to treatment for alcoholism (Miller, 1983) research supports the use of MI to substance abuse disorders, for example; cannabis and cocaine abuse, and other health problems including smoking cessation and eating disorders (Britt et al., 2003; Chanut et al., 2005; Resnicow et al., 2002). Additionally, Knight, McGowan, Dickens, & Bundy (2006) provide a systematic review to evaluate the effectiveness of MI in physical health care settings, in particular for the management of diabetes, asthma, hyperlipidemia, heart disease and hypertension. Britt, et al. (2003) recommend further research into the use and benefits of MI is warranted. For example, further research into the essential processes and key components of MI, and the effects of combining MI with CBT.

Systems Therapies

Family Therapy

Family therapy, also referred to as systemic family therapy, describes an integrative approach to therapy that draws on a range of systems, theories and techniques for working with individuals and families (Asen, 2002; Bitter & Corey, 2005; Gilliland & James, 1998; Thwaites, 1999). Systems theory, originally developed by L. Von Betalanffy forms the basis of family therapy. Systems theory assumes that all elements of a system are inter-related (Hanson, 1995). A human system may involve individuals, couples, families or larger groups of people. In human systems the beliefs, actions, behaviours and relationships

of individuals are both affected by, and affect others, thus a forming a complex interrelated feedback system (Thwaites, 1999).

In New Zealand the term family has been defined as:

> A set of relationships that is defined as family by the tangata whai ora. Family is not limited to relationships based on blood ties, and may include:
>
> - relatives of the tangata whai ora (including a spouse or partner)
> - a mixture of relatives, friends and others in a support network
> - only non-relatives of the tangata whai ora (Ministry of Health, 2000, p. vii).

Family therapy models include, structural family therapy, strategic family therapy, and a range of cognitive and behavioural therapeutic models that provide short-term interventions designed to promote change within the family system (Bitter & Corey, 2005; Thwaites, 1999). Current models of family therapy are mindful of culture, ethnicity, gender, the variation in construction of family groups and the wider societal context of families (Asen, 2002; Stratton, 2005; Thwaites, 1999).

Change in family therapy is not only about the individual, but about the individual and their relationships in context with the family system (Bitter & Corey, 2005). Therapy is focused towards challenging unhelpful behaviour patterns, interactions and dysfunctional communications within the family system (Asen, 2002; Thwaites, 1999). The *Blueprint for Mental Health Services in New Zealand* endorses a systemic therapeutic approach for working with families, for example, "…People with mental illness are not ill in isolation. Their families, extended whanau, and significant others, whatever they think about the illness, cannot escape being affected by it…" (Mental Health Commission, 1998, p. 9). Family therapy, usually in conjunction with other forms of treatment is used for children, adolescents and adults with mental illness (Stratton, 2005). Systemic therapy may also be a treatment of choice for people when there are individual or interpersonal difficulties that can be addressed by reviewing the way these difficulties affect relationships (Thwaites, 1999).

A recent review of the evidence base of systemic family therapy concluded;

1. That there is a substantial evidence for the efficacy and effectiveness of family therapy for a range of psychiatric disorders, including evidence to support the fact that family therapy is cost effective.
2. That there is little evidence to support views that one form of family therapy is more effective than another.
3. That treatment training and skill of health professionals affects treatment outcomes. Practitioners need to be well informed and able to draw on a variety of therapeutic approaches, according to the needs of each situation.
4. That the effectiveness of family therapy extends beyond the immediate needs that may be determined by an initial referral process. Research supports the proposition that family therapy improves treatment outcomes, medication compliance and families find access to family therapy interventions helpful (Stratton, 2005).

Research to support evidence for the efficacy of family therapy presents some interesting challenges. A randomised controlled trial (RCT) methodology conducted in a specialist setting is frequently the only method used and reported on that measures treatment efficacy and outcome. However, qualitative research conducted in a non specialist practice environment is also required to measure treatment efficacy and inform professional practice (MacKenzie, 2006; Stratton, 2005, 2007). MacKenzie, although acknowledging the place of rigorous, scientifically structured research, encourages family therapists to conduct research in an integrated manner, planned from a philosophical perspective and to be more inclusive of the unique circumstances of individuals, their families and their stories.

The Stratton (2005) report identified that the number of health professionals trained in family therapy in the United Kingdom was inadequate and that the National Health Service (NHS) has acknowledged that a coordinated cohesive approach to increasing the numbers of health professionals trained in family therapy was required to meet the needs for consumers and their families. The situation in New Zealand is similar (Mental Health Commission, 1998; Ministry of Health, 2000, 2005b, 2006b).

Child and Adolescent Psychotherapy

Weisz, Doss, and Hawley (2005) define psychotherapy as "…an array of non medical interventions designed to alleviate non-normative[1] psychological distress, reduce maladaptive behaviour, or increase deficient adaptive behavior through counseling, interaction, a training program, or a predetermined treatment plan" (p. 338). The practice of psychotherapy involves listening, questioning and the discussion of issues identified by individuals to be important. Weisz et al. suggest that Socrates first developed the method for psychotherapy and later Sigmund Freud (1856-1939) developed the theory and practice of psychoanalysis. Other prominent theorists also contributed to the development of psychoanalysis, in particular Anna Freud, (1895-1982) whose work focused on children. The theoretical origins of a psychoanalytical approach for young children, in particular those under five years of age, was also influenced by two major theorists, John Bowlby (1907-1990) and Donald Winnicott (1896-1971) (Barrows, 1999). Bowlby was a British psychoanalyst notable for his work in child development and attachment theory. Donald Winnicott was influential in work pertaining to Object Relations Theory. Cook and Tedeschi (2007) suggest that child psychotherapy in clinical practice may be provided from a psychodynamic or a psychoanalytic perspective, and state that in effect " child psychotherapy methods are typically more integrative, including work with other family members and commonly involving a combination of systemic, behavioural, and dynamic approaches simultaneously" (p. 139).

The most common problems for children and adolescents that require interventions are: Externalizing disorders such as oppositional, hyperactive or aggressive behaviours; Internalizing disorders such as anxiety and depression; Substance abuse disorders; Learning and mental disabilities including the range of difficulties from impaired academic functioning to mental retardation; Severe and pervasive pathology which may be early indications of a mental illness such as schizophrenia (Kazdin, 2003). Children and adolescents rarely self refer for treatment.

[1] Non-normative means not based on a norm.

Children and adolescents with obvious and disruptive behaviours are frequently referred by parents and teachers and it is of concern that those with internalising or emotional problems may be overlooked (Kazdin, 2003; Kazdin & Weisz, 1998). Additionally, Kazdin and Weisz also emphasise that children are in a dependant, vulnerable position where the influences of "parental mental health and marital and family functioning, level of stress and life events, living circumstances, culture and ethnicity, and socioeconomic disadvantages.." (p. 20) also impact on treatment and recovery.

Therapeutic interventions for children and adolescents may include CBT, Interpersonal Psychotherapy, Parent/Family Psychoeducation, Parent Management Training Multisystemic Therapy and psychopharmacology (Kazdin, 2003). The list provided by Kazdin is not exhaustive and serves to highlight that an eclectic mix of psychotherapeutic interventions based on either a psychoanalytical or psychodynamic theoretical orientation may be used in child and adolescent psychotherapy. Very young children might be engaged in forms of psychotherapy that are specifically adapted to their needs. Hoagwood et al. (2001) identifies the challenge is to clearly define the term evidence based practice in child and adolescent psychotherapy in particular because "…children undergo more rapid physiological, neuronal, and psychological changes over a briefer period than adults" (p. 1181). For evidence based practice to be meaningful it requires the practitioner to consider:

1. The context from an individual perspective in particular the age of the individual.
2. The family perspective.
3. The wider influences of environmental and sociopolitical factors.
4. Where the treatment may be provided whether in a mental health service (inpatient or community), school, primary health or a private health care setting.

Key areas for future research in child and adolescent psychotherapy must include appropriate identification of sample selection and examining the effectiveness of treatment in context with the clinical practice setting (Hoagwood et al., 2001). This view is supported by others (eg: Kazdin, 2003; Weisz et al., 2005).

Most research relevant to child and adolescent psychotherapy refers to children and young people from age four to eighteen. Kazdin (2003) refers to national and international studies that address the prevalence of disorders for children and young people, mostly

undertaken in the United States of America, United Kingdom, Canada and European countries including The Netherlands. There are few explicit and easily identifiable references in research literature to therapeutic interventions for infants or the pre-verbal children. In addition, most research relevant to child and adolescent psychotherapy seems to be undertaken by psychologists and psychiatrists. There is a paucity of nursing research.

Interactive Drawing Therapy

Interactive drawing therapy (IDT) developed in New Zealand during the early 1990s by Withers (1990) provides for therapeutic drawing and writing techniques for individuals to explore issues. Although Withers suggests that IDT has been endorsed by health professionals as an effective therapeutic intervention and that training in IDT is popular there is no empirical research available in New Zealand to substantiate this.

Chapter Summary

The psychotherapies that contribute to the over arching term 'talking therapies' have been presented in this chapter grouped under three main headings. These were; humanistic-experiential-existential therapies, cognitive behavioural-action oriented therapies and systems therapies. Child and Family Psychotherapy was also discussed. The headings used for this chapter provided a systematic framework to discuss the theoretical orientation and practical application of the talking therapies relevant to this study in which I explore nurses' knowledge of talking therapies in clinical practice. Whilst the talking therapies have been addressed individually in this chapter, in practice, most therapists usually incorporate a number of these therapies in an eclectic manner. An eclectic approach is necessary to enable the provision of treatment interventions in a manner that accounts for complex human behaviours across diverse populations (Corey, 2005). Although an eclectic approach may be common, an eclectic approach must be informed by theoretical and practical knowledge gained through training. The use of talking therapies in clinical practice for nurses is reliant on appropriate training. Chapter Three reviews literature pertaining to nurses' views on their talking therapy skills and training.

CHAPTER THREE: MENTAL HEALTH NURSES TALKING THERAPY TRAINING AND SKILLS IN PRACTICE

Introduction

The purpose of this chapter is to review research literature pertaining to nurses' views on their talking therapy skills and training. Although talking therapy skills gained through experiential and informal self-directed learning contribute to nursing practice, the scope of this review is limited to knowledge gained from formal training. Knowledge is defined as "acquaintance with facts, truths, or principles, as from study or investigation; general erudition [scholarship]" (Dictionary.com Unabridged, 2006). This review seeks to identify from research literature, evidence of nurses reporting on their knowledge and use of talking therapy skills gained through training.

In New Zealand it has been identified that increased training in talking therapies for all health professionals, including nurses, is required (Peters, 2007a, 2007b). Furthermore, whilst interest groups have progressed talking therapy training, there has not been a nationally coordinated approach to the planning and development of initiatives to meet the training needs of clinicians who work in a range of mental health treatment settings. Although talking therapy skills are implicit in the *Standards of Practice for Mental Health Nursing in New Zealand* (Te Ao Maramatanga: New Zealand College of Mental Health Nurses Inc, 2004) it has been identified that many nurses in current practice have not been able to access training (Ministry of Health, 2006a). In contrast, anecdotally, some nurses have extensive training. Therefore from a nursing perspective, a review of literature to identify what it is that nurses already know and value about their talking therapy skills and training was used to shape the methodology of this study.

An international perspective of nurses and their talking therapy skills and training adds important context to mental health nursing in New Zealand. In the DHB central to this study there are a number of nurses from different countries and in particular the United Kingdom. Although it is important to understand the knowledge that underlies nursing practice in the New Zealand context (O' Brien, 1999), New Zealand is not isolated from the influences of international research and the skills and practices brought to New Zealand by

nurses from other countries. Accordingly, this literature review includes research from a national and global perspective. The inclusion and exclusion criteria that determined which studies would be discussed in this literature review are outlined below.

Inclusion and Exclusion Criteria

A series of searches were carried out across the PsychINFO, CINAHL, ProQuest, Wiley Interscience, Science Direct and Google Scholar databases. The Google Scholar search engine was utilised frequently as it enabled comprehensive access across a wider range of materials than a single database. The key words most commonly used included but were not limited to: nurs*, mental-health, psychiatric, talking therapy and/or psychological-intervention, skills, knowledge, training, evaluation, research and the relevant therapeutic model, for example; cognitive behaviour [behavior] therapy. Reference lists for articles were consulted and a range of publications were also searched.

Overall, the search process identified a small body of research that reported on nurses' knowledge views (eg: Calvert & Palmer, 2003; Crowe & Luty, 2005; Gournay, Denford, Parr, & Newell, 2000). Literature that reported on nurses' training in talking therapies was strongly aligned with the countries where training was provided. Therefore this review has been structured accordingly. The review commences with research from New Zealand followed by a discussion of the international research relevant to this study. Exclusion criteria excluded studies that did not include nurses, and research that evaluated the efficacy of talking therapy models for the treatment of mental illness. This chapter will conclude with a formulation of the relevant questions that underpinned the data collection for this study.

New Zealand

Nurses in New Zealand have accessed training in talking therapies, but few nurses have reported on their knowledge or views of talking therapy training and skills in research literature. For example, only one nurse participated in a pilot study conducted by Brassington and Krawitz (2006) devised to ascertain the clinical effectiveness, utility and feasibility of implementing Dialectical Behaviour Therapy (DBT) into a standard New Zealand mental health service. Reporting from a nursing perspective on the DBT training and subsequent application of skills in practice would have been advantageous. One nurse

and nine clinicians from a range of disciplines attended two weeks of intensive training and six months of self-directed learning that incorporated the theoretical and practical elements of the DBT model. Outcome data pertaining to treatment efficacy were collated from the six month study, during which the trainees utilised their skills to work with consumers with a diagnosis of borderline personality disorder. The authors report that the pilot study was successful and recommended further research to compare DBT to other treatments for borderline personality disorder. Whilst the authors proposed to evaluate whether the clinician training and skills would be sufficient to implement DBT into a New Zealand mental health service setting, the relevant data were not presented. Brassington and Krawitz (2006) claimed clinician effectiveness in their study was congruent with a study undertaken in the United States of America by Hawkins and Sinha (1998). Hawkins and Sinha following a state-wide training programme in DBT for 109 clinicians from diverse professional backgrounds examined their knowledge to ascertain the influence of educational background and disciplinary affiliation on performance criteria. Trainees were required to complete a questionnaire and a formal examination. Ongoing training was also offered and some clinicians were re-examined to identify if their knowledge had continued to expand in conjunction with specific aspects of their training. Conclusions drawn were that the clinicians were able to demonstrate knowledge of the theoretical and practical aspects of DBT. Appropriate training not professional discipline accounted for the variance in knowledge. Hawkins and Sinha did not identify a nursing perspective from their study.

Skills in Cognitive Therapy (Calvert & Palmer, 2003) and Interpersonal Therapy (Crowe & Luty, 2005) are important psychotherapeutic intervention models relevant to mental health nursing practice. Calvert and Palmer (2003) describe the application of the Cognitive Therapy model to crisis assessment in a community mental health treatment setting. The authors use a clinical example to describe the efficacy of the Cognitive Therapy model used by nurses during assessment and brief interventions for the treatment of depression. They recommended that inexperienced nurses need to be able to access relevant training to develop evidence-based talking therapy skills for practice. Crowe and Luty (2005) promote the advantages of skills in Interpersonal Therapy. The authors use a case study to describe the application of Interpersonal Therapy to the treatment of depression. Mental health nurses need training in psychotherapeutic intervention models

that have proven efficacy to enable the provision of evidence based nursing care (Crowe & Luty, 2005). Crowe and Luty state that mental health services have responsibility to support nurses to access training, implement and maintain their skills in nursing practice. Currently the responsibility for advancement of psychotherapeutic skills falls on individual nurses. The authors therefore argue that organisational change is required. The recommendations for change include, a coordinated approach to talking therapy training for all nurses, support for nurses using evidenced-based talking therapy skills in practice, and valuing the role of mental health nurses with talking therapy training and their contribution towards the provision of quality services for consumers (Crowe & Luty, 2005). These recommendations are aligned with proposed New Zealand workforce development initiatives for mental health clinicians, including nurses (Peters, 2007a, 2007b).

A national workforce development initiative in New Zealand used a train-the-trainer model to provide training for all health professionals, including nurses, in Family Therapy skills (Steinberg & Whiteside, 2005). The training was designed to facilitate change at a clinical practice and organisational level to improve the inclusion of family/whanau in treatment planning. Although Steinberg and Whiteside provide a report on successful training outcomes from a regional and national perspective, individual clinicians, nurses in particular, have not reported their views of the training programme in research literature. The lack of nursing research in this area leaves the benefits of Family Therapy training and identification of skill transfer into mental health nursing practice open to conjecture.

Anecdotally, nurses in New Zealand have attended a range of talking therapy training opportunities from a variety of training and education providers but their attendance and views on training and talking therapy skills in practice are not widely disseminated in nursing literature. Research undertaken in Australia, Ireland and the United Kingdom that reports on nurses' knowledge and views of talking therapy training and skills adds depth to this review and will be considered next.

Australia

Five Australian studies have contributed to a body of research literature on nurses' talking therapy training and skills. Hafner, Crago, Christensen, Lia, and Scarborough (1996) aimed to introduce and evaluate a cognitive behaviour therapy (CBT) training programme for four

case managers who took part in a six month, part time course to develop basic skills and knowledge in CBT. The training programme conducted in South Australia included, self-directed learning, group and individual supervision and weekly meetings to discuss relevant practical and theoretical issues. At the conclusion of training, participants reported that they valued their skills and knowledge, and that the training enabled the incorporation of basic CBT strategies into clinical practice. Hafner et al.(1996) recommend increasing the availability of training in CBT for nurses. Similarly, four nurses from an inpatient unit at the Flinders Medical Centre, South Australia attended six months of training in behavioural psychotherapy (Allen, Tolchard, & Battersby, 2000) as a pilot training programme. During the course the trainees actively incorporated the theoretical and practical principles from behavioural psychotherapy into assessment, treatment and clinical case management with clients in the inpatient unit. Oakes, Tolchard, Thomas, and Battersby (2002) use two case vignettes and a narrative report from one trainee's perspective to present their review of the training provided by Allen et al. (2000). The trainee reported that, supervision of trainees in subsequent courses, presenting conference papers, involvement in the development of an outpatient and group treatment programme for gambling contributed to personal and professional development.

Donoghue et al. (2004) described a programme to enhance access to appropriate treatment interventions for depression and anxiety in a rural community in Victoria by providing training for case managers, mostly nurses, in focused psychological strategies. The term psychological strategies means, strategies in CBT and Interpersonal Therapy. Specific objectives for the training programme included; to enable staff to develop skills in evidence-based treatments; to generate and maintain a culture of personal and professional development, and peer review. Ten training modules included theoretical and practical elements with resources and handouts given for integration into clinical practice. Follow-up group sessions, individual and telephone supervision was provided. The pre and post quantitative evaluations measured knowledge, attitudes, assessment of current practice and job satisfaction. Focus groups were used to measure qualitative information. The authors found that the programme led to improved knowledge and attitudes towards the use of psychological therapies in practice but that the translation of theoretical knowledge into practice required further attention**.** The need for ongoing training and supervision to support

continued skill development was identified. The authors recommended that attention should be paid to developing training options with a staged approach, from basic strategies to the provision of more complex psychological skills for use with complex clients. Further research was recommended with the focus on the application of CBT and Interpersonal Therapy to complex mental illness.

Ninety-four staff from a regional mental health service in New South Wales attended a two day introductory experiential workshop in DBT skills (Hazelton, Rossiter, & Milner, 2006). Trainees included people from all disciplines, of which the majority were nurses. Data were collected by pre and post training surveys and focus groups with the post training outcome indications demonstrating improved knowledge and skills. Twenty staff, mostly nurses, continued with advanced training. The authors identified the positive benefits of basic training whilst acknowledging the enormous challenge of providing education for such a large group. The advantages for using evidence-based research to address service-wide issues managing a complex client group were identified. Training nurses with evidence-based therapeutic and management strategies to work with clients with complex needs was considered a significant cost-effective enhancement for nursing practice and beneficial for the mental health service as a whole.

Common themes from these five Australian studies include that nurses reported brief training in talking therapies to be effective for learning basic therapeutic strategies for use in clinical practice. Although Donoghue et al. (2004) concur with this perspective, the authors questioned whether brief training addressed the level of skill required for working with clients with complex mental health needs. My study, in which participants described extensive training in specific talking therapy models, adds important context to the observation made by Donoghue et al.(2004). Provision for supervision, and processes to assist with the integration of new knowledge and skills from talking therapies training into clinical practice were addressed. Allen et al. (2000) considered that the translation of theoretical knowledge from talking therapy training into clinical practice was successful, however, Donoghue et al. (2004) were unable to confirm this in their study. Talking therapy training for nurses was considered cost effective (Hazelton et al., 2006) and was an important contribution to continuing professional development (Oakes et al., 2002).

Ireland

Talking therapy training and skills contribute to clinical practice and professional development (Neela, Scott, Treacy, & Hyde, 2007; Ryan, Cullinan, & Quayle, 2005) for mental health nurses in Ireland. Ryan et al. (2005) conducted a cross sectional study, sending out 257 nurses a postal survey that evaluated training provided from 1986-1999 in behavioral and cognitive techniques. Training was delivered over one calendar year and met specific requirements for theoretical content and the supervision of participants. A sample of 137 respondents provided their views on the benefits of training and the subsequent impact of training on their clinical practice. The first section of questionnaire sought information relevant to the respondent's skills and knowledge of behaviour therapy prior to training. The remaining three sections of the questionnaire sought to clarify respondents experience during the course (course structure and content, teaching and supervision); their current clinical position (whether behaviour therapy was the main focus of clinical work; job changes and professional development opportunities); and respondents perception of their current use of behaviour therapy skills in practice. Although the results indicated a high level of satisfaction with the course structure, content, teaching and quality of clinical supervision offered throughout the training programme the findings signaled a deficit in terms of the usage of skills in clinical practice. Ryan et al. (2005) identified that over a thirteen year period, only 17% of respondents indicated that behaviour therapy was still the focus of their current work. My study contrasts with these findings as all the participants have continued to use their talking therapy skills from training in clinical practice. This is discussed in Chapters Five and Six.

Ryan et al. (2005) acknowledged that respondents also recorded that their specific skills in behaviour therapy were valuable, even if they were no longer involved in dedicated behaviour therapy work, and that the skills were valued at the managerial level. The contribution to career changes and current job satisfaction were noted as participants believed that their participation in training had influenced their career direction and professional development opportunities. The results from the Ryan et al. study are consistent with other studies from Australia (eg: Oakes et al., 2002) and the United Kingdom (eg: Gournay, Denford, Parr, & Newell, 2000) that also found talking therapy training positively influenced clinical practice and professional development opportunities.

In a recent study, Neela, Scott, Treacy, and Hyde (2007) report on nurses valuing their skills and knowledge of psychological concepts and techniques in clinical practice. A small sample of 59 nurses participated in focus groups to explore their ideas about how nurses conceptualise nursing. The nurses were asked to consider:

- "How do nurses conceptualize nursing?
- What problems do clients present with?
- How do nurses perceive their contribution to care?
- How do nurses organize their care?" (p. 502).

Some of the questions posed bear no immediate relevance to my research project, however what this paper identifies, is that nurses valued their knowledge of psychological concepts and skills and how their knowledge contributed to their assessment skills and clinical practice. Neela et al. recommended that further investigation into the psychological work of nurses was warranted.

The United Kingdom

Nurses' training in talking therapy models and the use of their skills in clinical practice has been researched extensively in the United Kingdom. In particular, research pertaining to CBT and Psychosocial Interventions. Brooker and Brabban (2004) undertook a comprehensive search of the literature and included 37 studies in their review that aimed to determine what is known about Psychosocial Intervention Training to inform future training provision. Only some of these studies report on nurses' views of their Psychosocial Intervention training and skills (eg: Brooker & Butterworth, 1993; Brooker, Saul, Robinson, King, & Dudley, 2003; Ewers, Bradshaw, McGovern, & Ewers, 2001) as training has mostly been delivered to all professional disciplines simultaneously.

Comprehensive training for multidisciplinary health professionals in Psychosocial Interventions since 1992, particularly for people with psychosis, represents the commitment to implementation of national and local level strategic directions for mental health services (Brooker, 2001; Brooker & Brabban, 2004). Psychosocial Interventions include; case management; psychological management of symptoms; CBT, Family Therapy Interventions, psychopharmacology and, formal assessment and outcome measures (Brooker, 2001; Brooker & Brabban, 2004). Psychosocial Intervention training (eg:

Bradshaw, Butterworth, & Mairs, 2007; Ewers et al., 2001; McCann & Bowers, 2005) includes skill acquisition across the therapeutic interventions nominated above. In-depth training may also be focused on one or more specific Talking Therapy models, for example, Family Therapy Interventions (eg: Bailey, Burbach, & Lea, 2003; Fadden, 1997) or associated with treatment intervention studies. For example, nurses attended ten days of intensive CBT training to subsequently evaluate the efficacy of CBT for the treatment of schizophrenia (Turkington, Kingdon, & Turner, 2002). More recently, Curran and Brooker (2007) conducted a systematic review that sought to identify randomised control trials (RCTs) reporting on nurses contribution to the implementation and evaluation of effective delivery of psychological interventions in the United Kingdom. Fifty-two RCTs were included in the review. Curran and Brooker concluded that mental health nurses in a variety of treatment settings were involved in the effective delivery of psychological interventions and that CBT was the predominant intervention.

Ashworth, Williams and Blackburn (1999) evaluated training in Cognitive Therapy provided by the Newcastle Cognitive Therapy Centre. A year after the completion of training a postal survey was sent to gather descriptive data from 65 trainees who had undertaken the year-long training programme. Of the 52 questionnaires returned, 14 were from nurses. The researchers considered trainees views about the course, the provision for supervision both during and at the completion of training, the impact of training on the use of Cognitive Therapy in practice, and the contribution of training to ongoing professional development. The results demonstrated that respondents valued the quality of supervision and teaching highly within the course content and that the course had contributed to ongoing knowledge and skills development for use in clinical practice. The authors hypothesised that professional development as an outcome from training tended to move trainees into roles that potentially isolated them from using cognitive therapy interventions clinically. Recommendations for further study into skill transfer and the way CBT informs clinical practice were made.

The impact of training on clinical practice and professional development was viewed positively by Gournay, Denford, Parr, and Newell (2000). Gournay et al. report on twenty-five years of training for British nurses at the Maudsley Hospital, London in behavioural psychotherapy. The course provided by The English National Board Course

No.650-Diploma in Behavioural Cognitive Therapy has met strict delivery and evaluation criteria for a number of years. The most recent survey, undertaken during 1999, was sent out to 237 nurses. Information from the study examined clinical practice, organisational context, and career and professional development issues with a view to informing further workforce development directions. The outcome of the 1999 study included confirmation that nurses continued to maintain a commitment to using CBT in clinical practice but also applied their knowledge of CBT in areas such as supervision of other staff, teaching, research, management and policy development. Recommendations from this study included expanding the availability of training to other disciplines and that the course content needed to make provision for skills in brief interventions particularly for community mental health nurses.

The merits of the different approaches used to evaluate talking therapy training have caused debate (eg: Milne, Keegan, Westerman, & Dudley, 2000; Myles & Milne, 2004). Milne et al. (2000) reviewed evaluation methods utilised by a number of studies delivering training in psychological interventions worldwide and commented that few studies adhered to a methodologically sound process to effectively evaluate training. The authors argue that reliance on participant self-report is inadequate. Nevertheless, research design is based on the aim of the study with a range of design options providing a wealth of information on the research topic (Brown, 1999; Flick, 2006). Self-report data adds a useful perspective to research that has been incorporated into this review (eg: Ashworth et al., 1999; Ryan et al., 2005) and Gournay et al. (2000) have rigorously evaluated training in Behavioural Therapy for nurses for 25 years using self-report data. Their study has been described previously. Self-report data has been collected for this study as the most appropriate method to inform the research question, fully described in Chapter Four.

Milne et al. (2000) present the outcome of their study that involved forty-five health professionals, of which (62%) were nurses attending one of three Psychosocial Intervention brief in-service training programmes. The authors describe a longitudinal, quasi-experimental design for the evaluation process that included a baseline assessment of knowledge, a post training assessment and a final assessment after three months. In addition to self-report data, formal evaluation tools were used. Milne et al., suggest that the formal evaluation tools used in their study provided an accurate measure of training

effectiveness. Participants reported a better understanding of, and skill in, the Psychosocial Intervention therapeutic treatment approach. The relevant factors that contributed to the transfer of skills from training into practice included; peer support, supervision and the teaching and learning strategies incorporated into the training programme. Milne et al., acknowledge aspects of methodological weaknesses in their study but conclude that the brief training in empirically supported Psychosocial Interventions was effective. The authors also refer to aspects of their own and other studies about the benefits of training large numbers of staff inferring that training provision in this manner needs to be supported by organisational processes.

Myles and Milne (2004) argued for the use of formal evaluation tools to confirm the efficacy of a brief training programme in CBT. Myles and Milne evaluated a sample of 90 health professionals including 76 nurses after the completion of 48 hours of training in CBT delivered over 12 weeks at the University of Northumbria at Newcastle. Twelve participants did not complete the course and the final evaluations were only completed by 55 respondents. The Myles and Milne study utilised formal evaluation tools to measure the impact of training. These included measures of learner satisfaction, firstly a questionnaire that evaluated knowledge of CBT theory, principles and treatment strategies, and secondly a Video Assessment Task (VAT) (Milne as cited in Myles & Milne, 2004, p. 181). At three months follow-up an impact evaluation which involved two measures was also completed. A ‘Barriers to Change Questionnaire (BARCQ)’ (Corrigan, Karatanini, & Pramanan as cited in Myles & Milne, 2004, p. 182) was administered as well as a ‘Generalization Questionnaire’ (Milne, Gorenski et al. as cited in Myles & Milne, 2004, p. 182). These measures evaluated the extent to which the knowledge and skills from training transferred to the clinical environment. Of note from this study, the Barriers to Change Questionnaire identified that the most frequently occurring barrier was considered to be “institutional constraints” (Myles & Milne, 2004, p. 183). The authors identified relevant limitations to the study and drew an overall conclusion that brief training in CBT could be effective. However, the results were in fact inconclusive. Although the training course was rigorously evaluated, a rationale for the number of participants not completing the course, or the number of respondents not completing evaluations was not provided.

Multiple choice and scenario based questions were utilised to evaluate training that positively influenced nurses' attitudes towards managing a complex client group in a small scale study conducted by Ewers et al. (2001). The authors sought to evaluate knowledge, attitudes and the level of burnout for forensic nurses following six months of Psychosocial Intervention training. The quasi-experimental pre-test post-test design initially involved 33 nurses who all completed baseline measures of knowledge, attitudes and burnout. From this group, 10 nurses were randomly allocated to receive training and 10 to a control group. The knowledge, attitudes and burnout measures were repeated at the conclusion of the training for all 20 nurses. Training included theoretical and practical components delivered over 20 days in the clinical setting. The course covered case management; psychological management of symptoms; CBT, and formal client outcome assessment measures. Course requirements included the completion of a case study that demonstrated the application and use of Psychosocial Interventions skills with a client, practical assessments and attendance to teaching sessions. The researchers found that training improved nurses' knowledge of Psychosocial Interventions to manage complex clients with severe and enduring mental illness. Levels of burnout were also reduced. Outcomes from the Ewers et al. (2001) study include that nurses were better equipped to recognise behavioural symptoms as resulting from the negative symptoms of schizophrenia in clients. Therefore they responded with appropriate evidence-based interventions. The authors recommended increasing the availability of short courses to meet the specific needs of staff groups.

Similar to Ewers et al. (2001), tailoring the design of education and training programmes specifically to meet the needs of ward-based clinical staff was vitally important according to Bee, Richards et al. (2005). The researchers aimed to illicit the views of 61 nurses from four acute inpatient units following completion of an 18-day 'Addressing Acute Concerns' training programme on the course delivery, content and personal impact of the training. The training programme was specifically developed to provide training for the staff team in the acute unit, in contrast to individual health professionals attending specialist courses delivered through universities. A mixture of qualified and unqualified nursing staff attended the course that covered assessment and engagement skills, care planning, psychopharmacology, risk assessment, observation and de-escalation practices. Programme modules utilised didactic teaching methods, large and

small group work and presentations from external speakers. Skills practice and role plays were used to assist with transfer of theoretical and practical knowledge into the clinical setting. Data were collected from the use of multiple focus groups and a questionnaire.

From the focus groups the researchers found that the unqualified nursing staff were more prepared to acknowledge positive learning outcomes and a change in attitudes, skills and development. Qualified nursing staff were less satisfied with the course content and notably more pessimistic about implementing new knowledge in to their clinical practice. Despite this, in the questionnaire qualified nurses reported increased knowledge pertaining to all elements of the course content. This finding contrasted with the data from the focus groups. These results had implications for planning future training and, from an organisational perspective, provided a useful commentary on the effectiveness of professional and clinical development programmes. Recommendations included that, further training for qualified and unqualified staff should be progressed separately with the course content appropriate to the level of prior training and further training needed to occur in conjunction with organisational changes to maximize the implementation of skills into practice.

In contrast to the Bee, Richards et al. (2005) study, McCann and Bowers (2005) reported positively on training qualified and unqualified nursing staff simultaneously in Psychosocial Interventions on site in seven acute psychiatric inpatient wards in a staged approach. The staged approach meant that the training was targeted at a basic level for unqualified staff, at a more technical level for qualified staff with further training for specialist practice development. McCann and Bowers also acknowledged that this approach was not always adhered to, however on evaluation, most staff reported a greater appreciation of each others roles and found the training beneficial. McCann and Bowers reported on some key outcomes which they consider to be essential to support successful practice development in an acute inpatient unit. These outcomes were effective leadership and management structures and sufficient, stable staffing on the ward. McCann and Bowers considered that these outcomes had implications for the enabling an effective learning process and the implementation of knowledge into the practice environment. The authors argue for the benefits of on-site training for all staff in contrast to individual staff attending longer term academic courses at external academic institutions. In addition, McCann and

Bowers comment that further consideration needs to be given to achieving Psychosocial Intervention skills in undergraduate training. This perspective is similar to that provided by Prebble (2001) in response to a review of undergraduate nursing training in New Zealand. An important aspect of the studies in the United Kingdom conducted by Bee, Richards et al. (2005) and McCann and Bowers (2005) was the focus on nurses assessment of skill acquisition and their perception of knowledge transfer which, from their perspective, also included barriers to this process.

Nurses views on their Psychosocial Intervention training and the contribution of training to clinical roles and professional development are important. The identification of potential barriers from an individual and organisational perspective provides pertinent information to inform planning and development of training programmes. Brooker et al. (2003) conducted a two stage follow-up study that evaluated eight cohorts of trainees who attended Psychosocial Interventions training provided by the Sheffield and Maudsley training centres between 1995 and 1999. Stage one aimed to investigate the impact of training on respondent's current role description and career development using a postal questionnaire sent to 141 trainees. Of the 116 respondents, psychiatric nurses represented 86% of the sample. A sub-group of respondents identified from stage one were identified for stage two of the study. Service managers were identified from this group and surveyed for the same information. The second stage was designed to elicit data pertaining to both the course structure and the implementation of skills gained from training into clinical practice. The authors concluded that the nurses who had completed training utilised the skills achieved through training and indicated a commitment to the continued utilisation and development of Psychosocial Interventions in clinical practice.

The Brooker et al. (2003) study also specifically sought to investigate the long term effects of training on practice, service development and in particular sought to identify and prioritise the barriers that inhibit the effective implementation of Psychosocial Intervention skills in routine clinical settings. The possible barriers included the following; organisational readiness; supportive managerial structures; resourcing issues; and the need for a supportive team environment. Managers were asked to describe ways to overcome these barriers. The three most common solutions were; a reduction in size of case-loads for clinicians; increased training opportunities for clinicians and strategic planning for effective

utilisation of clinicians with skills and training in Psychosocial Interventions. Brooker et al. recommended development of a tool to measure trainee aptitude and from an organisational perspective the means to audit the benefits of implementing Psychosocial Intervention training.

Organisational processes that increase the chances of positive outcomes from training include the provision of clinical supervision (Bradshaw et al., 2007). Bradshaw et al. conducted an experimental study that aimed to evaluate the effectiveness of workplace clinical supervision of a group of 12 mental health nurses who were involved in a one year part-time post registration training programme in Psychosocial Interventions. Eleven students from the previous year who had not had the additional workplace supervision formed the control group. The course content covered all aspects of Psychosocial Intervention training including the provision of small group supervision. In addition, the experimental group attended structured workplace supervision delivered by one supervisor for small groups of up to three students. Supervision included presentation of clinical case studies and an additional assessment included submission of audiotape recordings of clinical sessions to the supervisor. Data were collected from the students on the first and last day of training using multiple-choice question examination papers. Each trainee was required to recruit six service users with a diagnosis of schizophrenia with whom they could work for the duration of their training. Service user data were collected using formal assessment tools and a semi-structured interview at the beginning and end of the training programme. Comparison between the trainee experimental and control groups showed that the experimental group demonstrated greater knowledge about psychological interventions. Service user outcomes also showed improvement across a range of measures. Bradshaw et al. found that workplace supervision during training enhanced knowledge gains and that this was also reflected in clinical practice. Recommendations for further research included comparing university and workplace supervision. In addition, for future studies the recruitment of trainees for the experimental and control groups should occur simultaneously instead of the retrospective design that was used for the current study.

Family Therapy Interventions have been widely researched in the United Kingdom with positive outcomes identified from training. Brooker and Butterworth (1993) sought to evaluate the impact of training in Psychosocial Interventions, in particular Behavioural

Family Interventions on the role of community psychiatric nurses working with families caring for a relative with schizophrenia living at home. Ten nurses recruited from a national advertisement campaign participated in a 17 day course delivered in stages over a period of six months. The course content included theoretical aspects and clinical skills in Behavioural Family Interventions. Workshop training included didactic teaching methods and clinical skills development through the use of role-plays and video feedback sessions. Ongoing training included feedback on audiotapes from samples of Behavioural Family Interventions in clinical sessions. Data collection occurred during the training as the students submitted audiotapes that were rated by the teaching team with formal measures of competency. Four formal questionnaires were used to measure changes in the way which trainees organised aspects of their work, including their clinical skills; their clinical role and management of caseload numbers; knowledge of and utilisation of interventions for working with clients with a diagnosis of schizophrenia. The participants were also requested to provide information pertaining to the overall benefits of training and the effect on interdisciplinary relationships. The authors argue that the training was cost effective. The nurses' reported that psychosocial interventions skills were readily acquired and that the course structure allowed for effective learning opportunities and changed practice.

Although clinicians can be trained effectively in Family Therapy Intervention skills, the implementation of skills into practice has proved challenging (eg: Bailey, Burbach, & Lea, 2003; Fadden, 1997, 2006; Milne, Keegan, Westerman, & Dudley, 2000). Time constraints, clinical areas and wider organisational issues affect the ability of clinicians to fully integrate their skills into routine clinical practice. Fadden (1997) describes the results of a survey following training in Behavioural Family Therapy in Aylesbury for 86 health professionals of which 19 were nurses. The training delivered over a total of 39 hours had been provided in four phases which included orientation to the course, a specific three day training course that focused on skill acquisition and incorporated learning strategies such as role plays, videotaped examples of Behavioural Therapy in practice and interactive learning activities. Course participants' managers were also included in a one day training to orientate them to the course contents and specific requirements. The third phase focused on weekly group supervision and in the final, fourth phase course participants were provided with a treatment manual with up to date resources and ongoing monthly supervision

provided by experienced trainers. Fadden comments that a number of respondents to the survey highlighted specific difficulties experienced in implementing their knowledge obtained from the completion of training into routine clinical practice. Of the issues highlighted by Fadden, the following two are of particular importance to this study:

- Time constraints, particularly working with families, required the working outside of normal work hours that involved overtime and / or a recognition of lieu time.
- The service area that the clinician worked in, and in particular for those clinicians working in inpatient clinical areas, the implementation of their knowledge from training was noted to be particularly difficult. Inpatient clinicians also noted that engaging in Behavioural Family Therapy in an inpatient clinical area was too "daunting" for families and that their knowledge of Behavioural Family therapy was "… not applicable to the needs of their clients and their client's families" (Fadden, 1997, p. 605).

Important aspects of the study conducted by Fadden include the focus on the transfer of knowledge gained from training into the clinical practice setting. Fadden notes that it may be more appropriate to offer training in Behavioural Family Therapy to selected clinicians to ensure that they are in a position to be committed to utilising their knowledge of behavioural family therapy in clinical practice in contrast to the provision of large scale workforce training initiatives. Fadden highlights the issues associated with service level responsibilities pertaining to all dimensions of the service structure, including line management and senior management. The issues were facilitating the use of skills and knowledge in practice and also the relevance of the service delivery focus at an institutional level as to whether the delivery of Behavioural Family Therapy is considered a priority. Bailey et al. (2003) conducted a similar study which compared the experiences of staff trained in Somerset with those trained in Buckingham in Family Interventions. Although overall the study outcome suggested that clinicians faced fewer challenges than those described in the study by Fadden (1997) and that staff mostly felt confident in implementing their knowledge of Family Interventions into practice, the Bailey et al. study confirmed that there were wider organisational issues that were of concern that affected the ability of clinicians to fully integrate their skills into routine clinical practice. However, Bailey et al. also highlight that for those staff who completed their training in Somerset the

features of the service that were described as helpful included a more flexible approach to service delivery, valuing the multidisciplinary nature of the teams in the service and also collaborative working styles and supervision. The difficulties with implementation of Family Therapy interventions into practice identified in these two studies remain of concern to mental health service providers, clinicians and families affected by mental health problems in the United Kingdom (Fadden, 2006).

Stanbridge and Burbach (2007) in contrast to a selected individual training approach argue that a systemic approach to training in Family Therapy would be advantageous. The authors describe a "Strategy to Enhance Working Partnerships with Carers and Families" (p. 27) in Somerset. The strategy involved 18 months of extensive consultation and culminated in a number of service level changes and the provision of a staff training programme. A range of awareness/basic skills packages were developed and modified to meet the requirements of specific clinical teams. The training was considered foundational with scope for staff to continue on and develop specialist skills if they wished. Training also included implementation of a survey for the identification of further training needs for staff. The training was delivered over the period of a year to all staff of the Somerset Partnership NHS and Social Care Trust. A pre and post training survey was used with the conclusion that staff had benefited from training. Although it can be assumed that nursing staff will have participated in the training strategy described by Stanbridge and Burbach, details specific to nursing and their perceptions of the training are not provided.

Chapter Summary

This literature review has shown that there is an extensive body of literature pertaining to nurses talking therapy training and skills in clinical practice. In particular research literature from the United Kingdom. As part of the search process for this review, research conducted in the United States of America, Canada and Germany that reported on nurses talking therapy training and skills in practice was found. However, it has been identified that the research from these countries did not add new knowledge to the review process. Most literature from these countries referred to workforce development and talking therapy training programmes from the United Kingdom as an important resource. Therefore the scope of this review was limited to research literature from New Zealand, Australia, Ireland, and the United Kingdom.

Nurses' views on their talking therapy skills have been reported. Specific aspects that nurses valued about their talking therapy training were identified in research literature. In particular training delivered concurrently with the opportunity for nurses to trial and use new skills in clinical practice (eg: Crowe & Luty, 2005; Gournay et al., 2000; Hafner et al., 1996; Oakes et al., 2002; Ryan et al., 2005). Most research identified the benefits of brief talking therapy training (eg: Hafner et al., 1996; Milne et al., 2000; Myles & Milne, 2004) but the value of training over an extended period of time was also identified (eg: Ashworth et al., 1999; Ryan et al., 2005). Training ranged from introductory in-service onsite training, or up to12 months of training provided through specialised undergraduate and postgraduate University programmes.

Training designed to be consistent with the needs of staff and their clinical area was considered important (eg: Bee, Richards et al., 2005; McCann & Bowers, 2005). However Donoghue et al. (2004) identified that brief talking therapy training did not address the depth of skill and knowledge required for working with people with complex mental health needs. Most courses were structured to include theoretical and practical elements, and assessments included video feedback and role plays to support effective skill acquisition. Well structured clinical supervision was considered vital to successful training outcomes and the transfer of knowledge from training into clinical practice (eg: Ashworth et al., 1999; Bradshaw et al., 2007; McCann & Bowers, 2005). Additional key aspects that assisted with the transfer of knowledge from training into clinical practice included peer support (Milne et al., 2000), adequate resourcing and effective organisational leadership (Brooker et al., 2003). Adequate staffing on inpatient units to ensure staff could access training was considered to be vital (McCann & Bowers, 2005). Equally, inadequate resourcing for all aspects of training, or ineffective organisational leadership and processes were presented as barriers that inhibited the transfer and integration of talking therapy skills from training into clinical practice (eg: Bailey et al., 2003; Fadden, 1997, 2006).

The most appropriate method for evaluation of training was debated, for example, the use of systematic formal outcome measures (eg: Milne et al., 2000; Myles & Milne, 2004). In contrast the advantages of nurses' self-report on their views of talking therapy training (Gournay et al., 2000) and the impact of training on nursing practice and professional development was also highlighted. Talking therapy training for nurses had

implications for personal and professional development (eg: Gournay et al., 2000; Oakes et al., 2002). Although Ashworth et al. (1999) considered that talking therapy training potentially isolated nurses from clinical work as they progressed to senior leadership or managerial roles.

Most researchers recommended increasing the availability of talking therapy training for all health professionals and in particular for nurses. The cost-benefit advantages for training nurses in Talking Therapies to manage people with complex mental health needs was identified (Hazelton et al., 2006). Talking therapy training in the United Kingdom focused on CBT and the psychological models, assessments and outcome measures most commonly incorporated into Psychosocial Interventions. However nurses' reporting in international research literature on their training, knowledge and skills in other Talking Therapy models for example, Transactional Analysis, Gestalt Therapy or Psychodrama that require a depth of knowledge and extensive training was not evident. This deficit identifies a gap in research literature.

This chapter has identified international research in which nurses' views on their talking therapy training and skills in clinical practice have been described. The important elements of training that support effective skill acquisition were identified. Aspects of talking therapy training that assisted with effective skill transfer or aspects that have represented barriers to skill transfer have been highlighted. In contrast to the extensive body of international literature pertaining to nurses talking therapy training and skills in clinical practice there is little evidence of this in New Zealand nursing literature. Therefore, it is vital to understand what talking therapy training, knowledge and skills mental health nurses have in New Zealand. The aim of this study is to consider nurses' knowledge and views on talking therapies in clinical practice in one District Health Board. Therefore the following research questions and framework were developed to achieve the aim of this study.

Key Research Questions

1. What do nurses consider to be important about their talking therapy training, knowledge and skills in clinical practice?
2. What helps or hinders the integration of their knowledge and skill in talking therapies into routine clinical practice?

Framework to Explore the Research Questions

Based on the research questions identified from the literature review conducted for this study, the following research framework was formulated for the collection of nurses' views on talking therapies in clinical practice.

1. Knowledge Views

- Identification of what nurses considered important about their knowledge of talking therapies.
- Identification of how this knowledge contributed to current clinical practice
- Do nurses consider that the use of talking therapies represents a core skill in clinical practice?

2. Skill Acquisition

- What do nurses consider to be important about their training in talking therapies and how were these skills achieved?
- Were there particular training strategies that they found helpful?
- Questions in this section also addressed assessment, qualifications, financial and organisational support, and supervision.

3. Skill Transfer

- What helped or hindered the use of talking therapies in routine clinical practice?
- How are the talking therapies skills used in clinical practice?
- What is the perception of peer support and colleagues valuing their use of talking therapies?

CHAPTER FOUR: METHODOLOGY

Introduction

Given the nature of the research question in which qualitative information was sought, a qualitative descriptive design was deemed most appropriate for the purposes of exploring nurses' knowledge and views on talking therapies in clinical practice. Brown (1999) suggests that the selection of a research design should be informed by the design that best answers the research question. Sandelowski (2000) concurs explaining that a "qualitative descriptive study is the method of choice when straight description of phenomena are desired" (p. 334). The aim for this study was to describe what nurses considered to be important about their training in talking therapy skills and what might help or hinder the integration of their talking therapy skills into clinical practice. This chapter will describe the use of a qualitative descriptive methodology to answer the research question, nurses' knowledge and views on talking therapies in clinical practice.

Research Methodology

Qualitative descriptive research methods have not been consistently differentiated from other forms of qualitative research as a distinct form of research inquiry in spite of methodological and practical advantages (Sandelowski, 2000). Sandelowski asserts that qualitative descriptive research is a valuable often under recognised methodology, that provides an existing framework for practice based research, particularly appropriate for nursing and policy development (Sandelowski, 2000). The primary goal of a qualitative descriptive research methodology is the provision of a summary of events without embellishment, using informal language appropriate to the situation (Sandelowski, 2000).

Sandelowski (2000) proposes that "qualitative descriptive designs typically are an eclectic but reasonable combination of sampling, and data collection, analysis, and representation techniques" (p. 334). Qualitative description includes the use of individual interviews designed to elucidate peoples' knowledge and experiences (Sandelowski, 2000). Qualitative content analysis is the procedure most frequently used to analyse text derived from the interview data collection process. Pre-defined categories derived from literature, and codes derived from the data may be modified for interpretation of explicit and implicit

data (Flick, 2006; Sandelowski, 2000). Where straight description of phenomena is required, a descriptive summary arranged in themes is appropriate to re-present the data (Sandelowski, 2000).

Qualitative descriptive studies are theoretically associated with naturalistic inquiry (Sandelowski, 2000). Characteristics of naturalistic inquiry include; that research is undertaken in context with the topic of inquiry; that although usually associated with qualitative research, elements of quantitative research methods may be included; that data collection is an interactive process between the researcher and participants; that knowledge is informed by implicit and explicit communication; that there are multiple constructed realities that must be studied holistically; that divergent realities between people engender more questions than answers from the research process (Lincoln & Guba, 1985).

Research Design

This study used a qualitative descriptive research design methodology to summarise nurses' views of talking therapy training and skills in mental health nursing practice. The literature search revealed that there was a paucity of research pertaining to nurses' views of talking therapy skills and training in mental health nursing practice in New Zealand. Therefore a qualitative descriptive research design was considered appropriate to examine a phenomena about which little was known (Brown, 1999; Polit & Hungler, 1997).

Information relevant to talking therapy models, their theoretical underpinning and practical application to treatment was conducted to provide background to this study. Chapter Two describes the talking therapies relevant to this study. A national and international literature search of nurses training in talking therapies was undertaken to establish a knowledge base to inform development of the questions for the qualitative descriptive survey and interview guide. Chapter Three describes literature pertaining to nurses' talking therapy skills, their knowledge views, skill acquisition and skill transfer following training. Utilising previous research to inform the development of the research questions and guide the analysis process is appropriate (Mayring as cited in Flick, 2006).

Although predominantly qualitative, the research design for this study contained a quantitative data collection component through the use of a brief survey questionnaire. In addition to providing demographic information this also enabled me to contact a small

sample of nurses to take part in interviews that provided the data to answer the primary research questions. Surveys are an effective means to gather baseline information, demographic facts and data about peoples' behaviours, beliefs, attitudes, or opinions (Brown, 1999), however the pre-selected parameters of a survey limits in-depth exploration of participant's views. This contrasts with qualitative descriptive research which accounts for a range of viewpoints and practices to describe participants knowledge and experience (Flick, 2006; Sandelowski, 2000).

Cutcliffe and Goward (2000) comment that attitudes that are central to mental health nursing such as " (a) the purposeful use of self; (b) the creation of an interpersonal relationship; and (c) the ability to accept and embrace ambiguity and uncertainty" (p. 590) are attitudes also closely linked to the practice of qualitative research. Cutcliffe and Goward link qualitative research to evidence based nursing practice citing the work of French (1999). French suggests that the important features of evidence based practice need to be determined in context with clinical practice by placing value on peoples' experience and knowledge. Evidence based practice rather than an inactive term, proactively combines research and knowledge from a clinical practice perspective and provides for both "quality of service " and a "quality assurance activity" (French, 1999, p. 76). These factors are important if this research is to provide any meaningful feedback to inform further training and development in talking therapies for mental nurses locally and contribute to the body of knowledge that underpins mental health nursing practice in New Zealand.

Design Credibility

According to Sandelowski (2000) qualitative description provides researchers with the opportunity to report their research as a "summary of events in the everyday terms of those events…" (p. 336). For the purposes of this study, this means, reporting a truthful and accurate account of what nurses said in the semi-structured interviews. Maxwell (1992) terms this process descriptive validity. Sandelowski (2000) adds, that although it is unlikely that everything noted within the research investigation will be reported on, what is reported usually represents a consensus view of the phenomena under investigation. Maxwell (1992) terms this interpretive validity. Both descriptive and interpretive validity are relevant to the design of this study, in particular to report with simplicity what nurses considered to be

important about their knowledge and views of talking therapies and what might hinder the integration of their skills into clinical practice.

Credibility for the research design also rests on transparent declaration of limitations. The design for this study demonstrates a level of “plausible logic” (Brown, 1999, p. 75) which Brown suggests means that the research process was conducted in a manner that accounted for variables, or controlled variables, that appropriate recruitment strategies were used, the sample size was reasonable, that appropriate data collection was used and finally the analysis processes were also appropriate to the design of the research. Sandelowski (1997) in turn, contests the appropriateness of the concepts of rigour, validity, reliability and generalisability and the application of quantitative scientific constraints to qualitative research, instead proposing adherence to “connoisseurship and intellectual craftsmanship” (p. 127).

The limitations of this study are not ascribed to the qualitative descriptive design of the study. Instead the limitations are only attributable to the influences of a novice researcher and the size and scope of the research project. For example, the small sample size of nurses for the interviews. Although both the survey questionnaire and interview schedule were constructed thoughtfully, the scope of this study did not allow for testing and retesting the questionnaire. For example, albeit that every effort was made to construct questions in an unambiguous way retesting would have identified that question five of the survey could be misinterpreted by participants. Nurses’ who had talking therapy training indicated they would like additional training whereas I had wanted to identify if nurses’ with no training would access training if accessible.

Although the findings may reasonably represent the knowledge and views of the nurses who participated in this study, there is no assumption that this will be similar to the experiences of nurses in other DHBs in New Zealand. Additionally, the number of talking therapies addressed in this study cannot be considered exhaustive and only represents a few of those described by Peters (2007a) commonly used for treatment in mental services in New Zealand.

Research Theoretical/Philosophical Orientation

According to Sandelowski (2000) qualitative descriptive research studies are the least "theoretical" (p. 337) of the range of qualitative research methodologies and draw on elements of naturalistic inquiry. Polit and Hungler (1997) define a naturalistic paradigm as: "An alternative paradigm to the traditional positivist paradigm that holds that there are multiple interpretations of reality, and that the goal of research is to understand how individuals construct reality within their context…" (p. 462).

For this study this has meant exploring with nurses their individual experiences and understanding that although there may be similarities, the experience and context remains individual. Polit and Hungler (1997) also add that naturalistic studies have the potential "to elucidate the multiple dimensions of a complicated problem" (p. 15), a statement which is relevant to this study as each of the participants described different experiences related to their training in talking therapies. The purpose of this study is exploratory in nature and makes no attempt to naively assume a singular view or presume that all nurses who have knowledge and experience of talking therapies have a similar viewpoint. These elements of inquiry will be explored further in subsequent chapters. Sandelowski (2000) also highlights that qualitative descriptive research may have "*Hues, tones and textures*" (p. 337) drawn from other theoretical compositions, which may mean that aspects of individuals' words or experiences may be accentuated in a narrative or phenomenological style but according to Sandelowski this is not to be confused with "erroneous references to or misuses of methods or techniques" (p. 337). Accordingly, the current study attempts to retain a simplistic philosophical and theoretical orientation, which consistent with the tradition of qualitative descriptive research, remains minimally theorised.

Ethical Implications and Consent

Conducting research with people requires thoughtful consideration of the potential ethical and cultural implications of the study. Prior to commencing the current research project consent was sought and granted from the Lower South Regional Ethics Committee, the DHB and during the research process from individual participants. Additionally, cultural advice was sought from the Cultural Advisor for the DHB including making copies of my proposal available to the Maori Mental Health Team (Te Oranga Tonu Tanga). I was invited to meet with the Maori Mental Health Team to present my proposal and

subsequently incorporated their suggestions into my research project. In particular this included a question in the survey that would identify respondent's ethnic origin.

Ethical considerations relevant to this study included truthful, accurate reporting on the statements made throughout the research process. Additionally, the traditional ethical considerations that Rogers and Niven (1996) suggest are important in nursing practice, which include beneficence - seeking to do good, non-maleficence - prevention of harm, (pp. 11-12) and autonomy or self-determination – the provision of adequate information to enable choices (p. 66) are equally relevant to nursing research.

Autonomy includes providing for adequate communication and information. For this study a comprehensive information sheet was sent out with the initial survey detailing all aspects of the research project. In particular, the information sheet informed potential participants that the audio recording of the interviews, the interview transcript, the analysis of interview proceedings and the written results were all a component of an assessment for a Masters degree thesis. Individuals had a choice whether to return the survey questionnaire or not, a return implied consent. Respondents to the questionnaire also had a specific contact form to arrange meeting with me for an interview at a time, date and place convenient to them. Prior to commencing the interviews the relevant information details were discussed again and a signed consent form obtained. Withdrawal from the study was an option at any time with no repercussions. Privacy and confidentiality were maintained with only the researcher having access to the database with individual names. All research documents were coded and raw data stored in a locked cabinet. The interview transcriber also signed a detailed confidentiality agreement.

Throughout the research process an awareness of the potential for "actual and inadvertent coercion" (Rogers & Niven, 1996, p. 67) or perceived position of power was acknowledged because of my current position as a clinical nurse specialist in an acute ward, and more particularly because of my previous role as an educator for all staff of the mental health service, therefore individuals may have felt pressured to participate. Every effort was made during the interview process not to induce stress particularly as participants were asked to reflect on their clinical practice. All participants acknowledged that the interview

was a positive experience and that they appreciated the opportunity to contribute to the body of knowledge relevant to nurses and talking therapies.

For a copy of the relevant documents pertaining to the ethical and consent processes utilised in the current study refer to Appendix 1(A-F).

Participant Sampling and Recruitment

Purposeful sampling techniques are commonly associated with qualitative descriptive research (Sandelowski, 1995, 2000). Theoretically, purposive sampling is aligned with naturalistic inquiry which orientates the study to explore commonalities and differences across a broad range of experiences. These dimensions confer depth to the study (Lincoln & Guba, 1985; Sandelowski, 1995, 2000). Names of participants for this study were obtained from a staff database which identified nurses with New Zealand registered psychiatric training, comprehensive nurse registration and nurses from overseas with equivalent registered nurse qualifications that have worked in either an inpatient, community or specialist mental health service settings in a South Island District Health Board (DHB) Mental Health Service. Two hundred and twenty five nurses were sent a quantitative survey questionnaire with questions seeking both demographic information and a list of training experiences including talking therapy type, training location and duration. From the questionnaire responses a small sample of nurses were invited to meet with the researcher for the qualitative data collection component of this study being the semi-structured interview. The sampling criteria for the qualitative component of the research project was determined by obtaining the participants' consent to meet with the researcher to discuss their experience of training in talking therapies. Three additional criteria influenced the selection of participants for the semi-structured interview. These criteria were as follows:

1. Number of weeks/years of training in the specific talking therapy/therapies
2. Breadth of experience in talking therapies, typically those with experience in more than one type of talking therapy.
3. Clinical setting, equal distribution between inpatient, community and specialist treatment areas.

Sandelowski (1995) points out that sample size is relative and usually determined by the research topic. Sandelowski also suggests that purposeful sampling includes, firstly; "maximum variation sampling", which allows for the identification of "common and unique manifestations of a target phenomenon across a broad range of phenomenally and/or demographically varied cases" (Sandelowski, 2000, p. 338) and secondly; "phenomenal variation, or variation on the target phenomenon under study" (Sandelowski, 1995, p. 181). For this study the survey across a wide sample to identify individual's knowledge of talking therapies with demographic variability such as gender, age and workplace was consistent with maximum variation sampling. Phenomenal variation was appropriate to support meeting individually with nurses from different clinical areas to discuss their personal knowledge, experience and views of talking therapies.

The Participants: Who Were They?

The participants for this study were registered nurses from inpatient, community and specialty areas of the DHB Mental Health Service. A positive response to the survey provided access to 26 nurses with knowledge of talking therapies from which the sample of eight nurses was drawn for the semi-structured interview. Their selection was based on criteria previously explained. All of the nurses interviewed were experienced and contributed substantially to the value of the research process with their knowledge and views of talking therapies in clinical practice. Of concern however was that none of the nurses were from an inpatient clinical area although all had clinical experience in inpatient treatment settings. Most nurses had training in more than one form of talking therapy and without exception had training beyond an introductory level. These aspects of the findings of this study will be discussed in Chapter Five.

Data Collection Process

Sandelowski (2000) suggests that data collection for qualitative research is designed towards discovering the "*who, what,* and *where* of events or experiences…" (p. 338). To achieve this aim, two data collection processes were used in the current research project.

- Part A: Quantitative Questionnaire.

In addition to demographic details including clinical practice area, the questionnaire sought information pertaining to nurses' knowledge of talking therapies. Questions were structured

to enable identification of the particular talking therapy/therapies, the length of training, where this occurred, whether in New Zealand or overseas, and the type of supervision that the participant had received during training. In addition, if an individual had not received training in talking therapies there was an opportunity to indicate a willingness to access training. The questionnaire was predominantly seeking quantitative information but also allowed nurses to provide non-structured responses to open ended questions and general comments.

- Part B Qualitative Semi structured Interview

The semi-structured interview is commonly used as a qualitative data collection tool because the interview method enables gathering in-depth information from the participant (Creswell, 2003). A semi-structured interview can take various forms however in general the interview format is based on a series of questions that have been formulated into an interview guide which are then asked of each participant (Creswell, 2003). The open ended questions for this study were formulated under headings pertaining to knowledge views, skill acquisition and skill transfer with opportunity for participants' to disclose thoughts or experiences about talking therapies that they considered to be important. Knowledge views referred to participants' knowledge of talking therapies, how their knowledge contributed to clinical practice and if they considered talking therapy as a valuable core skill in clinical practice, thus in-depth knowledge about the research topic (Flick, 2006). Skill acquisition elicited participants' experiences associated with training. Skill transfer identified their views on what helped or hindered the integration of talking therapy skills into clinical practice. The interview was structured to encourage participants to present their views of talking therapy skills in nursing practice.

Creswell (2003) promotes the semi-structured interview format as it allows the interviewer to provide a framework for the line of questioning without limiting the response from the participant. Disadvantages include the potential for interviewer bias, the possibility that participants' responses may not be "equally articulate and perceptive" (p. 186) or that the adequacy of a response may be limited by one or more nuances being expressed by the participant. For this study the participants were provided with a copy of

the interview guide a week prior to the interview to allow time for reflective and considered responses in the interview.

The interviews were conducted in an office in the participant's clinical area. Each interview lasted between 45 and 50 minutes. Although my challenges included managing the electronic recording equipment all of the participants were gracious with their patience and their contribution towards my research project. Creswell (2003) advocates for the researcher to "…look for involvement of their participants in data collection and seek to build rapport and credibility with the individuals in the study" (p. 181). Apart from commencing interviews with reminders relevant to ethical process and consent, I invited each participant to describe what they considered to be important about their talking therapy skills in clinical practice. Dimensions integral to mental health nursing practice, for example, the interpersonal relationship, and accepting and valuing different viewpoints were important. The interview guide provided an important structure to the interview process, but participants' presented their own ideas. The interviews were an interactive process and I endeavored to affirm participants' contributions that enabled me to gain insight into their depth of knowledge and skill of talking therapies in practice.

Copies of the relevant documents pertaining to data collection processes utilised in this study are appended (Appendix 2).

Data Analysis: Tools and Processes

Part A: Quantitative Survey Questionnaire - Quantitative Analysis

Data were collected by means of a 6 item survey questionnaire. The six questions were structured and required either, a "yes/no" response, a selection from a range of options and two open ended questions that sought the respondent's comments. The data were entered into an excel spread sheet for representation of the data in tables in Chapter Five. Descriptive statistics were used to describe and combine the data, in particular to describe averages and percentages relevant to the demographic data from this study.

Part B: Qualitative Semi-Structured Interview - Content Analysis

According to Flick (2006) qualitative content analysis provides an appropriate method for the analysis of interview data. Prior research and theoretical models contribute to the

development of categories that are applied to the empirical material to enable a process of reduction or summary. The categories may be modified during the analysis process to ensure that the most appropriate framework for analysis of the data is employed. Flick provides an overview of three methods relevant to content analysis. They are; “Explicative Content Analysis… Structuring Content Analysis and Summarizing Content Analysis” (pp. 313-314). Flick states summarising content analysis means that similar text is paraphrased and summarised, and the information that is identified as not relevant to the study is put aside. Further analysis across the data set enables the identification of major themes and subthemes. The summarising content analysis process recommended by Flick provided an analytic framework for this study.

The categories, knowledge views, skill acquisition, skill transfer relevant to nurses’ talking therapy training and skills in practice were consistently used in the qualitative descriptive approach of this study. The headings were used as a guideline for the literature search, informed the survey and interview guide for the data collection process and the categories for analysis of the empirical data from the interview recordings. The interview recordings from this study were transcribed and the texts rechecked against the audio recording to ensure accuracy. Copies of the transcripts were returned to the participants with an invitation to make any amendments they chose. None of the participants wished to make any alterations to their transcript. As Flick (2006) suggests the major goal initially was to “reduce and summarize…” (pp. 312-313) the information provided by the participants. Each interview amounted to approximately four thousand words, or between eight to ten pages of script. During the analysis process a constant checking and rechecking occurred between the original text, the major categories of knowledge views, skill acquisition and skill transfer and the summarised data to ensure that resulting summaries were an accurate reflection of participant’s views. Following analysis of the eight transcripts the emergent themes were compared across the data sets and major themes and sub-themes were formulated as findings for representation as results in Chapter Six.

Chapter Summary

This chapter has provided a rationale for the use of a qualitative descriptive research design as the most appropriate method for this study. A description of the relevant ethical approval processes that included approval for data collection and analysis processes relevant to this

study have been described. The research framework of knowledge views, skill acquisition and skill transfer that supported the data analysis and collection processes will ensure continuity in presentation of results in Chapter Six.

CHAPTER FIVE: RESULTS

Introduction

This study used both quantitative and qualitative methods to explore nurses' knowledge and views of talking therapies in clinical practice. As Sandelowski (2000) recommends, the results of this study are presented as a cohesive summary of the qualitative and qualitative data collection processes. This chapter commences with presentation of the results from a quantitative survey questionnaire sent to two hundred and twenty five (n=225) registered nurses in a District Health Board (DHB) Mental Health and Intellectual Disability Service in New Zealand. Section 1 of the questionnaire was used to elicit demographic information while section 2 recorded details of training and talking therapies. The survey results are presented in table and text format with qualifying statements to provide context and clarity.

The second part of this chapter presents the results from the qualitative component of this study that involved semi-structured interviews with a sample of nurses (n=8). Content analysis methodology recommended by Flick (2006) for analysis of interview data was used and has provided for the identification of significant themes expressed by the interview participants with respect to knowledge views, skill acquisition and skill transfer. The results are presented in table and text form as appropriate and supported by excerpts drawn from participants' comments during the course of the interviews.

Quantitative Survey Results

Section 1 - Demographic Information

Of the two hundred and twenty five (n=225) surveys that were sent to registered nurses in the DHB, sixty nine (n=69) or 31% were returned. The age range of respondents ranged from twenty three to sixty five with the average age being forty four years. Refer to Figure 1. More female (n=54) than male (n=15) nurses responded to the survey questionnaire. For ethnicity data refer to Table 1 below.

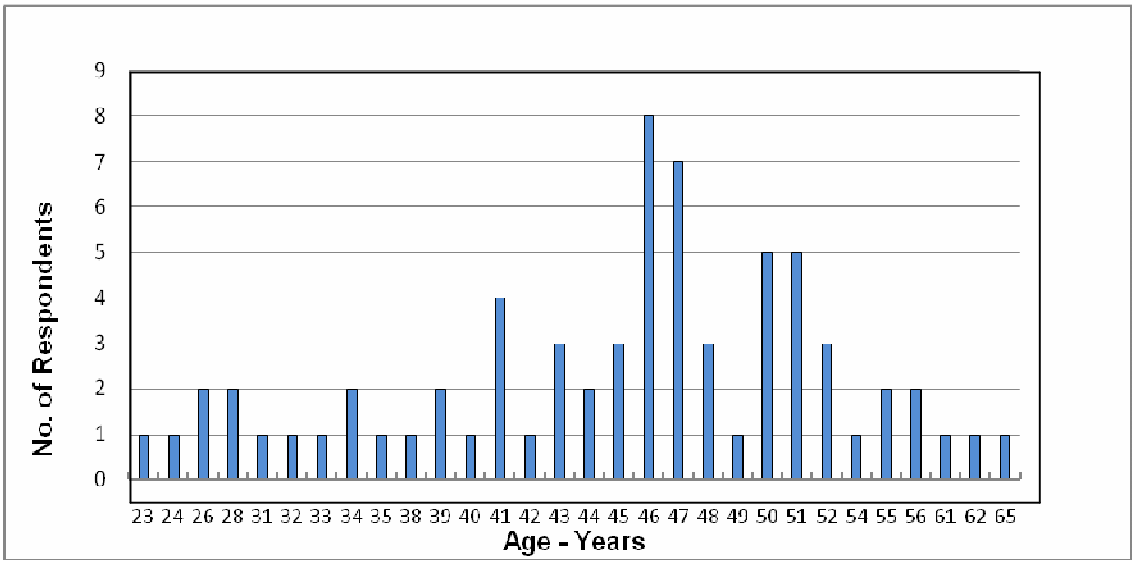

Figure 1: Demographic Data – Age Distribution of Respondents

Table 1: Ethnicity of Respondents

Ethnicity	No. of Respondents
Asian	2
British	4
European	3
Maori	1
NZ	16
NZ/European	40
NZ/European / Scottish	1
Scottish	1
USA	1
Total	69

Section 2 - Knowledge of Talking Therapies

Question - 1 Training in Talking Therapies

The sixty nine (n=69) nurses that responded to question 1 provided information on training in talking therapies within the last ten years. Thirty (n=30) respondents identified that they

had not attended any form of training while thirty nine (n=39) indicated that they had attended training in talking therapies.

The second part of Question 1 recorded the specific talking therapy training gained by the nurses who responded to the questionnaire. The results established the following:

- The majority of nurses had accessed training in Motivational Interviewing (MI) and Cognitive Behavioural Therapy (CBT) with a number of nurses also trained in Dialectical Behavioural Therapy (DBT), Transactional Analysis (TA) and for those nurses from the United Kingdom training in Psychosocial Interventions (PSI).
- The range of training for the sample of (n=69) nurses also indicates that some nurses attended training in a talking therapy more than once.
- Nurses frequently had training and experience in more than one type of talking therapy.

The type of talking therapy training and the number of respondents with the respective talking therapy training is presented in Table 2.

Table 2: Number of Respondents with Training in Each Therapy

Therapy Type	No. of Respondents with Training	Therapy Type Cont'd	No. of Respondents with Training Cont'd
Motivational Interviewing	32	Psychodrama Training	2
Cognitive Behaviour Therapy	22	Psychosocial Interventions	3
Dialectical Behaviour Therapy	7	Self-psychology	1
Transactional Analysis	6	Psychodynamic Therapy	1
Rational Emotive Behaviour Therapy	2	Ashburn Psychotherapy Seminars	2
Family Therapy	2	Primal Therapy	1
Child Psychotherapy	1	RJF	1
Constance Dahlenburg	1	Role Theory	1
Counselling Course	1	Interactive Drawing Therapy	1
Couple Counselling	1	Sexual Abuse Counselling for Men - Psychotherapy	1
Gestalt Psychotherapy	2	Action Methods	1
Group Work Training	1		

The responses recorded for Question 1 were used to select participants for the semi-structured interviews. The duration of training, depth and breadth of experience guided my selection process. The length of time committed to training varied from half days to over nine hundred hours. A summary of respondent age and their duration of training is presented in Figure 2. The graph differentiates between the respondents that were and those who were not interviewed.

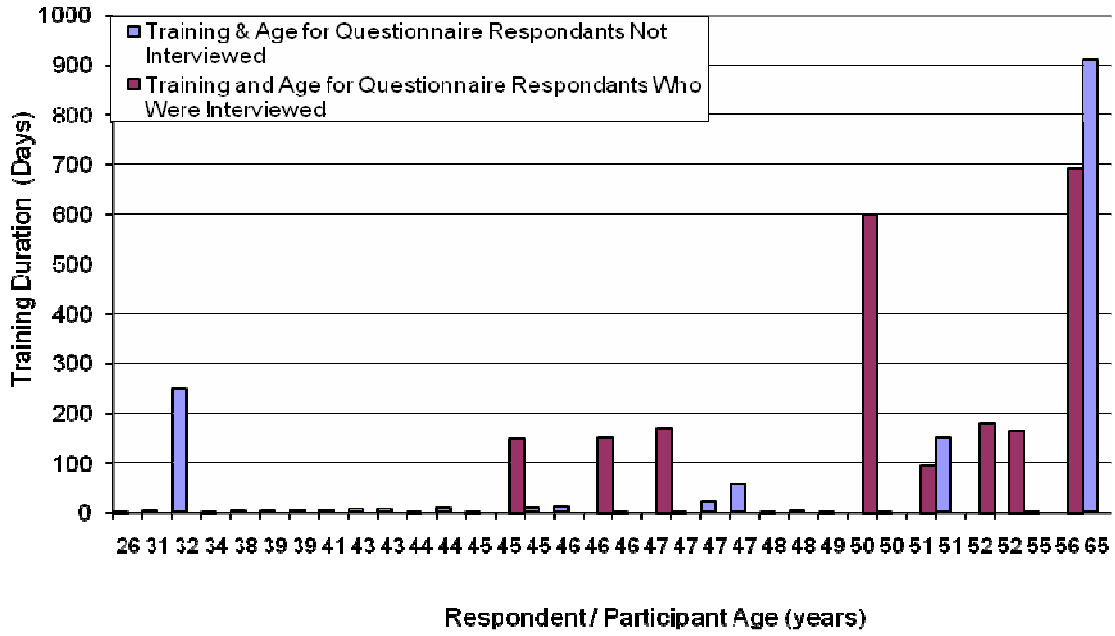

Figure 2: Length of Training in Talking Therapies and Age of Respondents

Although Question 1 also sought to identify the year that respondents had attended their training a number of nurses were unable to provide exact information. Identification of the year that nurses had completed training may have established a link to organisational processes or regional / national workforce development projects that had facilitated access to training, however, this link could not be fully extrapolated from the results.

Of those nurses that had attended training in New Zealand, this was mostly provided in the main centers, Auckland, Christchurch and Dunedin. A number of nurses (n=8) had attended training in talking therapies in the United Kingdom. Nurses had also attended training in Australia and United States of America. Refer to Table 3.

Table 3: Training Locations and Number of Respondents per Location

Country of Training	Number of Nurses
New Zealand	28
Australia	1
Australia and New Zealand	1
United Kingdom	6
United Kingdom and New Zealand	2
United States of America	1
Total	39

Question 2 - Supervision

In answer to the query about access to specific supervision during the respondents' training in talking therapies, of those individuals that indicated that they had extensive training specifically in Psychodrama, TA, Gestalt, Child Psychotherapy, Family Therapy and CBT, all recorded that they had accessed supervision and continued to do so to support safe clinical practice. However, in contrast, some nurses that had attended training in talking therapies did not have supervision provided as a specific component of the course content, although some nurses indicated that they had continued their usual clinical supervision arrangements and others recorded that they did not access supervision at all.

Question 3 – Clinical Setting

The clinical practice setting information from question 3 revealed that fewer nurses (44%) from inpatient clinical settings had attended talking therapies training compared to nurses (64%) in community treatment settings of the mental health service. Refer to Table 4.

Table 4: Total number of participants with talking therapies training and their respective clinical settings

Clinical Setting	Inpatient	Community	Total
Talking therapies training			
Yes	11 (44%)	28 (64%)	39
No	14 (56%)	16 (36%)	30
Total Number of Respondents	25	44	69

The results in Table 4 indicate that there is need to improve sustainable access to training and development for nurses working in inpatient clinical areas. This result is consistent with what has already been clearly documented in international research and has been stated in New Zealand national workforce development strategic documents (Peters, 2007a, 2007b).

The distribution of respondents by clinical setting is presented in Table 5 on page 69.

Question 4 – Use of Talking Therapy in Practice

Forty one (n=41 of n=69) individuals responded to the question that required them to identify how frequently they used talking therapies in their current clinical practice. Thirty (n=30) replied often, eight (n=8) replied occasionally and three (n=3) replied never. This result indicates that most nurses consider their knowledge of talking therapies important in their clinical practice.

Question 5 - Access to Training

Question 5 was designed to elicit whether respondents without talking therapy training would attend training if it was available. All respondents who did not have talking therapy training indicated that they would like training. However nurses that had previous talking therapy training also answered this question indicating that they would like further training. Although this result confirms that talking therapy training is important to nurses I should have designed Question 5 as two distinct questions. One question for nurses without talking therapy training, and a second question to elicit the continued education needs for nurses with talking therapy training.

Table 5: Count of Nurses by Clinical Setting

Clinical Setting	**No. of Nurses**
Community Settings	
Community Alcohol and Drug Service (CADS)	3
Child and Family Service (CAFMS)	1
Community Mental Health Team (CMHT)	16
CMHT & Private Counsellor	1
Community Day Programmes	1
Consult Psychiatric Liaison	1
Early Intervention Psych Services	2
Emergency Psychiatric Services	6
ID - Community	1
Outpatient Groups	1
Youth Specialty Service	3
Inpatient Settings	
Inpatient Acute	25
Inpatient - Intellectual Disability Service	4
Inpatient - Older Peoples Health	4
Total	**69**

Question 6 - Additional Comments.

The sixth and final question in the survey component of this study provided respondents with the opportunity to contribute any additional comments. The following three quotes capture the essence of what can be described as a predominantly positive view expressed by nurses relevant to their knowledge of talking therapies;

> I think it is essential to the continuing practice of a good nurse to have knowledge and skill in the talking therapies to maintain our professional credibility and to give optimum care in our assessments and counseling of clients.
>
> I found such training very valuable and would welcome further and more up-to-date training to be available for nurses. Although not frequently using the formal tools the underlying principles shape and provide a useful model in clinical practice.
>
> I was under the impression that talking therapies underpinned all theoretical knowledge related to all aspects of psychiatric nursing and is essentially the basis of all therapeutic relationships.

These statements emphasise the important link between the theoretical underpinnings of mental health nursing, previously described in Chapters One and Two of this study, training in talking therapies and the practical application of their knowledge to clinical practice. Nurses that had training in talking therapies at this point in the survey reiterated the importance of their knowledge, and identified that if additional training was available and accessible they would respond positively to the opportunity to develop their skills further. All respondents who identified that they had not accessed training in talking therapies reported that if training was available they would attend.

One respondent noted that they found obtaining funding to support their study and training a barrier to continuing professional development. Some respondents noted their preference for training in a group format over three to four days rather than needing to commit to anything as long as six months or more.

In contrast to the predominantly positive comments related to nurses' knowledge and views of talking therapies, one respondent replied that they did not consider the use of skills in talking therapies to be particularly relevant in inpatient clinical settings. Although this statement represents a minority perspective it warrants further consideration in Chapter Six. Peters (2007a) in her summary document relevant to talking therapies in the New Zealand Mental Health and Addictions Service also refers to staff voicing similar doubts although whether the clinicians work in an inpatient, community or primary health care setting is not clear.

Qualitative Interview Results

The duration of training, depth and breadth of experience guided my selection process of nurses for participation the semi-structured interviews. Within the sample of nurses (n=8) that participated in an interview CBT and MI were the most common. Refer to Table 6 on page 72 for a profile of the interview participants, their age, duration and type of talking therapy training.

Table 6: Age and Talking Therapy Training for Interview Participants

Participant Number	Age (years)	Training Duration (days)	Talking Therapy Training
1	45	150	Cognitive Behavioural Therapy Psychotherapy Seminar Series
2	46	153	Motivational Interviewing Psychosocial Interventions
3	47	170	Psychodrama / Group Work Training
4	50	600	Child Psychotherapy: Post Graduate Diploma in Child and Adolescent Psychotherapy
5	51	96	Motivational Interviewing Rational Emotive Behaviour Therapy Psychotherapy Seminar Series
6	52	180	Cognitive Behavioural Therapy Motivational Interviewing Transactional Analysis (*)
7	52	167	Cognitive Behavioural Therapy Transactional Analysis Management Leadership Training
8	56	694	Cognitive Behavioural Therapy Dialectical Behavioural Therapy Motivational Interviewing Gestalt Psychotherapy Interactive Drawing Therapy

(*) Others forms of Talking Therapy under taken by Participant Number 6:
Music Therapy; Art Therapy; Seminars on Death & Dying (Elizabeth Kubler Ross); Spiritual Practice- Reiki; Grief Workshops; Micro Counseling Skills.

The above table records the training and experience in the use of talking therapies in clinical practice for nurses that participated in this study.

Qualitative Results: Themes

The presentation of the qualitative interview results are described as themes under the major headings from the interview guide.

Theme Headings

Knowledge Views

- Theme 1: Knowledge of talking therapy that informs nursing practice
- Theme 2: Knowledge of talking therapy that is applicable to the participants' clinical setting
- Theme 3: Knowledge that supports evidence based practice

Skill Acquisition

- Theme 1: The construction of training courses needs to be clinically relevant to nursing and the individual
- Theme 2: Learning strategies
- Theme 3: Supervision and refresher training

Skill Transfer

- Theme 1: Evidence of skills in talking therapies in mental health nursing practice
- Theme 2: What helps the integration of talking therapies into nursing practice
- Theme 3: What hinders the integration and use of talking therapies in nursing practice

Minor Themes that Contribute to this Study

- Theme 1: CBT in nursing practice

Knowledge Views

Theme 1: Knowledge of talking therapy that informs nursing practice

All of the nurses interviewed considered that training in talking therapies was integral to their nursing practice in mental health. For example: "… so it really informed my practice hugely, and I feel that TA gave me a lot of stuff to work with people within the therapeutic relationship. I think it informs nursing practice, especially in mental health". The participants stated that their knowledge of a talking therapy assisted with determining a direction and focus to therapeutic interventions and informed the decision as to which

interventions would be most appropriate for the situation. For example one participant stated the following:

> … because you know that you are basing what you are doing on something that is well founded and well researched, but it also means you have got some tools there … to add to practice.

Participants were all individually able to clearly articulate what they considered to be important about their knowledge of talking therapies and indeed they were passionate about their selected area of interest using words such as "…vital…" "…valuable…" and "…informs practice…" to describe how their knowledge of talking therapies contributed to core interpersonal skills in their mental health nursing practice. For example;

> … I call myself a nurse therapist because I feel that that captures it fully. Because I think I'm special, I'm a specialist nurse in a field that I've chosen [therapeutic outpatient groups] and for the most part, it does look like we're just doing therapy [psychodrama] but I'm also nursing all the time.

Three participants presented their views on the importance of talking therapy skills in nursing practice within a predominantly bio-medical practice environment. They expressed their concern about the reliance on pharmaceutical solutions for the treatment of mental illness. This was described by one nurse by stating "… I think that we're a medically based service. The predominance in the pharmaceutical solutions is there. That's what people expect, I think, from the service as much as the service… meets the expectation". These participants stated that their knowledge of talking therapies provided an important counter-balance to the use of pharmaceutical interventions for the treatment of mental illness. The use of talking therapies was central to defining the nursing role in a predominantly biomedical practice environment. One participant voiced this as:

> And so I think that that's why the talking therapies are so important, particularly for nurses … because talking therapies give nurses another way of making sense of the world that they live in which is working with this medical model.

The use of talking therapies with knowledge of pharmaceutical interventions in nursing practice provides the balance necessary for holistic mental health nursing practice.

A further two participants also commented on the tension between elements of nursing that have a focus towards *"making it better"* [giving of medication for immediate symptom reduction] and talking therapies which may involve an escalation of short term stressors that as a nurse may be at odds with the more immediate desire to make it better.

> I think in psychotherapy it means sitting there with a lot of uncertainty…I think this [psychotherapy] is somehow paradoxical to being a nurse because I think as nurses, we need to go in and fix it and make it better… quite often, I think, well we don't want to hold on to the pain of people. We don't like observing distress and pain in people so we want to make it better for them and quite often, it means, actually saying to somebody, I know you're in pain. I can see that, I can feel that, but that's okay. Rather than saying, ohh, right, let's do this, let's do that, let's make it go away… so you're experiencing what they are experiencing really…

A nursing focus that accepts *"that's okay"* means the nurse needs to manage the tension between the desire to diminish the effects of emotional pain whilst enabling the recovery process for people using psychotherapeutic interventions. Both participants were firmly committed to the sense that their knowledge of talking therapies assisted them to "*make sense*" of their mental health nursing practice and affirmed the use of their knowledge in talking therapies as a means to support the recovery of consumers.

Self knowledge was also an important dimension to participants' knowledge of talking therapies informing practice. Four participants elaborated on their understanding of knowing "one's own processes …" and "…noticing…" and how this informed their practice. The essence of this theme is captured in the following statement.

> …yes, and also it helped me, it's helped my own soul, my own essence of who I am, to grow and extend myself this way…sometimes I say things and I will chew it over and think why did I say that. That was quite destructive or that was an unhelpful comment to make to that person. So TA and CBT have helped me to be more aware and in tune with the person I am dealing with.

For four nurses the sense of 'self knowledge informing practice' was vitally important because in their view self knowledge facilitated gaining insight into others' experiences and

thus supported safe practice. Safety was also described as a rationale for completing training in a talking therapy. "…I'd done no post-grad work at all. It was like I needed something. Something I could stand on and work with and because I got to work here I chose psychodrama". Each of the nurses in their own way recounted this theme, to support how, in their view, their particular knowledge of a talking therapy both informed and maintained safety in their nursing practice.

Theme 2: Knowledge of Talking Therapy that is applicable to the participant's clinical setting

All participants commented that their knowledge of a specific talking therapy assisted them to work effectively in the clinical setting. Although each nurse described similarities in their experience in talking therapies, or the use of similar models, there were also differences and each participant was able to articulate why they had chosen training in particular talking therapies and how they applied this knowledge in their clinical practice setting. For example;" I guess what it did for me, working with children, adolescents and families…what it did for me was pulled it all together and made perfect sense of the way in which I worked". For this particular nurse her knowledge of Child and Family Therapy was important, equally, for another nurse her knowledge of MI enabled her to support the consumers that she worked with in a manner that promoted self determination. Two participants echoed the theme that their knowledge of TA and the theoretical perspectives that underpin TA were particularly relevant to early intervention and crisis intervention. One nurse reiterated that her knowledge of TA was invaluable in her current managerial role with staff and that in addition, her knowledge of TA provided a framework for the provision of clinical supervision. This participant also noted that in a previous role as a psychiatric district nurse her practice was mostly informed by training in CBT. For another nurse, knowledge of psychodrama and group process was considered integral to every day clinical practice although she also described the benefits of her knowledge of TA. Extensive training in Gestalt Psychotherapy and Family Therapy was very important to another nurse to inform her practice for working effectively alongside adolescents and families. For one nurse, her knowledge of REBT was considered applicable in a community day programme treatment setting in contrast to previous clinical experience in an inpatient area where she considered the use of REBT was not as appropriate.

> It's really nice to find a place to use it as solidly as this because ward work doesn't necessarily allow you…the wellness of the person to do that much cohesive sort of work because it's not a single sort of event. [REBT] It's a repetitive [therapeutic intervention] … so take away the information and practice…come back … I can't imagine why anybody well enough to actually work with the process should be in hospital, in acute areas. They should… one would imagine be well enough to be at home.

Notably, all of the respondents had more than one form of training in talking therapies with four nurses having completed CBT and MI training as well. From this information it could be assumed that training in MI and CBT was considered important foundational knowledge and respondents developed further knowledge and skills in a talking therapy specific to their clinical setting as appropriate. The concept that CBT and MI may be considered foundational knowledge for mental health nursing practice will be discussed further in Chapter 6.

Theme 3: Knowledge that supports evidence-based practice.

All eight participants reiterated the importance of the theoretical and evidential background to their use of talking therapies in nursing practice. This was reflected by the following statement:

> It's really important that they have a solid foundation from theory to practice so I felt the Gestalt had that and Family Therapy, CBT and Motivational Interviewing.

Additionally, participants stated that their knowledge of the theoretical and central tenets of a particular talking therapy would determine how talking therapies were used in practice, for example, the participants stated that they predominantly used CBT as a short term intervention. CBT as a short term intervention is supported by research literature previously discussed in this study. Another participant noted the importance of "rolling with resistance" for her therapeutic work with clients in the Alcohol and Drug Service. Rolling with resistance is acknowledged as an important interpersonal interaction between client and therapist and is central to effective therapeutic engagement for the appropriate use of MI. Another participant described the concepts of "I'm OK, YOU'RE OK …transference,

countertransference and engagement" that underpin the TA theoretical model and effective use of TA in therapy.

All eight nurses linked their theoretical knowledge of talking therapies and their knowledge of research to the application of their skills in talking therapies in nursing practice. Evidence based practice informed which talking therapy might be the most appropriate to use to engage with the consumer for the best outcome. The participants clearly described their rationale for using a particular talking therapy intervention irrespective whether they were using TA, REBT, CBT, Child Psychotherapy or any of the psychological models.

Skill Acquisition

Skill acquisition refers to how training in talking therapies was acquired.

Theme 1: The construction of training courses needs to be clinically relevant to nursing and the individual.

The focus in this theme is directed towards the structure and content of talking therapy training courses. All eight nurses identified that it was important for training in talking therapies to be appropriately structured so that what was learnt was relevant to their clinical practice setting and to how they wished to practice nursing. The following two quotes explain this theme;

> It's [psychodrama] very important to me because I trained as a group therapist…Gestalt is absolutely fantastic training, brilliant if you want to be an individual therapist but if you want to train as a group therapist, you're in the wrong place.

> I guess many courses can be set up and they look really, really good on paper but how you actually adapt to working with real people I think that can be questionable…your learning environment and how real [congruent] that is with your clinical practice [is important]…that makes a difference.

This particular nurse emphasised the risk that nurses may adapt what they have learnt to fit the clinical situation so much so that the "intrinsic factors" or the central tenets of the talking therapy model are lost. The participants noted that although 'experience' was

helpful, appropriate training provided an essential foundation from which to develop experience in talking therapies. “There are lots of people with lots of experience and I suppose you could say lots of good experience…but I would still argue that the courses give you the advantage”. All of the participants expanded on the value of their training and how this was evidenced in their nursing practice.

Seven participants noted the importance of training occurring in tandem with practice, meaning that new skills could be incorporated into practice, critiqued and brought back to the training environment for refinement and reflection with training colleagues and tutors. The interface between talking therapy training, and nursing practice was referred to as congruency. Participants emphasised that training was not an isolated event from practice, that provision for clinical supervision within the course content was essential to ensure consistency between the learning environment and practice environment. Talking therapy training needed to include both theoretical and practical components for effective learning. This result will be discussed further in Chapter Six.

Theme 2: Learning strategies.

This theme pertains to the participants’ experience of the course delivery that enhanced their learning. Five nurses talked about the benefits of a variety of learning tools such as group work, video recording and feedback and role-plays. Despite acknowledging that interactive learning such as role plays presented challenges, the participants stressed the importance of experiential and participatory learning. The opportunity to practice new skills in the group setting and receive feedback from fellow trainees and the tutors was considered important. For example one participant expressed this as follows:

> That there wasn’t anything that I was expecting clients to do that I wasn’t prepared to do myself. That I was actively engaged with the consistent, constant group of people who were able to notice me and be with me over extended periods of time, so that if I had blind spots they were noticed… I mean because quite often unless you’re engaged in long term training, your trainees and trainers they don’t see you [in action].

The timeframe over which training was delivered was relevant to learning strategies with the participants. Training varied in duration from six months to four and eight years. “… it

takes years and I think that's how it is for the people we look after. Illnesses take a long time to develop". The participant contrasted the investment in training over a number of years with the impact of mental illness for people that may also take years to recover from.

The theme relevant to participant views about learning strategies builds on the previous theme which highlighted that training, the practice setting and the individual needed to be clearly linked to achieve congruency and effective learning.

Theme 3: Supervision and refresher training.

Supervision was considered from two perspectives. Firstly, clinical supervision provided within the framework of the talking therapy model that nurses were receiving training in was considered central to effective learning. One nurse stressed that she benefited from tutors that were "pro-active" during the course and with their input to her learning and skill development between attendances to block courses. Secondly, ongoing clinical supervision was considered essential to ensure safety in their continued use of talking therapy skills in nursing practice. All participants identified that they continued to access regular clinical supervision.

Two nurses also spoke about the importance of access to continued training and refresher training, both stated that the provision of a single training course did not address maintaining competence. Two other participants identified that they were involved in ongoing training because of the nature of the talking therapy that they used in practice, for example Gestalt Therapy and Psychodrama.

Skill Transfer

Under the heading of skill transfer, the results are presented in two parts. Firstly, participants' views on how they demonstrate evidence of the use of talking therapies in clinical practice. Secondly, their perception of what helps or hinders the integration of talking therapies into nursing practice.

Theme 1: Evidence of skills in talking therapies in mental health nursing practice.

The first dimension of this theme relates to participants' views of how their knowledge of talking therapies was evidenced in nursing practice. All eight nurses spoke about the use of skills in talking therapies to support a range of nursing interventions such as mental state

assessment, risk assessment, observation, communication, listening, de-escalation. The participants all elaborated on how they used long term psychotherapies or brief psychological interventions in their nursing practice. Four nurses equated their knowledge of talking therapies and the practical application of their skills to “holistic nursing practice”. The practical talking therapy skills used in assessment are captured in this statement:

> …and I think it’s really, really good. So in terms of applying that to how I work, I look at everything in the kid. I don’t just look at what’s presented. I look at the how this kid relates, within the systems, within the family system, within the wider systems, school, nursery.

Another participant framed their practical use of talking therapies informing assessment processes by stating:

> …it’s what you use, to develop the rapport with a person in order to make the calls as far as how they present. Are they indicating by their behaviour, by their attitude, by the words they use…if you give somebody a tablet, there’s no reason to believe they’re any safer than they were before they had the tablet. If you talk to somebody, and that’s where your information comes from…” (unintelligible) [then the effectiveness of the intervention can be measured].

The integration into nursing practice of talking therapy skills that involve a long term psychotherapeutic treatment model such as psychodrama was captured by the following statement:

> …and the person can say no, no, no. That’s not what it is or they can go, yes. Yes, that’s right. That’s exactly what it is. I’m feeling really upset about that and then away they go. So in terms of talking therapy, it’s not me talking. It might be speaking on behalf of. I mean you do talk a lot, at times, if someone’s very repressed. But there are other people who require mirroring, mirroring something that you’re noticing. I notice you tap your fingers a lot when you talk about your mother…Tap your fingers a bit more and see what, see what your fingers are trying to say to you and it’s like, God, I’m so sick of talking to my mother and she never,

> ever listens to me. You know, and it's, like that's psychodrama. It's the little things. It's, you notice the little things.

Whether participants were engaged in the use of talking therapies within a long term psychodynamic framework or using brief focused interventions such as CBT they all felt the way they worked was evidence of the integration of their knowledge of talking therapies in practice, and, therefore demonstrated skill transfer.

The second important aspect of the theme: *evidence of skills in talking therapies in mental health nursing practice* was expressed by four nurses as "holistic nursing practice". Although they all expressed their ideas differently the following quote captures the essence of how the four participants considered their knowledge of talking therapies equated to holistic nursing practice.

> I've always found that the most valuing part of nursing is, of the type of nursing that I do, is the holistic approach…so that the client is not the only person standing here…I'm part of it…my team are part of it and the family and their friends are and so I find, I found everything that I'd done has put that together so that I can feel safe and confident when working in that way, with the whole team, with everybody involved and bringing them all together and knowing that if there are huge issues or anything, that I actually feel very comfortable with that and maybe years and years ago, I would not have and I know that it, some of that comes with experience but I also know that it's really good to be able to have references and to have experience of, and some training behind you to be able to know that you're, you know the next step, you know exactly, we're moving into this part.

Finally, a minor theme relevant to evidence of talking therapies in nursing practice was a comment from two nurses who wished to redefine the term talking therapies to "*thinking therapies"*. They both highlighted that thinking, observation and holding uncertainty was an important skill in talking therapies that was underpinned by their practical and theoretical knowledge of psychological interventions.

Theme 2: What helps the integration of talking therapies into nursing practice

Peer or collegial support was nominated by seven participants as being important to *'help'* the integration of talking therapies into nursing practice. The following aspects contributed towards participant's sense of peer and collegial support:

- The opportunity to share skills through role modelling and teaching in the clinical setting.
- The opportunity to share and value knowledge about different talking therapy skills within the clinical team and gain different perspectives.
- To share similar perspectives because of similar talking therapy training and appreciate the value of a team approach. For example one respondent stated "…and we tend to work really well together, those that have done it you know, when you are on call, you notice maybe the difference".
- Colleagues understanding the commitment to training and being supportive.
- Supportive organisational structures and good supervision to ensure that training in talking therapy skills, irrespective of which particular therapeutic model, can be implemented into the practice environment. This was explained by one participant as follows:

> In some ways, I don't think it really matters what you do, as long as you're held in a process with good supervision and you're well supported by your management structure, that it doesn't go into a hole. You know, that you're not scapegoated or seen to be, you know, above your station, if you're wanting to implement some of your new ideas… I think that there's a big risk if you're one person in a team and you're wanting to develop yourself and then you're wanting to come back and implement your ideas …I mean we see it all the time with the new grads coming through with their ideas.

The participants also noted that all of the experiences described above contributed towards sustaining a cohesive team approach in the work environment and that this assisted with the maintenance of well organized systems and processes that benefited consumers.

All of the participants noted that the clinical practice environment affected the integration of skills in talking therapies into practice. The environment was considered

either helpful or a barrier. The participants noted that as nurses working in community treatment settings accessing training was easier because it was part of the ethos of the environment. In contrast they considered that working in inpatient clinical areas presented challenges. For example one participant stated the following:

> …but as far as nurses go, and informing our practice, on the inpatient units, I think that, you know, there's just that whole band aiding and burnout [eg staff not attending clinical supervision and increased use of temporary measures such as sick leave to cope with stress and burnout without taking steps to initiate long-term measures for change]….no one can get past that. No one knows about how to take care of themselves … they don't have time to draw breath. No one's breathing.

Theme 3: What hinders the integration and use of talking therapies in nursing practice

All eight participants expressed their views from a range of experiences that they considered hindered the use of talking therapies in practice. These experiences are described under two sub-themes; Organisational processes and access to training; The inpatient clinical environment.

Organisational Processes and Access to Training

Seven participants commented on their experience of organisational barriers to accessing training and/or refresher training in talking therapies. These predominantly included comments about access to funding support to cover the costs of training, the time commitment required for training and being accorded appropriate study leave. Two participants commented that it was difficult to obtain recognition and particularly funding for talking therapy training that was not considered to be "…mainstream". For some, training was completed in the evenings, weekends and at times using annual leave. Two nurses also commented on their workload. For example:

> Being allowed to go, getting study leave. Maybe getting fees paid and things like that. Yeah, and maybe workload, I mean I find that huge. Because I can't actually do it very well because I've got a huge caseload and that you're stressing about that and then you're expected to do, well not expected, but you choose to do other training, so you try to fit that in and live as well.

Four participants commented about the impact of inadequate staffing levels and reduced funding resources for training and professional development. For example:

> There's a tension line between maintaining the workplace and its function and taking the time out to attend to your own educational needs and then I think that, that there's organisational sanctions in that, that there is no fat in the system to make it easy for people to go and do things. So I think that that is, is going to be, and currently will be a hindrance to me, stepping out more.

Two nurses noted that access to training was more difficult for nurses in contrast to the availability of training, refresher training and funding for other health professionals. For example*:* "I think for nurses, I think it's very difficult. I think it's very difficult to access funding for nurses. I'm not sure what it's about. I think doctors and psychologists have a much easier time". Another participant framed this concern slightly differently stating the following:

> I mean … the mental health review said we need more psychotherapy or talking therapies and it's true. You know, you only have to look within the service to see that there's long waiting lists for psychologists. We don't employ any psychotherapists but we do have a number, we have a lot of skilled nurses who are and have been actively involved in the psychotherapy sessions.

This comment adds an interesting perspective to the results pertaining to organisational process and will be discussed further in Chapter Six.

The Inpatient Clinical Environment

The inpatient clinical environment was a barrier discussed by five nurses from a number of different perspectives. For example one participant commented on her experience of colleagues that had discouraged the use of talking therapies in an inpatient area:

> …it was just we really don't have time for that, so that's, it wasn't so much that they were disparaging but more like, you know, it's not realistic. What I felt from patients' perspectives, even those who were psychotic, these things [talking therapies], these could still be used.

Three participants commented on the acuity and intensity of an inpatient ward environment presenting a barrier to the integration of talking therapies into routine practice. For example, the participants commented on the impact of shift work on the continuity of psychotherapeutic work for consumers:

> … like I say, until I came to the day programme, the erratic-ness of being a nurse in a shift based environment means your ability to actually see anybody, even if they are moderately well, to talk about this stuff, is small… that would be a barrier…there's not necessarily a continuity of message when you're absent, you can't be sure that other people are necessarily aware of what you're doing with this person…its much harder in an inpatient area getting a cohesive approach.

The participants also commented that it was difficult to ensure that all staff maintained the continuity of psychotherapeutic work because individual staff were either not well informed about the treatment plan or because of different perspectives did not adhere to the treatment plan and that this compromised the effective use of psychological interventions. For example:

> I found it frustrating and probably unhelpful. Certainly unhelpful for the client because, in all honesty, I think whatever approach is going to be used, even if I didn't completely agree with it, I think … it's the consistency that's probably fundamental.

One participant commented that nurses in inpatient environments were at times at risk of jeopardising their own access to training and supervision because of a lack of maintaining boundaries. For example:

> I'm just thinking in terms of nurses. You see, I think nurses have got a wealth of knowledge and experience but I think sometimes, become so bogged down, we do get busy and I know on the ward, especially, you're just so busy that it's very hard to actually make some time but I really think nurses need to actually have some boundaries because I think the boundaries are a little bit elastic sometimes. I need to say, no, this is the time I go for supervision and people need to respect that as well.

> Yeah, so I think nurses need to be more assertive… and clear about what sort of learning they want to acquire.

Results: Minor Themes

The participants were offered the opportunity to contribute any further views, thoughts or experiences that they considered important. The results of this component of the interview contributed to the development of the following minor themes.

Theme 1: CBT in Nursing Practice:

Three participants commented specifically about CBT: One participant stated clearly that she considered that the use of brief CBT interventions was most appropriate in inpatient areas. Another participant commented that at times CBT was "pedantic" and unsuitable for use with some consumers and in particular for youth. The participant felt that CBT was useful for psycho-education, notably strategies for anxiety and anger management. However, the participant stressed that it was very important to have an integrated approach to the use of talking therapies in practice. The term using an integrated approach was also echoed by other participants in context with their knowledge of talking therapies and also as an encouragement for nurses to access training most relevant for the clinical environment and the consumers they work with. For example: "Yeah, what works for them, personally… Rather than, you know, ohh CBT's the thing of the moment, rather than going along that route, the behavioural route knowing it doesn't feel right". Another participant echoed this by commenting:

> Sometimes you might be working with someone you think, and this is not going anywhere, so you'll pull out, you might pull out something which is CBT, or something that's TA because this actually sits with this person better because some people don't, like some people don't understand CBT stuff. They're not into the thoughts …they're more into that softy feely, I've never done Gestalt but I've read a little bit about it but some people respond to that. It's all, it's fascinating.

Chapter Summary

This chapter has presented the results from the data collection processes for this study that included a quantitative survey questionnaire and semi-structured qualitative interviews. The results provide confirmation that nurses value their talking therapy training, knowledge and

skills for clinical practice. The results pertaining to nurses' perception of what helps or hinders the integration of their knowledge of talking therapies into practice has highlighted a number of important issues. The relevant results from the main headings "knowledge views, skill acquisition and skill transfer" will be discussed in Chapter Six.

CHAPTER SIX: DISCUSSION

Introduction

Nurses consider that their training, knowledge and skills in evidence-based talking therapy models are essential for competent mental health nursing practice**.** Using a qualitative descriptive research design this study explored nurses' knowledge and views on their talking therapy training and skills in clinical practice. In 2007, 227 registered nurses from a District Health Board (DHB) Mental Health Service were sent a survey questionnaire. Of the 69 respondents a sample of eight nurses participated in a semi-structured interview. Content analysis using the headings "knowledge views, skill acquisition and skill transfer" established the major themes from the data collection processes.

Nurses' knowledge and views of the use of talking therapies in their practice included identification of what they considered to be helpful or a hindrance to the integration of their talking therapies skills into practice. Their views were based on their extensive practical and clinical experience. Nurses noted that the provision of well structured training, in a manner that was considered clinically relevant was important. Additionally, appropriate supervision and supportive management and organisational structures were imperative to facilitating the effective integration of talking therapies skills into clinical practice. Nurses also identified that organisational, managerial and team based processes could also potentially act as barriers. The findings from this study confirmed that nurses considered their knowledge and skills in evidence-based talking therapies to be vitally important for practice in mental health nursing. These findings are consistent with studies carried out predominantly in the United Kingdom and Australia (eg: Gournay et al, 2000; Hafner et al., 1996) previously discussed in Chapter Three. However, most importantly, this descriptive study adds context to training in talking therapies for nurses in New Zealand.

Although a small study, the findings provide impetus for progressing the current proposed New Zealand workforce development initiative (Peters, 2007a, 2007b) to devise a national framework for the provision of training in talking therapies for all mental health professionals. Planning regarding workforce training in talking therapies remains a topical

issue in New Zealand, with strategic documents still in development stages (J. Peters, personal communication, February 21, 2008). As previously noted, nurses are an important and influential group in the mental health workforce nationally. This study therefore adds to the voice of nurses in New Zealand and contributes valuable knowledge to literature that informs training strategies in talking therapies as part of mental health workforce development in New Zealand.

The major headings of knowledge views, skill acquisition and skill transfer have provided a consistent framework and focus for the research process of this study. In this chapter these headings provide the framework for the discussion of the findings from Chapter Five with reference to research literature reviewed in Chapters Two and Three. Limitations to this study will be identified and the chapter will conclude with recommendations for further research.

Knowledge Views

Grouped under the major heading 'knowledge views' the three key themes are; knowledge that informs nursing practice; knowledge that is applicable to the clinical setting and knowledge that supports evidence based practice. Knowledge gaps will also be identified.

Knowledge of talking therapy that informs nursing practice

A knowledge of talking therapies is not considered an adjunct to other knowledge that informs mental health nursing practice. Instead, for those nurses who use their skills in talking therapies in routine practice, talking therapies are considered an integral part of mental health nursing practice. As noted in Chapter Five of this study, 225 questionnaire surveys were sent out to registered nurses, 69 surveys were returned and of this sample only 39 nurses indicated that they had training and experience in talking therapies. Although the sample group for this study was relatively small, the finding that a number of nurses have not been able to access talking therapy training to equip them to work with people with a variety of complex mental health needs indicates a knowledge gap (Refer to Figure 2: p.66). Given that nurses represent an important clinical group in mental health services (Peters, 2007a, 2007b), and assuming that the DHB sampled for this study is representative of 21 DHBs in New Zealand, this study signals that there is a disconcerting knowledge gap for nurses. Further exploration is therefore warranted to clearly establish if there is a deficit

pertaining to talking therapy training, knowledge and skill for registered mental health nurses in New Zealand.

Identification in this study of a knowledge gap in talking therapies for some nurses contrasts with the nurses who were interviewed and routinely used their knowledge and skills in talking therapies in nursing practice. In this study, the interview participants were selected on the basis of their depth of knowledge and training (Refer to Table 6: p.72). These nurses clearly articulated their views on the importance to their practice of a sound understanding of the relevant psychotherapeutic treatment models, and the underlying theoretical principles of talking therapies, to the provision of holistic nursing interventions for consumers and their families/whanau. Descriptors such as "…vital…", "…valuable…" and "…informs practice…" were used to describe the importance of their knowledge. Furthermore, the nurses identified that their skills in talking therapies provided essential tools that assisted them with determining a direction and focus for treatment interventions when working with people with mental illnesses. Rydon (2005) in a qualitative descriptive study carried out in New Zealand confirms that service users and their families value nurses' knowledge and use of therapeutic interpersonal skills. Nurses in this study considered that their knowledge of talking therapies was important to maintain professional credibility for working with consumers and their families/whanau. Recommendations in national strategic service delivery and workforce development projects (Ministry of Health, 2005a, 2006b, 2007) for improving access to, and utilisation of, evidence-based therapeutic interventions would support the views of nurses' interviewed in this study. In addition, nurses highlighted that their knowledge of talking therapies assisted them to "…make sense of…" working effectively in a predominantly bio-medically focused practice environment. In their view, their knowledge of talking therapies meant that they were more effective at integrating their nursing knowledge and skills in talking therapies to benefit consumers. The link between knowledge of talking therapies and self knowledge was also considered important to understand the experiences of others, and for maintaining safe clinical practice in mental health nursing.

The findings from this study are consistent with research undertaken in Australia (eg: Donoghue et al., 2004; Hafner et al., 1996; Hazelton et al., 2006), Ireland (Neela et al., 2007; Ryan et al., 2005) and the United Kingdom (eg: Ewers et al., 2001; Gournay et al.,

2000). In evaluations completed following training, nurses acknowledged the benefits to their nursing practice in mental health of their newly acquired skills in talking therapies. In New Zealand, Crowe and Luty (2005) use a case study to describe the benefits of knowledge of Interpersonal Psychotherapy (IPT) and argue that psychotherapeutic skills are essential to mental health nursing practice. Training in IPT was not identified by nurses in this study, however, the Crowe and Luty study provides an important point of reference because IPT is considered a talking therapy relevant for use by mental health professionals (Peters, 2007a). Crowe and Luty emphasise that mental health nursing is a specialty area of nursing practice and that generic nursing skills are entirely inadequate for meeting the needs of consumers of mental health services. The authors reiterated the value of knowledge and skills in psychotherapeutic treatment models for facilitating appropriate evidence-based interventions in mental health nursing practice. Evidence-based treatment guidelines provide guidance to the most appropriate therapeutic treatment intervention, for example Cognitive Behaviour Therapy (CBT) for treatment of eating disorders (eg: American Psychiatric Association, 2000; Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Anorexia Nervosa, 2004). Nurses' specialist interest, or the role and function of the nurse in the clinical practice area may also provide some guidance for training in the most appropriate talking therapy model.

In this study, positive comments supporting the benefits of training and the use of talking therapies in clinical practice could be expected from a group of nurses who met the criteria of 'breadth and depth of training in talking therapies' for participation in the interview process. However, the interview selection process also identified some important issues. From the quantitative survey it was apparent that the dominant group that responded to the questionnaire were all from the 45 to 56 year old age bracket and that nurses who identified themselves as belonging within the 20 to 35 year old age bracket indicated that they had either no skills or only rudimentary introductory skills in talking therapies with which to inform their practice in mental health (Refer to Figure 2: p.66). This is of concern when the quality inferred by the standards for mental health nursing practice includes the effective use of interpersonal skills, with knowledge and skills in appropriate therapeutic treatment models, to ensure the provision of holistic health care for people with mental illness, their families and whanau (Te Ao Maramatanga: New Zealand College of Mental

Health Nurses Inc, 2004). The qualities inferred in standards of practice for mental health nursing practice are underpinned by competencies for comprehensive nursing registration in New Zealand (Nursing Council of New Zealand, 2007). The results from this study suggest that nurses with the greatest depth of knowledge and skill in talking therapies predominantly belong to an aging group in the mental health workforce (Ministry of Health, 2005a) and therefore knowledge currently embedded in practice may be gradually lost over the next fifteen years as they enter retirement. Importantly, this study exposes a potential knowledge gap that lies generally with younger nurses including those more recently trained. Younger nurses appear to have limited knowledge of, or training in, talking therapies.

Although the nurses involved in this study may not be representative of all registered nurses in this or the 21 other DHBs in New Zealand, nor of a particular age group, it is reasonable to consider that a number of new graduate nurses may not have knowledge of the relevant theory, treatment models and practical skills for the use of talking therapies in mental health nursing practice. From the age distribution of nurses' with talking therapies training in this study (Refer to Figure 2: p.66) it appears that talking therapy training may have been more accessible twenty years ago. From this study it is reasonable to hypothesise that previous undergraduate training may have included an introduction to talking therapy models. This contrasts with the predominantly biomedically focused education currently provided in nurse training institutions. According to Prebble, (2001) "…psychiatric mental health nursing is a distinct scope of practice which requires specialty undergraduate preparation" (p. 136). This perspective was acknowledged in the *Strategic Review of Undergraduate Nursing Education, Health and Community Services* report to the Nursing Council of New Zealand which included recommendations for changes to be implemented by 2010 pertaining to the preparation for mental health nursing in undergraduate nursing education (KPMG Consulting: Reach Further, 2001). The need to include training in psychotherapeutic treatment models and the theoretical learning to support development of knowledge and skills to work with people with complex health needs has been restated in subsequent publications (Ministry of Health, 2005a; 2006a). Nursing undergraduate education is currently under review but the outcomes of this process

are not known at this point. Happell and Plantania-Phung (2005) raise similar issues for undergraduate nursing training programmes in Australia.

The findings from this study suggest that students in undergraduate nursing programmes might benefit from the provision of training in foundational skills in talking therapies. Inclusion of skills in talking therapies would provide for a more holistic approach to generic nursing practice and improve preparation for nursing in mental health. Best practice competencies and pre-registration capabilities for mental health nursing in the United Kingdom (Department of Health UK, 2006) includes competencies to ensure nursing students gain knowledge in "evidence based psychosocial interventions such as cognitive behavioural therapy, behavioural activation, relapse prevention, and psychosocial interventions that enable people to recover from mental distress…" (p. 15). Although the structure of nurse training in the United Kingdom is different to that in New Zealand, the measures taken to improve skills in talking therapies are noteworthy.

Workforce development initiatives in New Zealand for example; *Let's Get Real: Real skills for people working in mental health and addictions* (Ministry of Health, 2007) and the proposed framework for talking therapy training for health professionals (Peters, 2007a; 2007b), are linked to a proposed National Training Plan (Peters, 2007a). These initiatives provide for skill development for new and postgraduate nurses. Development plans to include undergraduate nursing students in talking therapy training programmes may also be included in the proposed National Training Plan. Details of the development plan have not been published.

Knowledge of Talking Therapy that is applicable to the participant's clinical setting

Nurses in this study emphasised that their knowledge of talking therapies enabled them to work effectively in their clinical setting, including work with consumers, families / whanau and as appropriate in the management and supervision of staff. This finding is consistent with research conducted by Gournay, et al. (2000) in the United Kingdom, who evaluated 25-years of nurse training in behavioural psychotherapy. Gournay et al. identified that nurses following training, maintained a commitment to using skills in CBT in practice and applied their knowledge in other areas such as supervision and the management of staff. The Gournay et al. study has been previously described in Chapter Three. In the current

study, the nurses in the interview group had extensive knowledge of a variety of talking therapies, and without exception, all had accessed additional training depending on the direction of their clinical work. From this it could be assumed that baseline training and the maintenance of knowledge appropriate to the clinical setting provided an incentive to continue professional development and access further training. This notion would be worthy of further research. A direction for future research could include elements of the following question; do nurses in New Zealand consider the use of talking therapy models contribute to advanced nursing practice and professional development in their clinical area? Research undertaken in Australia and the United Kingdom previously discussed in Chapter Three identified that talking therapy training positively influenced nursing practice and professional development in both inpatient and community clinical areas (eg: Donoghue et al., 2004; Gournay et al., 2000; Oakes et al., 2002).

MI and CBT could be considered foundational baseline knowledge talking therapy skills as it appears from the findings in this study that both these therapies were the most common form of talking therapy training (Refer to Table 2: p. 65). This finding was also evident within the group of nurses who participated in interviews with the researcher (Refer to Table 6: p. 72). Without further research using a larger sample this result cannot be generalized to all nurses with talking therapy training. Curran and Brooker (2007) in a systematic review that included 52 Randomised Control Trial (RCT) studies undertaken in the United Kingdom evaluated the interventions utilised by mental health nurses. CBT followed by "…problem solving / brief psychological therapy and education" was identified as the dominant psychological intervention carried out by nurses (Curran & Brooker, 2007, p. 503). Britt et al. (2003) suggest that CBT and MI are closely aligned, a comment that would support the finding in this study that a number of nurses had completed training in both of these talking therapies. MI and CBT are well supported in literature as evidence based therapies although Munro, Baker, and Playle (2005) highlight that little is known about the use of CBT in inpatient areas. In New Zealand, little is known about CBT as a culturally appropriate intervention for Maori and Pacific people with a mental illness. (Kazantzis, 2006; Peters, 2007a, 2007b). This study could not provide any information to address these concerns as only one respondent to the research questionnaire

identified as being Maori and unfortunately this respondent did not identify that they had specific training in talking therapies.

Although knowledge and skills in talking therapies are relevant to all areas of mental health nursing the findings of this study suggest that fewer nurses from inpatient areas than community teams have attended training to develop skills in talking therapies. In this study, only 44% of nurses from acute inpatient areas identified that they had talking therapy training in comparison to 64% of nurses in community mental health areas (Refer to Table 4: p. 68; & Table 5: p.69). This is of concern when inpatient clinical areas have been identified as challenging to work in for staff and equally challenging to be admitted into, according to the stories of consumers and their families/whanau (Mental Health Commission, 2006). Importantly, most strategic recommendations for service delivery changes over the last decade have included the recommendation to facilitate increased access to psychological interventions; inpatient areas are not exempt from this recommendation. It is documented in Australian and New Zealand research literature that major changes in service delivery models have included a changed treatment focus in acute inpatient units to provide crisis assessment and "…short-term intensive management as part of a continuum of care for people who are unable to be treated adequately in community settings" (Cleary, 2004, p. 53). Cleary (2004) used an ethnographic study to understand how Australian nurses' construct their practice in an acute inpatient unit in response to service reform and change. The unit described by Cleary was not dissimilar to many acute services in New Zealand. Cleary notes the demands and challenges faced by staff in a changing service delivery environment, working with consumers that are acutely unwell and have complex needs, and from a staffing perspective, the reality of recruitment and retention difficulties.

The changed service delivery models and the implications for nursing practice has been the subject of extensive research (eg: Cleary, 2004; Cleary, Edwards, & Meehan, 1999; Fourie, McDonald, Connor, & Bartlett, 2005; O' Brien, 1999). In line with service delivery changes nurses are challenged to articulate and progress new models of care appropriate to nursing practice in acute inpatient areas (Cleary, 2004) and utilise interventions that meet the needs of service users (Rydon, 2005). However, elements of mental health nursing practice have remained central to nursing practice. For example, the

centrality of the therapeutic relationship and use of interpersonal skills in inpatient mental health nursing practice (eg: Fourie et al., 2005; O' Brien, 1999, 2001; Rydon, 2005). Cleary (2004) states that to effectively manage crisis assessment and short-term interventions a range of knowledge and skill to support the effective use of interpersonal skills was required. From international research, the author identified that "training, experience and aptitude are necessary to acquire such skills…" (Cleary, 2004, p. 57).

The recognition that training and experience is necessary to effectively embed interpersonal skills in acute inpatient areas is important. Of concern, one respondent to the survey questionnaire in this study commented that training in talking therapies in inpatient areas was unlikely to be considered a service priority. Peters (2007a) discovered that this attitude was prevalent in mental health services in New Zealand, but did not clarify whether her finding stemmed from inpatient or community areas. Although the majority of nurses in this study identified that they used talking therapies frequently in their practice, some nurses in response to the survey questionnaire answered, "never". This response is of major concern. More education that clearly establishes the link between skills in talking therapies to formal standards for mental health nursing practice is required. However, it is also imperative that training initiatives are devised with careful consideration of the specific training and educational requirements for nurses working in acute inpatient environments. Research conducted in the United Kingdom supports this view (eg: Bee, Richards et al., 2005; Ewers et al., 2001).

Research worldwide has identified that education and training for staff in inpatient areas presents challenges and also highlights that training does not necessarily equate to changed practice, particularly if organisational structures and processes remain unaltered. Qualitative research conducted in the United Kingdom by Bee, Richards et al. (2005), also reported on by Bee, Baker et al. (2005), reports similar challenges to those faced in New Zealand to provide effective training for staff in inpatient clinical areas. Bee, Richards et al. (2005) recommend that firstly education and training initiatives must occur in conjunction with sustainable organisational change processes to enable the integration of knowledge and skills from training into practice. Secondly, that exercises in the process to facilitate organisational change need to be included in educational and training initiatives with the involvement of management and clinical leaders to enable sustainable effective change.

Key outcomes following training inpatient staff in the use of Psychosocial Interventions from a study conducted by McCann and Bowers (2005) in the United Kingdom included, that effective leadership and management structures and sufficient, stable staffing on the ward were essential to support effective practice and professional development in an inpatient ward. The Bee, Richards et al. (2005) and McCann and Bowers (2005) studies have been described in Chapter Three of this study.

Sustainable training in talking therapies in New Zealand has been considered a priority (Peters, 2007a, 2007b) but the workforce development project described by Peters will require a planned approach. Firstly, it is important to ensure that training provision for inpatient nursing staff meets their specific needs and is delivered in such a way that it maximizes opportunities for attendance. The ability to access training is always a contentious issue for staff from inpatient areas. In this study, organisational process that presented as barriers to accessing training and/or refresher training from an inpatient nursing perspective included; the acuity and intensity of the inpatient ward environment, shift work, staff shortages compounded by recruitment and retention issues, accessing funding and being accorded appropriate study leave. A comparison was also drawn between the resources and funding available to other disciplines to attend training in comparison to that available to nurses. Although these observations were made from nurses now working in community areas, their previous extensive experience in inpatient nursing contributed to their views.

Secondly, that talking therapies skills for nurses in inpatient areas become embedded in culture and practice, particularly as it would appear from this study that there is a knowledge deficit pertaining to talking therapies in inpatient clinical areas, where such skills are currently needed most. In this study, only 11 nurses from inpatient areas identified that they had talking therapy training and of these nurses, none met the inclusion criteria of “duration of training and depth and breadth of experience” to meet with the researcher for an interview (Refer to Figure 2: p. 66). As previously discussed, inpatient areas provide crisis management for people with potentially complex needs which also require nursing input based on knowledge and skills gained through talking therapy training (Bee, Richards et al., 2005). This was also identified in an earlier Australian study undertaken by Cleary et al. (1999) who found that nurses in inpatient areas require “ training, education and clinical

supervision to increase confidence and competence in the delivery of psychotherapy and counselling interventions". Crowe and Luty (2005) also promote the need for organisational change to ensure that nurses are able to access training in evidence-based Interpersonal Psychotherapy skills and implement their knowledge and skill into clinical practice.

Knowledge that supports evidence-based practice

Individual talking therapy models are underpinned by research that establishes their use as an evidence-based treatment approach for mental illness. The nurses in this study reiterated the importance of the link between theory, research and practice. Nurses' knowledge of the theoretical underpinnings, key concepts and practical application of the therapies informed the use of their skills in nursing practice. Their selection of the most appropriate talking therapy model for each clinical situation supports evidence-based treatment for consumers. This finding restates the importance that talking therapy training, or more specifically, training in the individual psychotherapeutic treatment models, includes all aspects relevant to the theoretical, practical and evidential dimensions of the therapy. This is important because nurses in this study described, from their point of view, practice based on research. Evidence-based treatment interventions for mental illnesses have been reviewed in Chapter Two of this study and in Chapter Three the relevance of talking therapies to mental health nursing practice is established from studies conducted predominantly in the United Kingdom. The importance of studies such as that conducted by Crowe and Luty (2005) in New Zealand described earlier, provides firm evidence of the value of Interpersonal Therapy (IPT) in nursing practice. However there appears to be a limited body of research literature from New Zealand for nurses to refer to inform the use of talking therapies in practice.

From previously reviewed research, there would appear to be evidential support for the use of Psychosocial Interventions, systems therapies, and therapies that are incorporated within the cognitive-behavioural–action oriented interventions in nursing practice. However, some nurses in this study also routinely used TA, Gestalt Therapy, Psychodrama, Interactive Drawing Therapy (IDT) and Child and Adolescent Psychotherapy. Although these therapies were comprehensively described in the literature review to inform this study, the link between TA, Gestalt Therapy, Psychodrama, IDT and Child and Adolescent Psychotherapy and nursing practice was more difficult to establish. I could not find nursing

research literature that described nurses' views on their training, knowledge and use of these talking therapy models in clinical practice. The findings from this study established that some nurses had knowledge and extensive training in these particular talking therapies and valued the integration of their skills into mental health nursing practice.

Skill Acquisition

The following section will discuss the important themes that were identified by nurses under the major theme heading, "Skill Acquisition". In this study, skill acquisition encompasses nurses' identification of what they considered to be important about how their training in talking therapies was acquired, including specific training strategies that they have found helpful such as supervision and access to refresher training. Research pertaining to training and skill acquisition is frequently measured within a defined time frame, at the time of course delivery, or soon after completion, often using formal quantitative pre and post test measures of skill acquisition. Self-report evaluations are considered an inexact measure because of the subjective nature and potential biased view that may emerge (Milne, Keegan, Westerman, & Dudley, 2000; Myles & Milne, 2004). However, this study has been guided by a qualitative descriptive research methodology so as to enable self-report evaluation as the preferred measure for nurses' perception of skill acquisition. The views presented in this study have been informed by a 'depth and breadth' of training and knowledge of talking therapies that includes four to eight years of experiential learning, formal training and up to thirty years of clinical experience. This provides for a rich source of information with which to support nurses' views of skill acquisition in contrast to structured evaluation measures that capture skill acquisition limited to immediately post training.

The construction of training courses needs to be clinically relevant to nursing and the individual

Discussion pertaining to the construction of training courses is unlikely to be news to education providers. However, in this study nurses stated that they valued the effort required on the part of training providers to ensure that courses were well structured so that training courses in talking therapies were clinically relevant and congruent with nursing practice in mental health services. A realistic interface between the training environment and the practice setting was considered important as this enabled trialing new skills in

practice and an opportunity for skills to be used, critiqued and subsequently brought back to the training environment for refinement and reflection with colleagues and tutors. This aspect identifies the benefits of training occurring in tandem with practice, in contrast to training as an isolated event, the nurses in this study termed it as maintaining "congruency' between training and clinical practice. This finding is consistent with research from Australia (eg: Allen et al. , 2000; Donoghue et al., 2004; Hafner et al. , 1996), Ireland (Ryan et al., 2005) and the United Kingdom (eg: Ashworth et al., 1999; Bee, Richards et al., 2005; Ewers et al., 2001) previously reviewed in Chapter Three.

The construction of courses also infers that attention has been paid to all the relevant aspects pertinent to the effective integration of talking therapies skills in practice. For this to be achieved, courses need to include theoretical and practical dimensions to learning. If this has not been the focus of course content, the nurses in this study considered that there was a potential that the "…intrinsic factors…" or fundamental central tenets pertaining to the specific talking therapy model could be lost. This could occur without full consideration being given to the risk this action could pose in particular to the efficacy of the talking therapy intervention for consumers. Although learning from colleagues talking therapy experience and role modeling their skills in practice provides for one form of learning, the findings from this study confirm the benefits of a commitment to training to support appropriate skill acquisition.

Learning strategies

Effective learning strategies are well represented in educational research literature, and the findings from this study are not controversial. Interactive, experiential and participatory learning strategies were all considered invaluable to embed new knowledge from training in talking therapies into practice. A variety of learning tools such as group work, video recording and feedback and role-plays were considered helpful. Despite the challenges associated with interactive learning, the nurses' valued the opportunity to practice new skills in the group setting and receive feedback from fellow trainees and the tutors. However, for this study, an important aspect to the theme "learning strategies" was that nurses identified that learning takes time. A parallel was drawn between consumers' stories that have identified that illnesses take time to evolve, with a life time commitment required on the recovery journey. Equally, the nurses in this study considered that training in talking

therapies required a long term commitment to ongoing learning and professional development. Therefore, it is important that objectives for the provision of training in talking therapies are clearly defined at the outset. Brief training may equate to effectively establishing foundational skills (eg: Hafner et al., 1996; Milne et al., 2000), but contrasts to the level of skill acquisition represented by the interviewees in this study with a 'breadth and depth' of knowledge gained over many years.

Supervision and refresher training

Continued practice development, access to refresher training and the provision of appropriate supervision were all considered integral to effective skill acquisition. These findings are consistent with other research studies evaluating talking therapy training (eg: Allen et al., 2000; Bradshaw et al., 2007; Gournay et al., 2000). Additionally, because of the nature of the talking therapy and ongoing training and use of the specific therapy in routine practice, notably, Gestalt, Psychodrama and TA, the findings from this study highlight that it was considered important to receive supervision appropriate to the model of therapy.

Skill Transfer

In this study skill transfer has been considered from two perspectives. Firstly, nurses' views on how they evidenced the use of talking therapies in clinical practice. Nurses related this to the practical use of their skills for working effectively with consumers and how the use of talking therapy skills linked to holistic nursing practice. Secondly, nurses' perception of what helps or hinders the integration of knowledge and skills in talking therapies gained from training into clinical practice.

Evidence of skills in talking therapies in mental health nursing practice

Routine mental health nursing practice includes crisis assessment, mental state assessment, risk assessment, observation, de-escalation, and therapeutic interventions with consumers, families/whanau. The nurses in this study confirmed that their practice included all of these fundamental nursing interventions. However they elaborated on how they use specific talking therapy models. For example; the application of systems therapeutic models to conduct a full assessment of the consumer, their family members and the wider relationships considered important by the consumer. Skills in psychodrama were described

by detailing the elements of theoretical and practical knowledge that informed group work. All of the nurses in this study believed that their talking therapy knowledge and skills remained the focus of their clinical practice. They emphasised that whether they were engaged in the use of talking therapies within a long term psychodynamic framework or using short-term interventions such as CBT, that the way they worked with consumers was evidence of their knowledge of talking therapy skills in practice. For some nurses, skills in TA, Gestalt and Psychodrama also contributed to leadership and managerial roles, and to the provision of clinical supervision for other staff. This finding is consistent with research previous discussed in Chapter Three (Allen et al., 2000; Gournay et al., 2000; Neela et al., 2007). However, Ryan et al. (2005) found that although some nurses no longer considered that behavioural therapy skills from training remained the focus of their work, their skills contributed to professional development and were valued at a managerial level.

Holistic nursing practice was considered a valued and important dimension to evidence of talking therapies in practice. Holistic nursing practice included all dimensions of physical and mental state assessments assessment, but also extended to the use of specific talking therapy interventions such as Family Therapy with consumers, their families/whanau and friends. Knowing what to do and how to progress in any given situation was informed by experience and expert knowledge of the most appropriate therapeutic intervention. Understanding the theoretical, and practical dimensions of talking therapies was evidenced through the use of the most appropriate talking therapy intervention with practice informed by a range of options. This finding reiterates the importance of foundational training, with further training in talking therapies informed by the needs of consumers and families in the treatment setting. Holistic practice was also extended to include collaborative team work with colleagues and to ensure that issues can be addressed in a safe and appropriate manner.

What helps the integration of talking therapies into nursing practice

Positive peer, collegial and team attitudes towards talking therapy skills and training were considered to be important dimensions that influenced the successful integration of skills in talking therapies into practice. The opportunity to share knowledge and skills through role modeling, teaching and learning from each other in the clinical setting emphasised the important influence that a collaborative well informed approach adds to the learning and

professional development opportunities for nurses. Nurses in this study identified that supportive organisational structures and processes at all levels including, the role of line manager and service managers, positively affected the integration of talking therapy skills into practice with the added benefits of positive interpersonal relationships between colleagues and team members.

The support for training in what could be considered a mainstream talking therapy model such as CBT, MI or DBT was contrasted with other therapeutic talking therapy models where nurses in this study considered that the level of assistance for financial support and study leave was less accessible. It was also made abundantly clear that for nurses who were working in community treatment settings, accessing training and professional development was considerably easier, and therefore advantageous for the integration of skills in talking therapies into clinical practice. Conversely, working in inpatient areas was considered a barrier to accessing training and professional development. Each of the participants in the interviews for this study had experienced working in inpatient clinical areas and expressed their concern for colleagues in these areas and the barriers that they would undoubtedly be experiencing.

Although individual aspects relevant to the overarching theme of what helps the integration of talking therapy skills into practice are unique to this study, the findings are consistent within the body of research relevant to nurses training in talking therapies.

What hinders the integration of talking therapies into nursing practice

Nurses in this study believed that without effective team leadership, including a positive means to influence culture and practice specifically in inpatient areas; without well structured organisational processes for the implementation and evaluation of outcomes from training; without adequate support to cover the costs of training and study leave, that the successful integration of skills in talking therapies into practice would be severely hindered. These findings are consistent with research discussed in Chapter Three (eg: Brooker et al., 2003; Crowe & Luty, 2005; Fadden, 1997; McCann & Bowers, 2005). The Brooker et al (2003) study specifically sought to identify and prioritise barriers that inhibited the effective implementation of skills following training in Psychosocial Interventions into practice. Input from managers identified solutions.

The reflections and observations of nurses involved in this study also included noting the challenges faced by nurses coming into the clinical environment with fresh ideas. These concerns applied to both new graduates or experienced registered nurses with new knowledge and therapeutic skills gained from training returning to either an inpatient or community clinical environment. Education and training in isolation without adequate support inhibited the successful integration of talking therapy skills into practice and unfortunately increased the potential for horizontal violence from colleagues. This negative experience was described as the being "…scapegoated…or seen to be above your station" which involved experiencing a range of overt and covert behaviours that actively disrupted the integration of new skills into clinical practice.

Concerns about inpatient clinical areas fall into two sub-themes that were, inevitably also interrelated. Firstly, concerns relevant to clinical practice and secondly, concerns related to ward based organisational processes. One nurse clearly described how the utilisation of skills in talking therapies in an acute inpatient unit was actively discouraged by colleagues and inhibited through ward processes. Bartholomew and Collier (2002) suggest that successful implementation of research-based nursing interventions in inpatient areas, requires supportive team based, managerial and organisational attitudes and processes. The authors also commented that factors that inhibit the implementation of research based skills into practice particularly in inpatient areas, includes resources and "resistance to change" (Bartholomew & Collier, 2002, p. 879). McCann and Bowers (2005) add that unstable and insufficient staffing also represents a barrier. This staffing limitation and the impact of shift work were also noted by nurses as a hindrance in this study.

The effect of differing clinical perspectives between nurses, the impact when some staff were not well informed about the theoretical and practical aspects involved in the talking therapy model being used, were described as a frustrating experience for the nurse as the therapist, and extremely detrimental to consumers and their recovery. The effect on practice of ward acuity, and the stress of a busy inpatient clinical environment were also described as barriers that also impacted on nurses adhering to plans to attend training and clinical supervision. Words to describe this such as "…band aiding and burnout…no one knows how to take care of themselves…they don't have time to draw breath… No one is breathing" present real barriers for accessing training let alone the integration of skills in

talking therapies in to nursing practice. Further research to explore the most efficacious talking therapies for use in an inpatient clinical environment would be an advantage, with full consideration given to the barriers noted by nurses in this study that hinder the integration of talking therapies into clinical practice in an inpatient environment.

Finally, it was also perceived that health professionals from other disciplines were advantaged by readily available access to financial and study leave support mechanisms in contrast to that available for nurses. Discipline specific limitations to professional development are of concern, particularly as it has been previously noted that nurses are a large and important group within mental health service delivery. At a service level, nurses noted the highly visible tension between workplace commitments, the constant issues relevant to resourcing and educational needs. Nurses within the mental health services in New Zealand are under increasing pressure to provide more services within strict budgetary limitations.

Discussion: Minor Themes

Theme 1: CBT in Nursing Practice

The use of CBT in mental health treatment interventions is currently the focus of attention in workforce development strategies (Peters, 2007a, 2007b). Nurses in this study considered that it was important that the choice to use CBT as a treatment intervention was guided by needs of the consumer. Maintaining an integrated approach for the use of talking therapy skills was deemed to be vital to support a recovery focused therapeutic partnership with consumers.

Evaluation of the Methodology

The use of a qualitative descriptive research methodology for this study enabled the exploration of what nurses considered important about their knowledge of talking therapies and what they considered helped or hindered the integration of their skills in talking therapies into clinical practice. Furthermore, this study has been conducted in the clinical practice setting and therefore aligns research with the reality of nursing based evidence for the use of talking therapies in clinical practice.

Study Limitations

This study had a number of overall and specific limitations. The overall limitations included the issues associated with time constraints imposed by an academic time-line to meet the requirements for a Masters Degree. For example, I would have had more time to fully appraise all the relevant research for the literature review to further inform the development of the questionnaire for this study. The ethical approval processes required the submission of all the documents associated with this study before I was able to refine the content of the documents further. Although there was a large body of research literature pertaining to nurse training in talking therapies available from the United Kingdom, including some from Australia there would appear to be few research studies published in New Zealand. In addition, I could not find research pertaining to nurses' views on using longer-term talking therapy models, for example TA, Gestalt and Psychodrama.

Talking therapy training and skills may be relevant to all health disciplines involved in mental health services however the scope of this study was limited to talking therapies in nursing practice and therefore only nursing literature was utilised to inform this study. Although the use of interdisciplinary literature may have strengthened the argument for education and practice development in psychological interventions for all health disciplines this argument was beyond the scope of this study.

More research from New Zealand would have assisted with developing a clearer focus for this study and provided relevant information for current national workforce development projects. Furthermore, I found that the term talking therapies did not identify the literature most relevant to this study. I used the term psychological interventions interchangeably with the term talking therapies. I now believe that this study would have been better entitled; "nurses' knowledge and views on psychological interventions in clinical practice" as this would have been more accurate.

Specific limitations to this study are associated predominantly with the data collection processes. Although I intended to use a qualitative descriptive research methodology for this study as the preferred data collection process a mixed methods research methodology would have expanded the parameters of the study. The sampling process highlighted some important limitations. The survey questionnaire data collection

process was structured to identify respondents that had completed training within the last ten years. This limitation, although not strictly adhered to by some respondents, may have lost a potential link to establishing that more training was available to nurses in talking therapies during and prior to the 1980s (Refer to Figure 1: p. 64). The results would indicate that this was in fact the case. Additionally, the qualitative data collection was limited to nurses that identified 'depth and breadth' of knowledge and training in talking therapies. If new graduates or respondents with brief introductory training to talking therapies had been added using a comparative study methodology, and a larger sample, this may have contributed an important additional dimension to this study.

Responses to the survey questionnaire specific to Question Five that sought to identify that if nurses had not had training in talking therapies, would they wish to access training, if it was made available, was misinterpreted by most respondents. Nurses that had training also answered this question, using the opportunity to identify their wish for update training. However, this clouded the potential for an accurate response to the question.

Although the Interview Guide for Participants (Refer to Appendix 1D, p.123) for the semi-structured interview provided a framework for conducting the interviews, unfortunately I was not consistent enough in my questioning to ensure that all respondents were asked exactly the same questions in a similar manner. However, I was influenced by the desire to capture what participants considered to be important and not to impose my ideas and potential bias on the interview process.

Cultural advice sought prior to this study included a recommendation to identify ethnicity and specifically seek Maori respondents' knowledge and experience of talking therapies if possible. As only one person identified as Maori, and acknowledged that they did not have formal training in talking therapies the question could not be answered with data from this study.

Finally, this study was small and used a geographically contained sample which although useful from a local point of view, has limitations. The findings of this study cannot be considered representative of all the registered nurses in the DHB as not all registered nurses in the DHB participated in this study. Furthermore, the findings cannot be generalized to other DHBs in New Zealand without further research.

Conclusions

The primary focus of this study was to explore nurses' knowledge and views of talking therapies in clinical practice and what might help or hinder the integration of their skills in talking therapies into routine clinical practice. The conclusions from this study have been drawn from the key themes identified from the headings knowledge views, skill acquisition and skill transfer that have provided consistency throughout the research process.

Nurses' believe that their knowledge of evidence-based talking therapies is not an adjunct to other knowledge that informs mental health nursing practice. Instead, for nurses who use their talking therapies in routine practice, talking therapies are considered integral to practice and are important to maintain professional credibility. A sincere personal commitment to training and professional development that spanned many years has built a foundation for mental health nursing practice on a 'depth and breadth' of knowledge and skill that is invaluable.

Conversely, this study also exposed a number of knowledge gaps that would benefit from attention through proactive intervention and further research. Younger nurses, potentially new graduates or nurses with limited post graduate experience are required to work with people with complex mental health needs with very limited or no knowledge or training in psychotherapeutic talking therapy skills. Further research to clearly identify the needs for this group of nurses is essential.

Nurses' believed that their talking therapy training, knowledge and skill needed to be applicable to their clinical area. This enabled them to work effectively with consumers and families/whanau. Unfortunately some nurses from inpatient clinical areas may be disadvantaged in accessing training and professional development pertaining to talking therapy skills. Sustainable measures at a managerial, organisational and workforce development level are considered imperative to address this difficulty. The issues exposed in this study are not peculiar to New Zealand, but for a sustainable outcome, solutions need to be consistent with current national strategic directions for mental health services in New Zealand.

Nurses' identified that talking therapy training courses need to be clinically relevant and that some learning strategies were advantageous. Well structured courses, with clearly

defined objectives, and training that is clinically relevant and congruent with nursing practice in mental health is important. Furthermore, the nurses in this study believed that training in talking therapies required a long term commitment to ongoing learning and professional development. To embed talking therapy skills into practice takes time.

Finally, New Zealand has a unique opportunity to develop a national strategic framework to progress training and professional development for health professionals in talking therapies. Nurses have an important contribution to make. Nurses therefore have an opportunity to clearly align their knowledge and skill with the foundational, historical and theoretical underpinnings of mental health nursing to current *Standards of Practice for Mental Health Nursing in New Zealand* (Te Ao Maramatanga: New Zealand College of Mental Health Nurses Inc, 2004) in a unique step to affirm competence in talking therapies as a nursing intervention.

Recommendations

The following recommendations have implications for mental health nursing practice, education and research. Further research is recommended as follows;

Mental health nursing practice

That further research is conducted using the term psychological interventions in contrast to the term used for this study ‘talking therapies’. Further research is conducted with a larger sample of nurses to validate the findings of this study. This could confirm the value of psychological interventions for advanced nursing practice and professional development in mental health nursing.

Research into mental health nurses training in long-term psychological models, for example; TA, Gestalt and Psychodrama to affirm the use of these models in mental health nursing practice.

Conduct observational research that evaluates the transfer of talking therapy skills from training into practice. In particular differentiate between what nurses say they do and what can be observed in practice with consideration given to conscious and unconscious processes.

Research associated with education

Conduct a three step qualitative descriptive study in the use of psychological interventions and therapeutic communication skills in mental health nursing practice. The study would evaluate the perspectives of; new graduates, clinical leaders and nursing training providers.

Research the evidence for promoting CBT and MI as foundational training in talking therapies for mental health nurses.

APPENDIX 1A: RESEARCH INFORMATION SHEET

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RESEARCH INFORMATION SHEET

Research Project Title: Nurses knowledge and views on talking therapies in clinical practice

My name is Trudy Dent. I am a registered nurse, employed as a Clinical Nurse Specialist in Ward 1a of the Otago District Health Board (ODHB) Mental Health and Intellectual Disability Service. I am completing a Masters of Nursing (Clinical) through the Graduate School of Nursing, Midwifery & Health at the University of Victoria, Wellington.

Invitation to Participate

You are invited to participate in my research project. Please read this information guide carefully before deciding whether or not to participate. Participation is completely voluntary and if you decide to participate, thankyou. Please be aware that you are free to withdraw at any point without giving a reason and without any detriment to your employment.

If you decide not to participate I thank you for giving consideration to my request.

Introducing the Research Study

The purpose of my study is to explore nurses knowledge and views on talking therapies and the contribution of talking therapies to nursing practice. Talking therapies in this study refers to evidence-based psychological therapies used by nurses including Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT) and Motivational Interviewing (MI).

My interest in this project has come from experience in clinical practice where it would seem helpful to be able to utilise talking therapies as part of routine clinical practice. It is not my intention to advocate for one therapeutic intervention as being more effective than another. As the requirements for service delivery are constantly changing and evolving, so too should we as nurses consider a 'toolkit' approach to gaining skills in a variety of therapeutic interventions that support effective nursing practice.

Ethics Approval

- I have sought and gained ethical approval for this project from the Lower South Regional Ethics Committee and followed all the necessary ODHB policies and procedures to gain approval for this research.

Research Project Overview

The research project has two parts, Part A and Part B as described below:

Part A: Survey (Up to 280 participants)

All registered nurses of the ODHB Mental Health Service are invited to participate in this survey. The purpose of the survey is to estimate how many have attended training in talking therapies in the past 10 years and will take no longer than five minutes to complete.

- An envelope is provided for the return of the completed survey questionnaire.
- Please note that the return of the completed questionnaire is an indication of consent to participate in this part of the research project.

Part B: An Interview (Up to 8 participants)

I would like to meet with up to eight registered nurses to explore their views and knowledge of talking therapies and what helps or hinders the integration of talking therapies into routine clinical practice.

Because of the scope of my project I am only able to interview a maximum of eight people. Your reply to my invitation will be greatly appreciated. However if there are more than eight replies to my invitation I may not be able to proceed with an interview with you depending on the distribution of replies from the inpatient and community mental health service areas. Thank you for your consideration and reply.

- The interview will be audio taped and take approximately 45 minutes. We will mutually determine the location / time / date of the interview.

- Taking part in this part of the research project is entirely voluntary. If you choose to participate you have the right to withdraw at any point. I will be providing you with a consent form to sign before starting the interview.

- I will give you a copy of the questions prior to meeting for the interview so you have time to think about them. However you will be free to deviate from the prepared questions and introduce your views and perspective from your personal experience.

- The transcripts will be typed up word for word and utilised for data analysis. There will be an opportunity for you to read the transcript of your interview before the analysis and alter the recorded information.

Confidentiality and Safe Storage:

- The information that I receive from you will remain completely confidential. There will be no names on the tapes, questionnaires or transcripts, they will be coded and the master list stored securely.
- The survey questionnaires / interview tapes / transcripts will only be heard and seen by my supervisor and myself and a confidential transcribing typist.
- Participants will be offered the opportunity to see and comment on the written transcripts of their recorded interview, prior to the writing up of the research project.
- When the project is written up it may include quotes from within the transcript. This will be written in such a way that that does not link information to individual participants to protect anonymity and privacy
- When not being analysed all personal information (questionnaires, tapes, transcripts) will be stored securely in a locked cabinet in a locked office in the ODHB Mental Health Service

Publication:

- At the end of the research project I will be submitting a thesis to the Graduate School of Nursing, Midwifery and Health which will eventually be deposited in the University Library. It is intended to submit an article for publication in a scholarly journal. Data will be kept in a locked secure environment for five years following the completion of the project, after which it will be destroyed.

Contact Details:
If you have any further questions or would like additional information please contact:
Trudy Dent (03)4740999 ext 8951, (email: trudy.dent@otagodhb.govt.nz)

Research Supervisor:
Professor Jo Walton. Telephone Contact (04) 4636135 or (email: jo.walton@vuw.ac.nz)
Graduate School of Nursing, Midwifery & Health,
Victoria University of Wellington, PO Box 600.Wellington 6140.

APPENDIX 1B: SURVEY QUESTIONNAIRE

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Survey Number: _____

SURVEY QUESTIONNAIRE

Research Project Title

Nurses knowledge and views on talking therapies in clinical practice

Thank you for your participation in this research project. I am researching nurses' knowledge and views on talking therapies and what might help or hinder the integration of training into routine clinical practice.

Survey Instructions

This survey has two sections to it:

- Section 1: Seeks demographic information necessary to describe survey respondents.
- Section 2: Has questions relevant to training and your knowledge of talking therapies.

Please complete the survey questionnaire and return to me in the addressed envelope provided. Your consent to participate this research is assumed by the completion and return of the survey.

Please return the completed survey preferably by the 16th November to the following address:

Trudy Dent (Clinical Nurse Specialist).

c/o Ward 1a

ODHB Mental Health Service.

Dunedin

Section 1: DEMOGRAPHIC INFORMATION

Gender (Circle answer that applies) Male / Female

Current Age: _____

Please can you clarify which ethnic group you most identify with (Circle answer that applies)

NZ, NZ/European, Maori, Pacific Island, Asian, or other please state: _____

Section 2: Questions relevant to knowledge of talking therapies.

1 Have you attended training in talking therapies within the last ten years? (please circle the answer that applies) Yes / No

If the answer to question 1 is "No" please continue with questions 5 and 6 otherwise please complete the details in the table below and continue with questions 2 to 6.

	When? (year)	**Where? (Institution / Country)**	**Length of training (hours / days / years)**
Cognitive Behavioural Therapy			
Dialectical Behavioural Therapy			
Motivational Interviewing			
Other: please specify:			

2 Did you access specific supervision during your training in talking therapies? (Please comment or illustrate your answer)

_____

_____

_____

_____

3 What clinical setting do you currently work in? (Circle answer that applies) INPATIENT / CMHT / CAFMS /YSS / CADS / OTHER or Specify _____

4 If you have attended training in talking therapies, how often do you use it currently in your clinical practice?

- (Circle answer that applies) **Never / Occasionally / Often.**

5 If you have not been able to access training in talking therapies and if it was available would you consider attending?

- (Circle answer that applies) **Yes / No**

6 Do you have any other comments or anything you would like to add?

_____

_____

_____

_____

If you have attended training in talking therapies would you consider participating in an interview with the researcher?

If so please provide complete the details on the contact form provided (See next page)

Thank you for taking the time to complete this questionnaire.

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Contact Form to Participate in an Interview

For

Nurses knowledge and views on talking therapies in clinical practice

Having completed the survey questionnaire I am agreeable to participation in an interview with Trudy Dent on my experience with talking therapies in clinical practice. I understand that consent will be discussed and a form will be provided for signature at the time of the interview.

In order to arrange a suitable interview time / date my contact details are as follows:

Name: _____

Phone Number: _____

APPENDIX 1C: INTERVIEW CONSENT FORM

VICTORIA UNIVERSITY OF WELLINGTON

INTERVIEW CONSENT FORM

Research Project Title

Nurses knowledge and views on talking therapies in clinical practice.

Consent Information:

I have received the information sheet and understand the purpose of this research project. I have had an opportunity to ask questions and have had them answered to my satisfaction. I am aware that I can request further information at any stage. I understand that I may withdraw myself, or any information I have provided for this project (before data collection and before analysis is complete) without having to give reasons or without penalty of any sort.

I understand that any information I provide will be kept confidential by the researcher, the supervisor and the person who transcribes the tape recordings of our interview. I understand that the published results will not use my name and that no opinions will be attributable to me in any way or included in the results in any way that would enable me to be identified.

Consent Confirmation:

- ☐ I understand that my participation in this research project is entirely voluntary. I am aware that I can withdraw at any point without giving a reason and without any detriment to my employment.
- ☐ I agree to meeting with the researcher for the purpose of a semi-structured interview, the content of which will be recorded.
- ☐ I understand that I will have an opportunity to check the transcripts of the interview before publication.
- ☐ I understand that the data I provide will not be used for any other purpose than described in the information guide, or released to others without my written consent.
- ☐ I would like to receive a summary of the results of this research when it is completed.
- ☐ By placing my signature on this form I agree to participate in this research project.

_____ _____

(Signature of the participant) (Date)

Researcher contact details: Trudy Dent; Phone 4740999 ext 985, email: Trudy.Dent@otagodhb.govt.nz

Supervisor contact details; Professor Jo Walton; (04) 4636135, email: jo.walton@vuw.ac.nz

APPENDIX 1D: INFORMATION GUIDE FOR INTERVIEW PARTICIPANTS

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INFORMATION GUIDE FOR INTERVIEW PARTICIPANTS

Research Project Title

Nurses knowledge and views on talking therapies in clinical practice

Please confirm the talking therapy / therapies chosen for discussion in the course of this interview.

KNOWLEDGE VIEWS

What is important to you about your knowledge of talking therapies?

How does your knowledge of talking therapies contribute to your routine / daily clinical practice?

Do you think that using talking therapies is a valuable core skill in your routine clinical practice?

SKILL ACQUISITION

What was important to you about your training in talking therapies?

Do you have any thoughts on how you gained your skills in talking therapies?

What training strategies did you find helpful?

Have you any thoughts about the following factors?

Were your talking therapies training skills assessed? Did you receive a qualification?

Did you receive any particular support for your training? (e.g. financial, study leave)

Did you receive any form of supervision during your training / following your training?

SKILL TRANSFER

What helps or hinders the use of talking therapies in your routine clinical practice?

How do you use your skills in talking therapies in your clinical practice?

Do your colleagues value the use of talking therapies? (peer support?)

GENERAL QUESTIONS

Have you any other views / thoughts / experiences that you think are important?

Are you aware of any policies / plans your employer might have for training in talking therapies?

Are there any other questions that you would like to discuss?

APPENDIX 1E: CONFIDENTIALITY AGREEMENT FOR THE TRANSCRIBER

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Confidentiality Agreement For The Transcriber

Of

The Research Study Entitled

Nurses knowledge and views on talking therapies in clinical practice.

Researcher: Trudy Dent

I have read the information sheet outlining this study. I have discussed with the researcher the nature of the research and have had any questions that I have had answered to my satisfaction. My role as the research transcriber has been outlined to me by the researcher.

At all times the research information (tapes and transcripts) will be inaccessible to other persons. The researcher has assured me that she will debrief me following transcribing to address any issues that transcribing may bring up for me.

Most importantly, I understand and agree to keep the information I hear and type in the course of transcribing confidential to the researcher and myself. I understand that this requirement is life-long and extends beyond my involvement in the project.

Full Name:_____

Signature**:**_____

Date:_____

Researcher's Signature:_____

Date:_____

APPENDIX 1F: ETHICS APPROVAL LETTER

10 October 2007
Trudy DentWard 1a247 Helensburgh RdDunedin

Dear Trudy,
Project Key: LRS/07/14/EXP

Full Title: Nurses knowledge and views in talking therapies in clinical practice.

Investigators: Trudy Dent

Localities: Ward 1, ODHB Mental Health and Intellectual Disability Service.

The above study has been given ethical approval by **Deputy Chairperson** of the Lower South Regional Ethics Committee.

Approved Documents

Information sheet and consent form version 1 dated 8 October 2007

Final Report

The study is approved until **30 June 2008**. A final report is required at the end of the study and a report form to assist with this is available at http://www.newhealth.govt.nz/ethicscommittees. If the study will not be completed as advised, please forward a report form and an application for extension of ethical approval one month before the above date.

Amendments

It is also a condition of approval that the Committee is advised if the study does not commence, or is altered in any way, including all documentation e.g. advertisements, letters to prospective participants.

Please quote the above ethics committee reference number in all correspondence.
It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. The organisation may specify their own processes regarding notification or approval.

Yours Sincerely,

Riria Tautau-Grant
Ethics Committee Administrator
Lower South Regional Ethics Committee
email: riria_tautau-grant@moh.govt.nz

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