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Narratives of mental health nursing in the emergency department

Abstract:

The telling, listening to, and re-telling of stories is a fundamental human activity. In the mental health context, storytelling can take on another layer of meaning, when clinicians begin to be more conscious of the stories they hear, recall these, and then re-tell them to their clients and carers. This process has many benefits. It helps to clarify communication between someone who may not be very trusting, with another who may not fully understand; and it can reconnect mental health clinicians with a deeply embedded cultural value that can be overwhelmed by the bio-medical approach – professional empathy. This article argues that the conscious use of re-storying, an aspect of Story Theory, can extend mental health nursing practice, deepening the quality of the interpersonal relationship so that the patient, family and nurse can mutually achieve greater understanding of needs and goals, and transform a crisis into a turning point. This suggests that stories shared, reflected upon and re-storied are not only relevant in creative practice terms, but can also contribute to health and wellbeing.

Biographical notes:

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Introduction

Emergency departments are busy places, where very sick people, with critical physical and or mental health issues are triaged and cared for in priority. It can be a frustrating, and distressing, wait for patients and families. Clinical staff are also under pressure to accurately and efficiently assess and treat patients, and to organise referrals and transfers that comply with strict policies. In 2012–13, there were an estimated 276,300 presentations to Australian emergency departments with a mental health-related primary diagnosis (Australian Institute of Health and Wellbeing 2015). In addition to the task of assessing patients efficiently, and maintaining a safe environment for all of the clientele, specialised mental health clinicians are also aiming to establish rapport with patients who may be ambivalent, reluctant, or even angry about being brought to a hospital.

The earliest theory describing the role of the mental health nurse emphasised the importance of establishing a positive nurse-patient relationship (Peplau 1952), and this complex interweaving of values and skills remains fundamental and usually implicit, to the role. Hildegard Peplau explained that in order to ensure that the relationship is therapeutic, there needs to be a common goal between nurse and patient, and that the onus is on the nurse to facilitate learning and growth by flexibly and subtly adjusting their input according to the patient's needs. So a nurse may sometimes be a stranger, offering simple courtesy, acceptance and respect; or a resource person, offering information; a teacher, a leader and even at times a surrogate friend, parent or sibling. By attending to the interpersonal relationship, a patient may begin to trust, connect, let down their defences and feel less anxious and out of control. In facilitating this openness towards self-revelation and change, a mental health nurse is also gathering information about thoughts, mood and behaviour in order to rule in or out particular mental illnesses. Thus, when mental health nurses are in practice, they are multi-tasking.

It is also a reality within the emergency department, for nurses to be pulled in many directions. Whilst aiming to establish rapport with one patient, give space to another, to assess, diagnose, educate, support and transfer, clinicians may not always get it right. One memorable evening is a case in point. The interpersonal relationship suffered because a common goal was not identified. The patient, family and their shared story were not given appropriate attention, and the limitations of hegemonic practice were exposed. The purpose of this article is to explore the story of that memorable evening from various points of view and to draw on Story Theory in order to more fully understand what went wrong, how missteps were corrected, and the benefits of re-storying as a fundamental skill for facilitating change in mental health nursing.

A busy shift

It was a typical night in the emergency department. The unit was busy, and I[1] was feeling pulled in multiple different directions, with not enough time to do it all. I received another referral from the triage desk; a man, I'll call him John, stated that he

was depressed and was having suicidal thoughts. With him was his upbeat wife, Irene. Irene had brought John to the hospital.

I greeted them both with a smile and a handshake as I called them from the waiting room. As was usual, I gave my apologies for the wait that was beyond my control, and ushered them towards the interview room. John didn't say much, rather, just stared melancholically at the other wall of the room. Irene, on the other hand, was quite talkative. She spoke clearly in a positive and buoyant manner, with her body language portraying a woman who was confident and charismatic. She told me that John had been sleeping longer than usual over the past few weeks, he did not want to get out of bed in the morning and had a complete lacklustre view of everything. They had talked about his dark thoughts. Sometimes John told Irene that he didn't want to be alive anymore and couldn't see a point carrying on. Concerned, Irene had taken him to their local doctor, who prescribed antidepressants and referred him to a psychologist.

Irene remained hopeful and believed that he would soon recover, but instead, his mood continued to deteriorate. Overwhelmed one day by the bleakness of existence, John walked into a local dam intending to drown. Waist deep and facing his mortality, he pulled himself back. Later, John told his wife what he had done and, without hesitation, Irene brought him to hospital – certain that he needed more help than what she was able to give, and uncertain that she was able to keep him safe any longer.

As I listened to Irene tell John's story, I was mentally compiling a list of his symptoms, strengths and risks, and reached a clinical decision. My assessment was that of a man with clear symptoms of depression and moderate suicide risks, however, he was someone who also had strong protective factors including a future orientation, a willingness to engage with treatment, and a very supportive wife. We discussed the next step of post-discharge follow up with mental health services so that there could be further assessment and treatment.

I thought the couple would be relieved and I did not expect what came next. This cheerful, helpful woman, who seemed to be John's rock, began to crumble in front of me. Her hand began to shake as she raised them to her face and sobbed. 'Discharge?' she cried. 'No! We can't lose him, and I can't go through this hell anymore'. Clearly, something had gone wrong. Was it my approach? Did they not understand the discharge plan? Had I missed something entirely?

On the back foot, and realising that my efforts to establish a trusting rapport, had not been sufficient in establishing mutual goals, I had to draw on a different suite of skills. I decided to go over the history of his ill-health once again, which might reveal to me why Irene was so upset about the thought of John going home with her. I decided to slow the conversation down, and what I did was more hunch, and happy accident, than anything that, at the time, I could assert was theory-based practice. I changed my interviewing style to be more tentative and to incorporate their words in my questions seeking clarification. I decided to retell the story that I had heard in a different way. Using their words, I went over what had happened, where they were now, and where they were going. It was as if I was revealing to them the narrative meaning of their story; a story that had a past, a present and a future. I included their own emotive and

descriptive words to make it clear that I had listened to what was said and how I perceived it must have felt – to truly empathise with them. I elaborated more on the treatment plan, which would best involve discharge and community follow-up, what this might mean to them as they moved forward, and how this path of recovery could be taken in partnership with mental health services.

To my surprise, when I broached the plan again, Irene was more accepting and agreeable with this decision. We had established a mutual goal. It was the same decision, but it produced consensus as well as calm. A reflection on the changed dynamics and the relevant literature helped me to understand the limits of change by simply using the nurse/patient relationship and the benefits of utilising story-telling techniques to help people clarify concerns and goals.

During this encounter, I was aware that I needed to complete a mental state examination as this is the expected evidence-based practice policy. This results in a clinical judgment being made about a person's mental health or illness and usually leads to a more specific diagnosis. Just as the biomedical model has become the foundation for modern nursing and medical practice (Corbally and Grant 2015), it also now drives mental health practice (Thomas 2014). Critics argue that the biomedical lens is not sufficient to assess and treat patients with mental health problems and it minimises the influence of psychosocial symptoms on mental health (Deacon 2013; Lilienfeld 2007). By overemphasising the interest in causation of disorders, such as pathology and genetics, the lived patient experience and effects of extreme distress are relatively ignored, trivialised or marginalized (Grant and Leigh-Phippard 2014, (Grant, Leigh-Phippard and Short 2015). This leads to inadequate understanding on the part of patients and families, as well as non-compliance or non-adherence with prescribed treatments (Ilic et al 2013). Examples of this are highlighted in the very moving book, *Our Encounters with Suicide* (2013), wherein Grant, Haire, Biley and Stone call attention to the lack of compassion and understanding in the emergency department for those who contemplate or who have attempt suicide.

Appreciating the role of narrative in mental health

Criticisms of the biomedical model have been voiced by mental health consumers. Bassman's narratives of adverse experiences from psychiatrists in the 1970's (1997) is one example of when consumers lobbying for a change. Eventually, as this movement gained momentum, it was finally heard, leading to research in this area (Botella et al. 2004, Adame and Knudson 2007). This is one reason for a paradigm shift towards recovery (away from illness), and the adoption of a more collaborative approach with patients and families (Deegan 2007). The bio-medical view is, however, still so deeply entrenched in the routines of practice for clinicians that it remains hegemonic and difficult to shift (Morris 2008).

Corbally and Grant (2015) argue that all nurses need to become narratively competent, and clearly none more so that the mental health nurse, who repeatedly listens to stories of adversity. Narrative competence refers to a finessed, ethically-charged respect for the lived and storied experience. It emphasises the idea that in developing a strong

nurse-patient relationship, nurses need to be skilled in attending to the patient, listening closely, clarifying and checking the meanings they make from the stories being told to them, and interpreting and intelligently responding to the stories of people in their care (Charon 2007, Corbally and Grant 2015). Story Theory adapts and applies concepts from narrative therapy (White and Epston 1990) to the nurse-patient relationship. According to its developers, Smith and Liehr, Story Theory is composed of three interrelated concepts: 'intentional dialogue'; 'connecting with self-in-relation' (2005: 3) and 'creating ease' (205), all of which can be applied to the nurse-patient relationship.

When nurses communicate with patients they are engaging in a purposeful, or intentional dialogue, they are seeking to explore that person's unique health-care story to find out what events occurred, and how that person responded or coped. Ideally, nurses are also conscious of how their presence within the relationship impacts upon the patient. They might sit down, to minimise any power differential. They might use silence or sympathetic utterances to demonstrate that they know that human connection can ease suffering. Other ways to create ease for the patient may be to give them space and time to gather their thoughts. Thus, within an encounter between a nurse and patient, there may still be an aim to complete a mental state examination, but another aim is to understand the story behind the reason for the patient being in care. According to Smith and Liehr (2005, 2014), people will be more likely to tell their story if they feel a sense of trust, which is an idea they share with Peplau, discussed above. But unique to this idea of Story Theory is that shared stories promote connection and dialogue, and thus it is important for the listener to pay attention to the way the story told unfolds and flows, offer feedback to the teller in order to show how the story is being heard, and check that the meaning being made about the narrative is accurate.

According to Smith and Liehr, intentional dialogue involves 'true presence' and 'querying emergence' (2014). True presence refers to the clinician being fully available to listen and accept the story being told to him or her. True presence also means being open to what was, is, and can be. It brings a sense of humanity to the moment of patient interaction. Querying emergence involves iterative clarification of elements of the health story, and offering the encouragement for stories to be elaborated, important because patients may not be aware that their stories are a significant aspect of care. This means that the nurse concentrates and tries to understand the stories from the other's perspective, and then attempts to draw out the nuances of the story. For example, a patient may have jumped from talking about a story of wellbeing and/or recovery to an illness-laden story, and the nurse might query what happened in between. By holding a conversation about this in-between time, both nurse and patient might begin to see more detail what that occurred to trigger ill-health.

Connecting with self-in-relation is the active process of recognising one's self as it relates to others in a story plot (Smith and Liehr 2014). This plot is developed from personal history filtered through reflective awareness. Personal history is the unique narrative uncovered when individual patients reflect on where they have come from, where they are now, and where they are going in their lives. Reflective awareness is being in touch with one's experiences, thoughts, and feelings. It relates to being in touch

with one's view of, and place in, the world and, more concretely, in the moment in which they are telling their story. Creating ease is, according to Smith and Liehr (2014) the energising sense of release experienced as a teller's story comes together towards a resolution. It can happen as a result of the realisation, acceptance and understanding that comes when story fragments converge into a meaningful whole. A pattern may be revealed, and the opportunity to end a story and begin a new one may become clear.

This idea of ending a story in order to begin a new one is also known as re-storying. Re-storying can be described as a transformational method of reflexive inquiry. It enables the re-narration, re-interpretation and re-framing of lived experiences and it happens as one may begin to see oneself differently because of the phenomenon of 'self-in-relation' (Richardson 2000). Self-in-relation is the theory advanced through psychotherapy that suggests that one can learn about the self through relationships with others. For example, a person may be able to begin to see themselves as a survivor rather than a victim, if the listener urges him or her to talk about what happens next in their story after some period of adversity. Thus, re-storying assumes that peoples' lives and stories continue to unfold as life goes on, and thus one's position in the world and one's identity is not fixed (in illness or other misfortune) but is, instead, continually evolving (Grant and Zeeman 2012). Essentially, people learn from their lives through the stories told about and by them (Goodson et al. 2010).

Conclusion

Drawing on these ideas about storytelling and active listening, and reflecting on the phases in the encounter that led to, at first, a failure to achieve a mutual goal for care and, then, success, I realise that although I was at first relying solely on the biomedical model of care, I was also intuitive enough to know that this approach was insufficient to achieve a moment of authentic communication. Because of the multiple demands of a busy emergency department, I did not take the time to understand and empathise with the people in front of me. I was gleaning only enough information to make a decision, as compared with spending enough time attending, and attuning, to these people's stories so that we could make a mutually acceptable decision.

Reflecting on what I gained in moving beyond intuition to the incorporation of theory-based knowledge, I can see the benefit of using a different lens to see patients, assess their needs and to communicate. Initially, as John's story unfolded, I was surprised by Irene's reaction. I assumed that because most people stigmatise mental health services, that both John and his wife would be relieved or even pleased for John not to be admitted. Being attuned to Irene's negative reaction was the trigger that prompted me to reflect and self-correct. I realised that my attitude not only conveyed a lack of compassion, but had trivialised their story. This revelation was humbling, but also disconcerting. In my forthright questioning (with the focused aim of achieving a judgement on John's mental state), I had pursued narrow pathways to understanding and had neglected the opportunity of 'querying the emergence' of the stories being told to me. Using a form of impromptu narrative re-storying, I was able to reignite a querying stance. Then, through narrative re-storying and telling John's story back to

them, a 'sense of ease' was created for Irene. Perhaps it reinforced in her mind that their story had been understood, and explains why we were able to achieve a mutually acceptable plan, and shared goals, for John's continuing care.

Intentional use of story and re-storying are skills to add to the tool-kit of everyday mental health nursing practice. The Rogerian ideas of acceptance and positive regard for all patients remains relevant, narrative approaches introduce the importance of a planned approach in communication, offering a more active role for nurses to assist patients to tell their story, and to consider the possibility that the story might be able to take new and more fulfilling directions.

It should be added that such use of story in mental health can be an emotive exercise. Story pathways are tentative and do not always produce firm outcomes or insights, and exploring and teasing out these stories can be an emotionally cathartic experience for all concerned. This activation, and inclusion of, the emotional act of listening and re-storying helps listeners feel a connection to the storytellers and leads not only to improved listening skills but also enhanced compassion – which is essential to building a therapeutic alliance between nurse and patient (Charon 2006, McAllister 2015). So powerful is story in this context, that it can help bring about change in individual practice; and even spur policy changes for improvements in the treatment and care of patients (Edwards 2014).

To our knowledge, Story Theory has not previously been applied to mental health nursing, let alone to the more specifics of crisis mental health presentations in the emergency department. As Story Theory provided an excellent lens for reflection on the case narrated in this article, its suitability suggests interesting possibilities for the future. It certainly indicates an opportunity to study further how Story Theory may be used to develop narrative competence in all mental health nurses, and how the action of re-storying could widen their communication repertoire, and ultimately improve not only patient outcomes, but also satisfaction with those results.

Endnote

1. The narrator of this story is Toby Price.

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