Mental Health Nursing

Applying Theory to Practice

Gylo (Julie) Hercelinskyj
& Louise Alexander

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1st Enhanced Edition
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BRIEF CONTENTS

CONTENTS

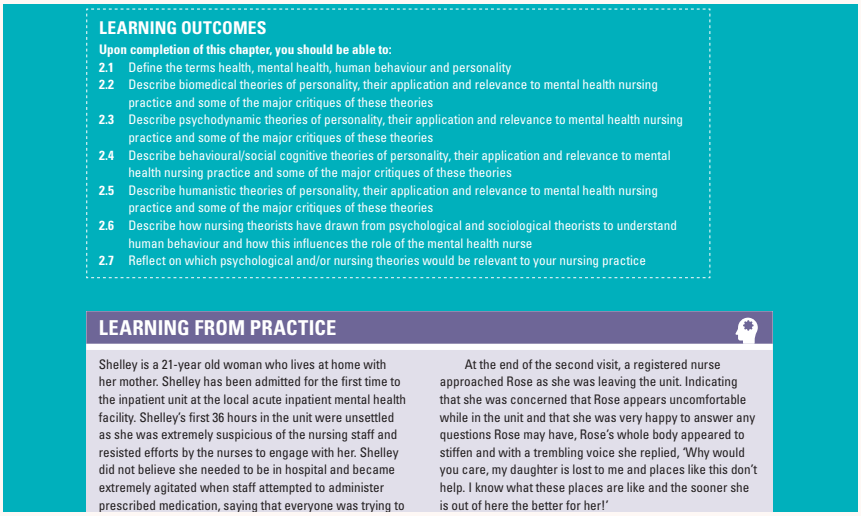
Guide to the text

As you read this text you will find a number of features in every chapter to enhance your study of mental health nursing and help you understand how the theory is applied in the real world.

CHAPTER-OPENING FEATURES

Identify the key concepts that the chapter will cover with the **Learning outcomes** at the start of each chapter.

Challenge your perspective on mental health nursing in the real world with the **Learning from Practice vignette** and reflective questions. Then, consider how the chapter has impacted your understanding, with the **Reflection on Learning from Practice** at the end of chapter.



LEARNING OUTCOMES

Upon completion of this chapter, you should be able to:

- **2.1** Define the terms health, mental health, human behaviour and personality
- **2.2** Describe biomedical theories of personality, their application and relevance to mental health nursing practice and some of the major critiques of these theories
- **2.3** Describe psychodynamic theories of personality, their application and relevance to mental health nursing practice and some of the major critiques of these theories
- **2.4** Describe behavioural/social cognitive theories of personality, their application and relevance to mental health nursing practice and some of the major critiques of these theories
- **2.5** Describe humanistic theories of personality, their application and relevance to mental health nursing practice and some of the major critiques of these theories
- **2.6** Describe how nursing theorists have drawn from psychological and sociological theorists to understand human behaviour and how this influences the role of the mental health nurse
- **2.7** Reflect on which psychological and/or nursing theories would be relevant to your nursing practice

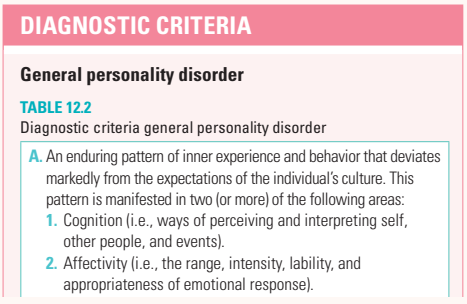
LEARNING FROM PRACTICE

Shelley is a 21-year old woman who lives at home with her mother. Shelley has been admitted for the first time to the inpatient unit at the local acute inpatient mental health facility. Shelley's first 36 hours in the unit were unsettled as she was extremely suspicious of the nursing staff and resisted efforts by the nurses to engage with her. Shelley did not believe she needed to be in hospital and became extremely agitated when staff attempted to administer prescribed medication, saying that everyone was trying to

At the end of the second visit, a registered nurse approached Rose as she was leaving the unit. Indicating that she was concerned that Rose appears uncomfortable while in the unit and that she was very happy to answer any questions Rose may have, Rose's whole body appeared to stiffen and with a trembling voice she replied, 'Why would you care, my daughter is lost to me and places like this don't help. I know what these places are like and the sooner she is out of here the better for her!'

FEATURES WITHIN CHAPTERS

Recognise the core DSM V Diagnostic Criteria for specific mental health conditions with the **Diagnostic criteria** boxes.



DIAGNOSTIC CRITERIA

General personality disorder

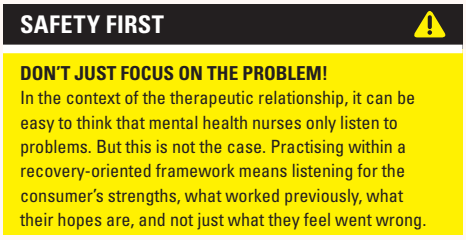
TABLE 12.2

Diagnostic criteria general personality disorder

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:

1. Cognition (i.e., ways of perceiving and interpreting self, other people, and events).
2. Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response).

Identify important client health and safety issues, and the appropriate response to critical situations with the **Safety first** boxes.

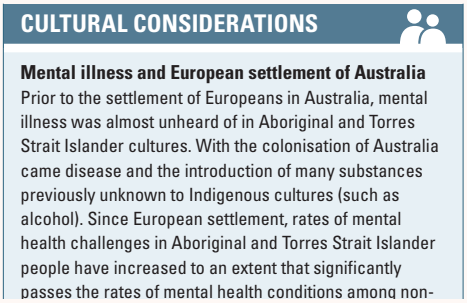


SAFETY FIRST

DON'T JUST FOCUS ON THE PROBLEM!

In the context of the therapeutic relationship, it can be easy to think that mental health nurses only listen to problems. But this is not the case. Practising within a recovery-oriented framework means listening for the consumer's strengths, what worked previously, what their hopes are, and not just what they feel went wrong.

Consider approaches to respectful care for clients from diverse backgrounds with the **Cultural considerations** boxes.

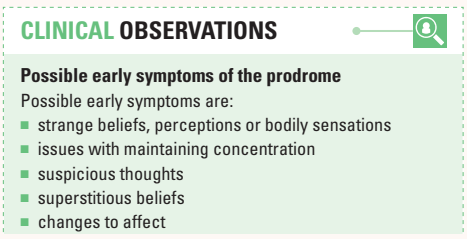


CULTURAL CONSIDERATIONS

Mental illness and European settlement of Australia

Prior to the settlement of Europeans in Australia, mental illness was almost unheard of in Aboriginal and Torres Strait Islander cultures. With the colonisation of Australia came disease and the introduction of many substances previously unknown to Indigenous cultures (such as alcohol). Since European settlement, rates of mental health challenges in Aboriginal and Torres Strait Islander people have increased to an extent that significantly passes the rates of mental health conditions among non-

Highlight specific key aspects of clinical presentation relevant to a specific mental health condition with the **Clinical observations** boxes.



CLINICAL OBSERVATIONS

Possible early symptoms of the prodrome

Possible early symptoms are:

- strange beliefs, perceptions or bodily sensations
- issues with maintaining concentration
- suspicious thoughts
- superstitious beliefs
- changes to affect

FEATURES WITHIN CHAPTERS

Analyse **Case studies** that present mental health nursing issues in context, encouraging you to integrate and apply the concepts discussed in the chapter.

CASE STUDY

A NEW CLIENT

Tomas is a 19-year-old client recently diagnosed with schizophrenia and living with his mother. He has been unable to return to his study course or find work since dropping out of his VET course the previous semester. He is reluctant to accept the diagnosis and struggles to agree with a need to take his olanzapine. His mother has expressed worries that she 'cannot talk to him any more' and get him to take his medication. She says he is becoming worse and with Tomas and support his mother. You decide to locate and review the most current and best evidence to develop your response.

Questions

1. What background questions need to be answered in order to then develop the specific foreground question?
2. Develop a searchable and answerable foreground question using the PICO format to locate the highest

Identify commonalities that you may see with consumers experiencing a specific mental health condition with the **Commonalities of the MSE** section in each chapter of Unit 2.

COMMONALITIES OF THE MSE: SCHIZOPHRENIA

General appearance and behaviour

An individual with schizophrenia *may* present with the following anomalies in their appearance and behaviour:

- dishevelled (due to disorganisation, issues with EF, motivation due to negative symptoms, etc.)
- uncooperative with interview (due to poor **insight** into illness and belief in the need to require intervention) or suspiciousness and **paranoia**

voices for some individuals may be negative ('You are worthless, you should kill yourself') or positive in nature ('You are important and special; this is why you have been chosen'). Voices can be male or female (and less frequently, childlike), although McCarthy-Jones et al. (2014) note in their study exploring hallucinations that male voices were more common. While the individual may recognise the voice as someone who is known to them, unknown voices are just as common.

Learn about the importance of evidence and clinical research in nursing with the **Evidence-based practice** boxes, which link research to nursing practice.

EVIDENCE-BASED PRACTICE

Seasons and bipolar disorders?

Title of study

Seasonal variations in rates of hospitalization for mania and hypomania in psychiatric hospitals in NSW

Authors

Gordon Parker and Rebecca Graham

Background

A number of studies have suggested that individuals with bipolar disorder experience higher rates of hospitalisation in spring; however, the same information about hypomania is not readily available.

Design

Quantitative data collected in New South Wales from December 1999 to January 2014 was extrapolated using ICD classification labels.

Participation

Admission information on 27255 mental health patients with mania and hypomania in all NSW mental health facilities was explored.

Follow an individual person's case and the process of planning care, identifying problems, performing interventions and evaluating outcomes for that person with the detailed **Nursing care plans**.

NURSING CARE PLAN

MANAGING PANIC ATTACKS

Consumer Diagnosis: Panic Attacks

Nursing Diagnosis: Extreme fear/panic whereby Maeve experiences feelings of intense dread and anxiety, tightness in the chest, palpitations, sweating and difficulty breathing.

Outcomes: Develop strategies to manage any future episodes of panic.

Maeve is a 42-year-old woman who recently presented to the emergency department. Maeve was driving to work along a busy arterial road when she suddenly felt faint and experienced tightness in her chest and difficulty breathing. She managed to turn into a side street, where she continued to experience these symptoms for several minutes before they subsided. Eventually, the symptoms settled down, which enabled Maeve to contact her partner. She attended the emergency department, where a range of tests was performed with all results being within normal parameters. Since this first visit, Maeve has experienced several more of these episodes. As nothing physiological was identified, Maeve has been asked to visit her local GP, who has referred her for assessment to the practice nurse.

END-OF-CHAPTER FEATURES

At the end of each chapter you will find several tools to help you to review, practise and extend your knowledge of the key learning outcomes.

Review your understanding of the key chapter topics with the **Summary**.

SUMMARY

- This chapter has explored the legal and ethical contexts for nurses working in the field of mental health in the context of mental health legislation in Australia.
- Mental health legislation in various jurisdictions of Australia is varied. However, commonalities lie in the preservation of dignity, upholding duty of care, and providing mental health
- Law and ethics apply in the context of nursing in Australia and all nurses working in health care need to be familiar with local Mental Health Acts and other relevant legislation.
- Of supreme importance are the issues of informed consent and involuntary or compulsory treatment, and the mental

Test your knowledge and consolidate your learning through the **Review questions**.

REVIEW QUESTIONS

1 Choose the statement that best defines the difference between law and ethics:
   a Ethics dictates behaviour, but law does not
   b Law is 'prescriptive' and ethics is 'guiding'
   c Ethics is based on law
   d A person can be punished for breaching ethics
2 Where there is an actual or perceived conflict between the code of conduct for nurses and the law:
3 The following requirements are necessary for all patient consent:
   a The consent must be voluntary, specific to the intervention/treatment, informed and the person must have capacity
   b The consent does not need to be voluntary as long as the person has the legal capacity
   c The consent can be considered valid if obtained

Challenge yourself to reflect on and discuss complex issues in relation to nursing with the **Critical thinking** questions.

CRITICAL THINKING

1 What factors would a mental health nurse take into account when considering which theoretical perspective might help them to understand a consumer's behaviour?
2 Jennifer has been receiving chemotherapy as part of her breast cancer treatment. The nurse notes that when her husband attends the appointment with her there is very
They are sleeping in separate rooms and she will not let him see her undressed. 'I just want to be there for her… but she's locking me out', Ivan states. 'I have no-one I can speak to.' Using a psychodynamic perspective, how could the nurse understand Jennifer's current behaviour?
3 Using Erikson's theory, identify what factors impact on a

Start your online reading and research using the short list of **Useful websites**.

USEFUL WEBSITES

- Approaches to Psychology – the humanistic approach: https://www.ryerson.ca/~glassman/humanist.html
- Australian Psychological Society: https://www.psychology.org.au
- Hildegard Peplau's interpersonal relations theory: https://nurseslabs.com/hildegard-peplaus-interpersonal-relations-theory

Reflect on this boxes encourage you to reflect on your learning and experience by drawing on real-world examples and concepts.

REFLECT ON THIS

Using the Cochrane Library to research COVID-19

There is a great deal of attention being paid to the evidence underpinning our developing understanding of coronavirus and the COVID-19 pandemic. While our understanding continues to develop, the Cochrane Library has begun to

2 Did the reviewers provide assistance in translating the results into your own practice?
3 Read the synopsis of evidence article 'Educational interventions for patients receiving psychotropic medication' (Joanna Briggs Institute, 2007).

Guide to the online resources

FOR THE INSTRUCTOR

Cengage is pleased to provide you with a selection of resources that will help you prepare your lectures and assessments. These teaching tools are accessible via **cengage.com.au/instructors** for Australia or **cengage.co.nz/instructors** for New Zealand.

INSTRUCTOR'S MANUAL

The Instructor's manual includes:

- Learning outcomes
- Key words and definitions
- Cases and case question solutions (including additional questions for instructors).
- Solutions to end-of-chapter review and critical thinking questions.
- Video activities for classroom teaching
- Websites and readings
- Search me! key terms and activities.

WORD-BASED TEST BANK AND STUDENT REVISION QUIZ

This bank of questions has been developed in conjunction with the text for creating quizzes, tests and exams for your students. Deliver these through your LMS and in your classroom. An additional bank of questions has been created to provide direct to students for their own revision and self-assessment.

POWERPOINT™ PRESENTATIONS

Use the chapter-by-chapter PowerPoint slides to enhance your lecture presentations and handouts by reinforcing the key principles of your subject.

ARTWORK FROM THE TEXT

Add the digital files of graphs, pictures and flow charts into your course management system, use them in student handouts, or copy them into your lecture presentations.

PREFACE

ABOUT THIS BOOK

Florence Nightingale once said, 'nursing is an art *and* a science'. This point perhaps best describes the dichotomy for students when entering mental health. For many students their previous learning has focused on technical psychomotor skill acquisition. For example, undertaking a physical assessment, blood pressure, or administration of sub-cutaneous medication. Mental health nursing requires a uniquely different, and *human* set of skills that can be very challenging for some. Mental health nursing centres on the individual, their needs, their challenges, their hopes and their goals, and nurses require competent therapeutic communication skills to help.

Mental health nursing proficiency is a standard requirement of every nursing graduate. Individuals with a lived experience of a mental health condition are understood to experience discrimination, stigmatisation and disadvantage that results in worsening of mental and physical health. While mental health nursing is a highly specialised sector of healthcare, the increasing prevalence of mental health conditions means that *all* nurses must be suitably equipped to engage therapeutically with someone experiencing a mental health challenge. This requires a combination of theoretical understanding of mental health and mental ill health, and how the person's lived experience of a mental health condition is central to working collaboratively with them. This understanding is then applied in practice through the multidisciplinary team by safely applying therapeutic skills in interactions with consumers experiencing a mental health condition. This text provides a comprehensive exploration of mental healthcare that enables practical application of skills.

Areas comprehensively covered in this text include:

- historical perspectives of mental healthcare
- recovery and trauma informed practice
- theory of communication
- legal and ethical considerations
- extensive exploration of conditions (e.g., schizophrenia, depression, personality disorders etc.)
- complements the acclaimed DSM5 (2013)
- therapeutic use of medicines
- suicide and non-suicidal self-injury
- non-pharmacological approaches to intervention
- community mental health
- carer and family input
- Indigenous perspectives
- mental health first aid.

One of the most difficult aspects of mental health nursing for students is applying what they have leaned into a clinical context. For example, how to undertake a mental state examination. This text has been developed with these issues specifically in mind by:

- providing examples of common mental state examination presentations specifically according to the mental health condition
- comprehensive exploration of mental state examination including provision of questions and definitions
- the use of clinical observation and Safety First boxes to highlight specific areas of practice that students must be familiar with.

This text provides a comprehensive introduction to mental health nursing where the consumer is central to the caring process, and how care is delivered by the multidisciplinary team. Core features of this text will provide students with the foundation knowledge and skills they can apply during their clinical placement and future nursing career.

Gylo (Julie) Hercelinskyj and
Louise Alexander

ABOUT THE AUTHORS

Gylo (Julie) Hercelinskyj is an Honorary fellow at Australian Catholic University (ACU), Melbourne. Julie's clinical, teaching and research background is in older person's mental health, perinatal mental health, interpersonal skills and psychosocial nursing practice. Julie completed her original nursing education in general nursing and then specialised in mental health nursing. Julie has a Masters in Nursing Studies and completed her PhD in philosophy in 2011, which explored professional identity in mental health nursing. She has presented at national and international conferences and has published in a number of areas, including the use of educational technologies, professional identity, and emotional labour in mental health nursing.

Julie believes that all nurses need to incorporate promoting mental health into their practice. This requires a clear understanding of mental health and mental distress, and how nurses work collaboratively with people who have a lived experience of mental distress, and their families and significant others.

Louise Alexander is a senior lecturer in mental health nursing at Australian Catholic University (ACU), Melbourne. Louise has a background in forensic mental health nursing in acute, subacute and rehabilitation areas. Louise is a registered nurse with post-graduate qualifications in psychiatric nursing, and professional education and training. She also has a Masters in Education, and a PhD in Psychology. Louise also remains active in mental health nursing research, and continues to publish her research in this field. Louise has presented at conferences both nationally and internationally about teaching mental health nursing and has a special interest in the use of simulation in mental health teaching.

Louise is passionate about students' developing a comprehensive understanding of the theoretical underpinnings of mental health nursing. In particular, students' understanding and ability to undertake a mental state examination, and activities that alleviate pre-clinical placement anxiety. Louise currently oversees the mental health nursing unit within the Bachelor of Nursing program and is the national course coordinator for postgraduate mental health nursing at ACU.

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Cengage would like to thank the numerous contributors who assisted in this publication.

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- **Chapter 15:** Neurodevelopmental disorders

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- **Chapter 17:** Obsessive compulsive and related disorders.

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Gylo (Julie): This has been a journey shared with a number of people. Thanks to Louise for agreeing to go on this rollercoaster ride with me. To my amazing husband Peter – your support, love and friendship have always been the mainstay in my life. You are my 'rock'. Here's to the future. To my children Ayisha and Shae and my amazing grandson Ralph, I am immensely proud of the people you are, and that I get to be your mum and grandma. Mum, your indomitable spirit inspires me to be best I can be personally and professionally. To my father, sister and brother, I miss you all. This book is dedicated to you.

Louise: I would like to thank my family for their support during this journey. You have all had to put up with an awful lot of literary suffering, far in excess of the usual undertakings of an academic: manuscripts, PhD thesis and this book. In particular, I want to thank my husband Christian, and children Madeleine and Charlotte. Christian, thank you for your support during this process, and for believing in me. I love you. To my daughters, I know it always seems like mum is always busy 'doing something' but I do hope you understand that I do it for you both. You are both my biggest motivation, and my proudest achievement. I love you both very much. Finally, I would like to dedicate this book to my nephew James. Never forgotten.

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SECTION 1

UNDERPINNINGS OF MENTAL HEALTH NURSING

From the days of the asylum and work of attendants through to contemporary mental health service delivery, mental health nursing has evolved into a discipline that is guided by humanistic principles and evidence for practice. Practice is founded on a range of theoretical perspectives, legislative requirements, a variety of treatment and management options and therapeutic processes. Section 1 explores these foundational ideas in order to set the scene for the remainder of the book.

To understand the role of the mental health nurse as a member of the multidisciplinary team in delivering recovery-oriented and trauma-informed care, Chapter 1 provides a sense of the historical development of the discipline. Chapter 2 introduces some of the key theoretical frameworks that underpin mental health nursing practice. You will read about ideas from psychology and medicine as well as key contributions from mental health nursing theorists. These ideas will be applied to practice and critiqued. Chapter 3 presents essential knowledge regarding how mental health legislation underpins mental health service delivery, how recovery has influenced recent legislation and the consumer perspective of compulsory treatment and nursing practice, as well as key ethical considerations and issues related to practice and ethical frameworks to identity these issues. Chapter 4 explores the range of pharmacological and psychosocial treatment options currently used in contemporary practice. Core to effective practice in mental health is the capacity to listen to, respond and work collaboratively with consumers and their families. Chapter 5 explores the concept of mental health nursing as a therapeutic process. The fundamental components of the communication process, and the application of knowledge and skills to the therapeutic process are identified and explored. Section 1 concludes with Chapter 6, which looks at how mental health nurses understand, apply and critique evidence for practice. This includes consideration of clinical reasoning and decision-making.

CHAPTER 1

MENTAL HEALTH NURSING – THEN AND NOW

Louise Alexander and Gylo (Julie) Hercelinskyj

LEARNING OUTCOMES

Upon completion of this chapter, you should be able to:

1.1 Describe early human beliefs in illness and disease that affected how mental illness has been perceived

1.2 Describe factors behind the rise and growth of asylums throughout the world as well as the conditions that historically prevailed at asylums

1.3 Describe the history of asylums in Australia and the emergence of mental health nursing as a distinct profession within Australia

1.4 Describe treatments of mental health conditions throughout history, including the improvement of care, conditions and more humane perspectives on mental health and mental health nursing

1.5 Explore the role and identity of the mental health nurse in contemporary mental health service delivery

LEARNING FROM PRACTICE

To be honest, when I started nursing, I didn't even realise there was an area of practice dedicated to working in mental health. But even in the beginning of my education, I was always drawn to those ideas and concepts that explored the person's response to both health and illness. All the science was important, but it was learning about people that interested me the most. Having a clinical placement at a community mental health facility provided my first experience of a positive learning opportunity. I loved the learning, the teamwork, and seeing the way consumers experienced their recovery journey. I wasn't made to feel small or insignificant and no-one made me cry. But even then, I still did not see myself as a mental health nurse. I was going to be a midwife and thought completing mental health nursing after graduation would be useful in that work. I never became a midwife. The closest I came to holding an infant was the time spent working in paediatrics. My postgraduate year had clearly shown me that I wanted to be a mental health nurse. It was there that I felt I could contribute and make a difference as a registered nurse.

But when I told my parents of my decision my father's response was: 'Why can't you be a normal nurse and work with babies?'

Even now many years later, when I say I am a mental health nurse I wait for what seems to be the inevitable reaction from people. I watch their eyes widen, their jaw drop ever so slightly and then they say: 'But what do psych nurses actually do?', 'You're a mental health nurse? That must be so hard', 'You deserve a medal' or 'Why did you choose that?' So, I tell them my story and hope they take even a small level of understanding away.

JD, mental health nurse

JD has described her journey into mental health nursing, one she herself admits she was surprised to have enjoyed. You may find yourself in a similar position – contemplating your future as a nurse, and finding certain areas challenge your preconceived ideas. What is your understanding of mental health nursing? Reflect on how you feel about your upcoming mental health studies.

INTRODUCTION

To understand where we are going in the profession of mental health nursing, it is important to consider where we have come from. Often the history of mental health, or psychiatry as it has been referred to historically, is understood in terms of its historical development, treatment of people with a lived experienced of mental illness and the plethora of iconic or infamous events and images that surround it. Mental health nursing has been largely ignored, and seen only in relation to psychiatry and promulgated through literature, art, film and television in ways that perpetuate many of the myths that surround mental health. Mental health nursing has been overlooked by historians in terms of the contribution it has made to the care of people with a mental health condition in Australia, with only fleeting references to mental health nursing in their work (Maude, 2002). Nolan (1993) also believes much of the literature that does exist relates primarily to the history of psychiatric services, with nursing only considered in a marginal capacity. For example, the image of nursing is inevitably viewed through the lens of Florence Nightingale's exploits in the Crimea, her establishment of the first formalised nurse training school and the publication of her text 'Notes on nursing' in 1859.

It is most likely that mental health nursing evolved from what was historically a correctional or custodial position within an asylum. Asylums were notoriously inhumane places to reside and a significant portion of the history of mental illness encompasses this suffering. Workers within asylums monitored the whereabouts and cared for the inhabitants confined there. From around the mid-nineteenth century, the acceptable term for attendants was 'nurse' and this included both male and female attendants. This chapter explores some main historical perspectives of the causes of mental illness, historical mental health rituals, the establishment of asylums throughout the world and then in Australia, and the development of mental health treatments throughout human civilisation. In this chapter, we argue that to understand and value the role of mental health care and nursing practice today, it is essential to see how it evolved over the course of history. We approach this task by first looking at the history of mental health and then introducing the role of the mental health nurse in contemporary mental health service delivery, including introducing recent debates on the professional identity of the contemporary mental health nurse.

Historical terms

While today it is unacceptable to refer to individuals experiencing a mental health challenge as 'mad' or 'insane', historically such terms were widely acceptable and originated from actual medical diagnoses. Unlike their usage today, they were not intended to be derogatory.

The following terms were all socially appropriate and, in fact, diagnostic labels of early mental health conditions:

- lunatic
- idiot
- raving mad
- feebleminded
- insane
- incoherent
- intemperate
- hysterical.

The institution that housed the mentally ill of yesteryear was commonly called an 'insane asylum' or a 'lunatic asylum'.

BELIEF IN SUPERNATURAL ORIGINS OF ILLNESS AND DISEASE

In today's modern and civilised society, it seems abhorrent to consider that disease and ill health have a basis in any realm outside modern medicine. This was not the case in the fourteenth century, however. We consider a time where preoccupation with witchcraft, sorcery and demonology was a common justification for regular occurrences of that era: plagues, famine and general social unrest. By trusting in such supernatural concepts, believers of those times had something tangible on which to project their anger, fear and blame.

Witches

Witches and witchcraft were blamed for many events of the early and Middle Ages, ranging from simple misfortune (such as the death of a child, crop blighting or adverse weather events) to the bizarre that had no basis in fact (such as riding on a broomstick or changing form from human to animal). It is perhaps human nature to seek an understanding of why 'bad' things occur, and for many people ascribing blame to an evil, mythological being made sense. While there were varied and numerous reasons why women were ultimately tried as witches, many of which were purely matters of politics or the result of religious differences, it is understood that some of those who were persecuted were mentally unwell individuals who were probably suffering psychosis. In the majority of cases, there was no treatment offered to the suspected guilty party, and 'confessions' were obtained under torture or other duress; usually to make a deliberate example of the victim. Witches were burned at the stake (see **Figure 1.1**) or suffered what is known as the 'dunking test'. In this ultimate no-win situation (see **Figure 1.2**), the witch was tied to a chair and lowered into a body of water such as a river or lake. She was dunked in the water repeatedly, and if she died it was determined that she was *not* a witch. If she managed to survive the dunking, this meant that she *was* a witch, and she would be outed as a devil and killed regardless. Alternative recollections of this historical perspective also suggest that if she sank, she was deemed innocent (yet was

now dead) and if she floated, she was guilty and was killed anyway. It is unknown how many women and clergymen died under the pretence of supernatural and/or spiritual causes of civil unrest, but it has been suggested that hundreds of thousands of people were killed due to such beliefs throughout the centuries (Elmer, 2016).

SOURCE: IMAGE FROM ALT- UND NEU-WIEN. GESCHICHTE DER KAISERSTADT UND IHRER UMGEBUNGEN, ETC BY MORIZ BERMANN (1880), BRITISH LIBRARY

FIGURE 1.1
Witch being burned at the stake

SOURCE: IMAGE FROM CHAP-BOOKS OF THE EIGHTEENTH CENTURY BY JOHN ASHTON (1834)

FIGURE 1.2
The dunking test

In Scotland in 1662, Isabel Gowdie was accused of being a witch and she readily confessed to this crime without requiring any torture. During her trial, Isabel was quoted as saying, 'He would have carnal dealing with us in the shape of a deer or any other shape that he would be in. We would never refuse him' (Zacks, 1994). Isabel described in great detail the intimate knowledge of her sexual encounters with the devil:

> And within a few days, he came to me, in the New Ward's of Inshoch, and there had carnal copulation with me. He was a very huge, black, rough man, very cold; and I found his nature [semen] within me all cold as spring well water. He will lie all heavy upon us, when he has carnal dealing with us, like a sack of barley malt. His member is exceedingly great and long; no man's member is so long and big as his. He would be among us like a stud horse among mares.
>
> The youngest and lustiest women will have very great pleasure in their carnal copulation with him, yea much more than with their own husbands; and they will have an exceedingly great desire for it with him, as much as he can give them and more, and never think shame of it. He is abler for us that way than any man can be (Alas! that I should compare him to any man!) only he is heavy like a sack of barley malt; a huge nature [outpouring of semen], very cold as ice.
>
> Source: Zacks, 1994

Given the content of this extract, it is possible that Isabel was experiencing psychosis in the context of mania or schizophrenia. Her plight was met with the response that was common for the 'witches' of the Middle Ages: she was killed.

Exorcisms and spirit possession

Most religions have a history of exorcism and the history of such practices goes back thousands of years. Exorcism has a place in the management of the mentally ill in some countries even to this day, and demonic possession has been attributed to many strange beliefs or behaviours that now are commonly associated with psychosis or schizophrenia (Craig, 2014). In the Middle Ages countless people suffered painful treatments at the hands of clergymen seeking to exorcise spirits from their inhabitant and these frequently resulted in death (McNamara, 2011). **Figure 1.3** depicts St Francis Borgia providing the last rites to a dying man who appears haunted by demonic spirits.

While exorcism is predominantly associated with Catholic practices throughout history, there are many other historical examples in other cultures. Aboriginal Australians have an embryonic history of spiritual Dreamtime dating back 50 000 years, which includes entering spiritual dreamlands that have included possession (McNamara, 2011). Spirit possession is also recounted in the histories of Native America, pre-Columbian South America, West African Yoruba, Islam and Northern and Southern Asia (McNamara, 2011).

SOURCE: ST. FRANCIS BORGIA HELPING A DYING IMPENITENT BY GOYA (CIRCA 1788), PUBLIC DOMAIN

FIGURE 1.3
St Francis Borgia (1510–72) helping a dying impenitent Francisco José De Goya

ASYLUMS OF THE WORLD

An **asylum** was an institution where people with a mental health condition were housed. This process became colloquially known as **institutionalisation**. Asylums tended to be large buildings with dorms or rooms (which were locked) under the proviso that they were providing specialised care for people with mental illness. In reality, they were places of disease, distress and depravity (Arnold, 2009). The world's first hospital for the mentally insane was opened in Baghdad in 792 CE, and Europe soon followed suit, but prior to this, families were generally responsible for the keeping of mentally ill people, much to their immense shame and embarrassment.

The superstitions associated with mental illness rendered many families with disturbed family members deemed to be unlucky and cursed, thus resulting in them being isolated and ridiculed. Lunatic asylums began to emerge in the sixteenth century. These were not places of healing, but were locked penal colonies where the mentally ill could be abandoned by their long-suffering families, often never to be seen again. Conditions were appalling – vermin and disease were rife, the food insufficient, sanitation grossly inadequate and the caretakers sadistic – and overcrowding resulted in inmates being unable to lie down or move around (as they were almost always chained up anyway) (Arnold, 2009). Individuals with an intellectual disability were also housed in asylums in the same horrendous conditions, and this is hypothesised as being one of the more common reasons why many people wrongly think even today that those with a mental health condition are of lower intellect. These horrendous conditions continued worldwide until around the 1850s, although in some countries they continued well into the 1900s.

CASE STUDY

THE ROSENHAN EXPERIMENT

The Rosenhan experiment is a further example of subjectivity within psychiatry. David Rosenhan was a psychologist, and in 1972 he and seven colleagues presented to various hospitals across America fabricating mental illnesses of varying degrees. All were admitted to hospital for periods ranging from seven to 52 days, given invasive treatments against their will, and despite trying to convince doctors they were undertaking an experiment, they were only released when they appeared to comply with their diagnosis and subsequent treatment (Fontaine, 2013).

Questions

1. The participants of the Rosenhan experiment were trying to make a point about diagnostic subjectivity in psychiatry. What do you think this means?
2. Reflect on your understanding of general medical conditions. Is psychiatry unique to such ambiguity in diagnosis?

Bedlam

One of the most notorious and infamous asylums in the world was Saint Mary of Bethlehem, located in London in the mid-sixteenth century (see **Figure 1.4**). This asylum was quickly named 'Bedlam' and is in fact the origin of the moniker itself. Bedlam has a dark, well documented and researched history. Locals were encouraged to come and view the 'lunatics' of Bedlam as entertainment, and on the first Tuesday of the month people could peer through holes in the stones for free. On other days, this outing would cost a penny. Around 100 000 people visited the site every year, and Bedlam remained a popular tourist attraction into the nineteenth century (Arnold, 2009).

FIGURE 1.4
Saint Mary of Bethlehem, or 'Bedlam'

HISTORY OF AUSTRALIA'S ASYLUMS AND MENTAL HEALTH NURSING

The first lunatic asylum to operate in Australia was New South Wales' Castle Hill Asylum, which opened in 1811. Like many asylums of its time, Castle Hill has a dark history. Treatment of mental illness did not usually serve as part of the purpose of such asylums, and if it did, many 'treatments' were both inhumane and barbaric when they were instituted in similar asylums in Europe. A vast majority of the treatments of mental illness were experimental, and often formed the basis of a speculated theory. The purpose of these institutions was to contain the uncontainable – to control the uncontrollable. This included restricting (or preventing) access to the community (and thus eliminating perceived threats), as well as cohabitation of prisoners, those suffering dissolute or intemperate habits (such as alcoholism or sexual promiscuity) and intellectually disabled individuals.

The gold rush of the 1850s resulted in both an influx of migrants and serious increases in mental illness exacerbated by the use of alcohol and drugs such as opium. By the 1880s, more than 3% of Australia's population were identified as lunatics (this figure was more than three times higher than just 30 years prior) and services were ill-equipped to manage them. As a result, between 1811 and 1912 close to 30 asylums were opened across Australia. Despite this, it seemed nothing could keep up with the influx of those afflicted with 'diseases of the soul', and most asylums filled beyond capacity quickly, adding to the despair inhabitants were already experiencing.

While the personal tolls of drugs and alcohol provide a justifiable rationale for the increases in people committed to asylums across Australia, they are not the only cause. In fact, a more sinister reason exists. Being committed to an asylum was a seemingly easy task if you were a woman, married to a man who wanted to be rid of you. Getting out of such a facility was much harder (or seemingly impossible), and given the penchant for men to hold the powerful and authoritarian roles in historical psychiatry; many women remained institutionalised for mere convenience (Toy, 2014).

Mental health nursing in Australia

Formerly custodial attendants, mental health nursing emerged as a distinct profession in Australia around 1890 with the increased medicalisation of mental health (Sands, 2009). Generally, men were responsible for the care of the mentally insane, until women were employed in the early twentieth century (Happell, 2007). Identification of nursing as a profession emerged in the mid- to late twentieth century and this resulted in the notion of specialisation in the field of psychiatry. With the development of psychotropic medication in the 1950s, psychiatry experienced changes in credibility and further interest in psychiatry as a nursing specialisation. The **deinstitutionalisation** of people with a mental health condition in the late 1980s saw a move from institutionalised care to community-based care, and thus the role and expertise of the psychiatric nurse also adapted (Happell, 2007).

Mental health nursing history and education

The history of psychiatry, or mental health as it is now referred to, has had a considerable impact on the development of nursing practice. The history of (psychiatric) mental health nursing differs significantly from that of other branches of nursing (Happell, 2007), where the influence of iconic figures such as Florence Nightingale and Lucy Osborne on the development of nursing services in the Colonies is clear and has been extensively documented (Bessant, 1999). Prior to the establishment of the first asylums in Australia, individuals with a mental health condition were confined to jails or cared for privately. There was no distinction between those individuals experiencing mental illness and those who were intellectually disabled (Happell, 2007). Jails were always custodial rather than treatment oriented, so incarceration of individuals with a mental health condition was obviously ineffective.

The introduction of the first Australian asylum at Castle Hill in 1811 failed to provide a feasible alternative to existing options in the lives of the mentally ill. Although the philosophy underpinning care was based on humane treatment, the day-to-day reality of caring for patients was primarily about containment. While this could partly be a consequence of the overcrowded conditions at Castle Hill (Curry, 1989), it also reflected the prevailing attitude that mental illness was incurable (Sands, 2009). The people who managed and cared for individuals with a mental health condition were referred to as 'attendants' and their work came under

the control of the medical profession in Australia at the same time that the first legislation relating to mental health was enacted through the 1843 *Lunacy Act* (Curry, 1989). Prior to this, the first superintendent had been a layperson, whose approach to the care of individuals with a mental health condition was focused on using psychosocial care as a means for managing their behaviour.

The ideological conflict between proponents of such models of care and those who supported medical approaches to treatment 'based in neurophysiology and neuropathology' (Curry, 1989, p. 10) contributed to the establishment of the Select Committee on the Lunatic Asylum, Tarban Creek in 1846. The findings of this committee enabled medical practitioners to assume the responsibility for governance and treatment. This development meant that the lay superintendent was demoted to the position of senior warden. Curry (1989) argues that this arrangement established the medical and nursing systems for the asylums and was copied everywhere throughout the colonies.

The first facility for individuals with a mental health condition in Victoria was established in 1848 and was proclaimed a ward of the NSW asylum at Tarban Creek. It became locally known as the Merri Creek Lunatic Asylum. Following separation from New South Wales, it became known as the Yarra Bend Lunatic Asylum (Reischel, 2001). The first evidence of education for 'mental nurses' in Victoria was noted in the Annual Report for 1887 of the Kew asylum in Victoria (Reischel, 1974). This was the beginning of a formal training system for staff in asylums. Reischel (2001) observes that lectures were provided by medical staff who also oversaw and controlled the educative process. In 1902, a number of general trained nurses were employed at the Kew asylum and several trained and untrained female nurses were employed in the main male ward (Reischel, 1974). This was the first recorded occasion of female staff being involved in the care of individuals with a mental health condition. Women were specifically referred to as nurses now, defining them differently from their male colleagues who were known as **attendants** (Reischel, 1974). Education continued to be provided to attendants and nurses by medical staff and a three-year training program approved by the relevant health authority in Victoria was introduced. However, this qualification was not recognised outside of Victoria, and nurses and attendants were not registered with the Nurses' Board of Victoria (Reischel, 1974).

Modern mental health nursing education commenced in the mid-twentieth century (Reischel, 2001); for example, recognised education and registration as psychiatric nurses commenced in Victoria with the passing of the Victorian *Nurses Act 1958* (Reischel, 1974). Parallel with these developments, statements regarding changes to health care delivery generally, and mental health care in particular, were also being reported. Holland (1978, p. 16) stated that 'A greater emphasis was emerging on health services outside institutions such as hospitals'. Since this time, nursing education in all disciplines has come under the control of nursing bodies such as the Nursing Board of Victoria and, in contemporary times, the Nursing and Midwifery Board of Australia. This organisation sets the requirements for accreditation of educational programs and defines the standards for nursing (and midwifery) practice. The development of the treatments for mental health disorders throughout history is dealt with in more detail in the following section.

CULTURAL CONSIDERATIONS

Mental illness and European settlement of Australia

Prior to the settlement of Europeans in Australia, mental illness was almost unheard of in Aboriginal and Torres Strait Islander cultures. With the colonisation of Australia came disease and the introduction of many substances previously unknown to Indigenous cultures (such as alcohol). Since European settlement, rates of mental health challenges in Aboriginal and Torres Strait Islander people have increased to an extent that significantly passes the rates of mental health conditions among non-Indigenous Australians. Currently, rates of psychological distress among Indigenous Australians are more than twice those of non-Indigenous Australians (AIHW, 2021).

CASE STUDY

PENNY'S 'CALLING'

I completed my nurse training in the 1970s, back when nurses trained in a hospital and also lived there too. I guess I sort of 'fell' into mental health. I did a rotation in the psychiatric ward and the nurse manager pulled me aside and told me I would be a good addition to their staff, and I haven't really looked back since. I certainly haven't regretted it. I've been nursing so long that I have been fortunate enough to see the amazing progression of mental health care, to even play a part in this... things weren't always great in mental health when I first started, but we were doing the best we could with what we knew. I really believe I was able to help many of my patients even in the early days where medications were limited and

care was almost custodial. It didn't feel like that at the time though. We thought we were cutting edge! Helping patients and their families has always been my motivation for staying in mental health nursing. Mental illness is so destructive, and the suffering and pain it causes is immense. To play a part in easing someone's distress is my calling.

I've seen deinstitutionalisation firsthand, and the benefits and challenges that this created. One of the big changes in my career was the move from hospital-based training to university-educated nursing. I remember there was a lot of resistance from some nurses when this happened. But I embraced it; change is inevitable, and I have had the firsthand experience of seeing a student realise their 'calling'. What advice would I give a student nurse? Don't disregard mental health nursing… maybe it's your calling too.

Penny, registered nurse

Question

Penny has described the types of transitions that someone who has worked in health care for a long time will encounter. Her experience of change was welcomed and she was able to embrace it. Not everyone embraces change, however. Consumers in the mental health system also experience great adjustments during times of hospitalisation, diagnosis and treatment, and may be resistant to such change. How do you think you can support someone experiencing change?

TREATMENTS THROUGHOUT HISTORY

The term '**consumer**' is used to describe a person who identifies as having a lived experience of a mental health condition (Fuller Torrey, 2011). This experience may be past or current. The term consumer is preferred to 'patient', and throughout this book, you will see this term used frequently, and interchanged with other terms such as 'individual' or 'person'. Consumers of today are afforded a range of management options such as medication and talking therapies that have benefited from extensive testing prior to their use in human populations, and this is a strictly regimented requirement of pharmaceutical companies.

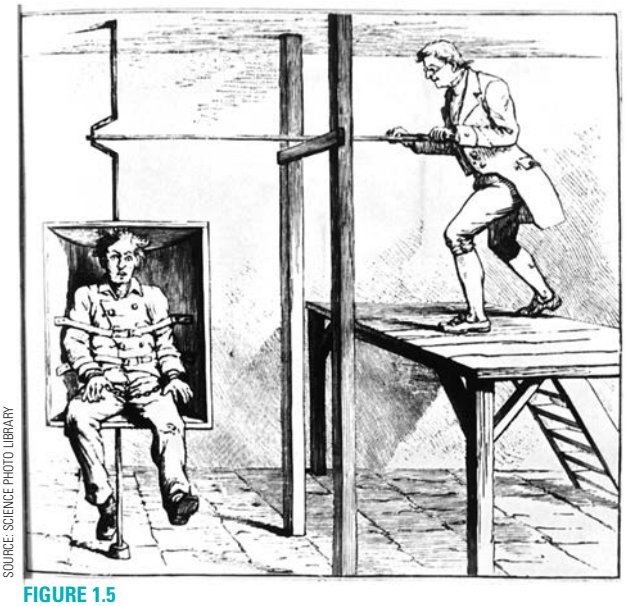
Recovery-oriented models of practice now place the person with a lived experience of a mental health condition at the centre of their care. It is understood that they are the experts on their lives. This, however was not always the case, and while consumers today have a central voice in how they are treated, patients of the past were exposed to brutal and barbaric 'treatments'. Some earlier treatments focused on Hippocrates' belief in the four 'humours' (blood, yellow bile, black bile and phlegm) and their imbalance as a precursor for all types of illness, including psychiatric illness. **Table 1.1** outlines many of the treatments for mental illness throughout history.

TABLE 1.1
Timeline of treatment of mental disorders through history

TREATMENT	TIME OR ERA	PERCEIVED BENEFITS
Trephination – the drilling of a small hole into the skull	8000 BCE to 600 BCE	It was believed that this process would allow evil spirits to exit the mind.
Fumigation of vagina – alleged to encourage the vagina to realign to its correct positioning	Ancient Egyptian and Greek	Fumigation of the vagina was thought to cure a 'wandering uterus', which was commonly associated with hysteria in women.
Imbalance of humours – use of leeches, laxatives and substances to induce vomiting	Middle Ages	This process purged the individual of melancholy and rebalanced their 'humours'.
Bloodletting or **scarification** – of brain, rectum, large leg veins	Middle Ages	It was believed that this resulted in the drawing away of poison from the brain.
Flogging – beating, sometimes in public	Middle Ages	People believed that poor behaviour could be 'beaten' out of the person.
Freezing or scalding – being immersed in hot or cold water, or throwing it at the individual	Middle Ages	This process was believed to shock the person back to sanity.
Gyrating chair – a chair that spun around wildly until the strapped patient lost consciousness (see **Figure 1.5**)	Mid-1700s	The spinning and gyrating was believed to result in mixing blood and tissues and re-establishing balance.
Straight jacket – a confining garment where the patient's arms were strapped securely across their body	1700s	Deemed to be a 'humane' treatment for a patient who needed to be restrained, as it permitted the individual to move about freely (from waist down) while preventing them from harming themself and others.

TREATMENT	TIME OR ERA	PERCEIVED BENEFITS
Tranquillising chair – a movement-restricting chair that included a box held over the person's head to keep them immobile	Late 1700s	Used the premise that agitation was a form of inflammation of the brain, exacerbated by movement. By preventing movement, the inflammation would diminish and the madness would be cured.
Rotary chair – a chair that turned on its axis and was propelled at high velocity, resulting in fright and painful cranial pressure	1850s	The chair resulted in feelings of terror, nausea, a sense of suffocation and distress and some believed that it would restore balance in the brain.
Utica crib – a fully enclosed 'cot' or crib where the opening was also sealed with bars	1860s	Resulted in containment and some perceived therapeutic calming benefits.
Shock treatments: **Insulin** – large doses of insulin injected over a period of weeks resulting in coma **Fever** – malaria was injected into the patient to induce fever **Medicine** – induced seizures	1920s to 1950s	Insulin shock was believed to effectively treat schizophrenia and the resulting coma and seizures were believed to reset the brain. It was believed that a severe episode of fever could restore a previously insane person, to calm and sanity. Seizures were induced with a variety of medicines (including metrazol) in persons with schizophrenia as it was falsely believed that schizophrenia and epilepsy could not coexist.
Lobotomy – prefrontal lobe lobotomy is a surgical intervention that severs the pathways between frontal lobes and lower regions of the brain. The physician would often gain access to the brain via the tear duct of the eye, or through the nose	1935	Usually reserved for those experiencing depression (and schizophrenia), the lobotomy was a highly invasive procedure that rendered the individual calm and compliant, and more frequently cognitively impaired. It was often used on patients who were violent, highly emotive and deemed too difficult to manage.

SOURCE: ADAPTED FROM VALENSTEIN, 2010



SOURCE: SCIENCE PHOTO LIBRARY

FIGURE 1.5
Dr Herman Boerhaave's gyrating chair

In the late eighteenth century, conditions began to improve in many asylums. Treatments became more focused on improving mental illness through humane treatment, fresh air and interaction. A number of **talk therapies** were developed in an effort to explore an individual's past experiences and consider the impact of these experiences on the person's current mental health. Pioneers of modern psychiatry included physicians such as Sigmund Freud and Carl Jung.

In the mid- twentieth century, the emergence of **psychotropic** medication resulted in a revolution in both the treatment and care of persons with a mental health condition, and in part helped facilitate the eventual deinstitutionalisation of people with a lived experience in the late 1980s. **Table 1.2** outlines the emergence of psychotropic medications in psychiatry.

TABLE 1.2
Timeline of psychotropic medications

YEAR	MEDICATION	USES
1952	Chlorpromazine (typical antipsychotic)	First antipsychotic used to treat schizophrenia
1952	Lithium	Bipolar disorder
Early 1950s	Monoamine oxidase inhibitors (MAOIs)	Depression
1958	Haloperidol (typical antipsychotic)	Schizophrenia
1958	Tricyclic antidepressants	Depression
1960s	Benzodiazepines	Anxiety and insomnia
1970s	Clozapine (atypical antipsychotic)	Treatment-resistive or refractory schizophrenia
1980s	Selective serotonin reuptake inhibitors (SSRIs)	Depression and anxiety
1990s	Atypical antipsychotics	Schizophrenia and mania

While the history of mental illness may make some believe that psychiatrists and nurses were motivated by experimenting on and hurting vulnerable people,