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ORIGINAL RESEARCH

# Psychosocial care in mental health nursing: a think aloud study

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## Abstract

**Title. Psychosocial care in mental health nursing: a think aloud study.**

**Aim.** This paper is a report of a study identifying psychosocial interventions relevant to routine care and exploring their content critically and analysing patterns in the use of these interventions.

**Background.** People experiencing enduring and serious mental disorders value psychosocial engagement as a means of achieving recovery and rehabilitation. However, mental health nurses' use of person-centred and directive psychosocial engagement in routine care is unclear, with the potential arising for benevolence and paternalism.

**Method.** A think aloud study was carried out with 37 mental health nurses responding to a simulated case depicting a person with an enduring mental health problem. Participants were recruited from community and acute hospital facilities across Ireland and responded to two tasks: identifying the nature of the person's problems and recommending what to do next. Transcripts were coded using judgement and intervention themes designed for the purpose. Patterns in the use of psychosocial intervention themes were described and further analysed by level of experience (highly experienced or not) and practice setting (acute/community setting).

**Findings.** A task-oriented psychosocial intervention labelled *structured engagement* was used extensively, followed by *reassurance and encouragement* based on pragmatic communication. A minority of nurses used *dialogue*, representing person-centred care. Highly experienced community mental health nurses were the most likely to talk in terms of intensive psychosocial engagement.

**Conclusion.** Relying on pragmatic problem-solving is problematic in terms of decision-making transparency and service user involvement. The use of informal knowledge in practice should be negotiated through more open discussion by nurses, including adoption of a consensus on the components of psychosocial care.

**Keywords:** decision-making, enduring mental health disorder, mental health nursing, psychosocial care, simulated case, think aloud

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## Introduction

Enduring and serious mental problems entail persistence of a mental disorder for over 2 years, along with significant functional disability (Kai *et al.* 2000, Ruggeri *et al.* 2000). Mental health nursing interventions in this domain of care are intended to promote rehabilitation and recovery (Repper 2000, Borg & Kristiansen 2004). The psychosocial work carried out by nurses is important in achieving the aim of helping service users achieve sustained independence in the face of stigma and isolation (Kai & Crosland 2001).

This aspect of professional performance is recognized as critical to care, but there is no consensus on how to classify the psychosocial interventions that underlie it. Despite this, psychosocial care links into many existing perspectives, including research into formal psychosocial interventions and the more experiential therapeutic relationship.

### Perspectives on psychosocial care

Theoretical perspectives on psychosocial care in mental health nursing have helped prompt policymakers' adoption of collaborative, phenomenological approaches to recovery (e.g. Adam *et al.* 2003, Altschul 1972, Barker *et al.* 1999, Finfgeld 2004, Peplau 1952). Research into interpersonal skills such as active listening and empathic communication show how these may operate in practice, with these strategies integrated through a therapeutic relationship based on trust (Moyle 2003, Welch 2005, Reynolds & Scott 2000). Discussion of these interpersonal skills is well-developed in the research literature, but there is again uncertainty as to their use in routine practice.

Mental health policy also carries the influence of formalized, skills-based psychosocial interventions, illustrated by cognitive behavioural interventions which have been linked to outcomes such as lower readmission rates (McCann & Bowers 2005). This picture of mental health policy internationally is consistent with service user preferences for engagement through empathy, trust, exploration of emotions and making plans to address problems (Welch 2005, Adam *et al.* 2003).

Collectively, these influences describe nurses' psychosocial work in regulatory terms, a normative model drawing on principled and evidence-based sources (e.g. Department of Health & Children 2006). However, significant and overriding factors intervene to impede routine implementation of this model, with a 'gulf…between these recommendations and the reality of what services can provide' (Brooker & Brabban 2004, p. 6). They can be explained by structural features, including restricted resources, biomedical dominance and a habitualized approach to practice (Kerr *et al.* 2007, Couldwell & Stickley 2007). Attitudinal reactions by practitioners to formal regulation of assessment and interventions include scepticism and resistance (Godin 2004). Given the limited applicability of formal interventions in describing everyday care, the meaning of routine psychosocial care continues to lack clarity.

### Psychosocial work in practice

While often resisting regulation of professional practice, nurses have put forward an alternative, implicit mode of practice, a craft based on experiential knowledge, informal communication skills and trust (Lutzén & Nordin 1993, Estabrooks *et al.* 2006). The implicit model that clinicians favour has been challenged, described as error-prone and typified as self-trained 'counselling' with limited effect (Thompson 2003, Couldwell & Stickley 2007). Moreover, nurses' claims to be consistently patient-centred are refuted by studies with patients (e.g. Moyle 2003). In practice, the nursing role may be benevolent or coercive rather than collaborative (Lutzén & Nordin 1993, Kerr *et al.* 2007). Nurses may see patients with enduring mental health problems as passive, with motivational deficits to be shaped through pragmatic compliance strategies (Latvala *et al.* 2000).

Nurses' wide-ranging role means that empathic perspective-taking must sit alongside clinical risk management, underlining the complex relationship between patient-centredness and a risk-oriented perspective based on psychopathology (Crowe 2000). Given the need to classify the interventions comprised by routine psychosocial work, there is potential to explore professional knowledge through relatively naturalistic designs such as the think aloud methodology (Lipshitz *et al.* 2001). The think aloud method involves verbalization of thought processes, usually while completing a problem-solving task (Ericsson & Simon 1993). Further exploration of the psychosocial interventions can be achieved by considering naturalistic factors linked to differences in psychosocial work. These are operationalized here as community-based and acute hospital-based practice settings (Godin 2004, Hamilton & Manias 2007), and duration of domain-specific nursing experience (Benner *et al.* 2009).

## The study

### Aim

The aim of the study was to identify psychosocial interventions relevant to routine care, exploring their content


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critically and analysing patterns in the use of these interventions and to address ambiguity concerning nurses' therapeutic engagement with people experiencing enduring mental health problems.

## Design

We used a think aloud task performance design (Ericsson & Simon 1993) to generate verbal data on mental health nurses' performance of tasks related to psychosocial care.

## Participants

Thirty-nine mental health nurses (12 men and 25 women) were recruited from eight mental health services across Ireland to ensure that relevance was not limited to one particular region or service. They were contacted through internal advertising and personal contact and identified by a number (e.g. P39). Two were deleted from the analysis because of incomplete demographic information and an incomplete recording.

Fifteen participants worked in acute in-patient units (seven men and eight women) and 22 in community settings (five men and 17 women). Nurses were sampled within these settings on the basis of experience working in that area (0–5, 6–9, ≥10 years experience), leading to six sub-groups. To simplify the analysis those in the two less experienced groups were pooled and compared against those with ≥10 years experience. Ten years' domain-specific experience is generally acknowledged as a necessary condition for expert-level performance (Ericsson & Ward 2007).

## Data collection

*Case simulation*

Participants responded to four simulated cases. In this paper, we report on the case that elicited the most extensive discussion of psychosocial care. This case simulation focused on a service user (Karen) whose profile of social withdrawal, inactivity and schizophrenia diagnosis matches that of enduring mental health problems (Kendrick *et al.* 1994). The simulation comprised a video depicting Karen using strong language towards a nursing student in her bedroom at a rehabilitation hostel, written case notes and two related tasks for participants to complete.

The case simulation was based on an anonymized set of nursing documentation recorded in another study in the same research programme. The nursing notes were first broken down into a matrix of key information elements. The information matrix was then developed into a naturalistic case by devising a video script and handwritten nursing notes. The video script was filmed using professional actors. Nursing notes gave more information on Karen's clinical history and recent events, including a cancelled family visit. Revisions were made following pilot testing with a panel of three community care nursing specialists and seven nurses working in academic and clinical settings.

## Data collection

Data collection took place with nurses individually in their workplaces. They were familiarized with think aloud task performance through a practice session. The four case simulations to which all participants responded were presented in random order to avoid order effects. A focused task was devised for each simulation. In case of Karen, two tasks were devised – to describe her current situation and to recommend the next steps to take in her nursing care.

The case simulation and related tasks were introduced and the participant had the opportunity to review the nursing notes. The video clip was presented via laptop computer on two occasions, followed by further review of nursing notes until the participant was satisfied with the task answer. The participant was requested to think aloud throughout the task and researcher interaction was minimal, except to give brief clarifications or prompt the person after 10 seconds of silence. The audio-taped session was transcribed and imported to a NVivo7 (QSR Informational, Melbourne, Australia) dataset for further analysis. The mean transcript length was 701 words (SD = 448·69), with considerable variability from 169 to 1886 words (first quartile 367 words, second quartile 514 words and third quartile 921 words), representing 2–15 minutes duration.

## Ethical considerations

Permission for the study was received from university and health service research ethics committees. Nurses gave informed consent to participate on the basis of anonymity.

## Data analysis

The analysis to identify categories representing psychosocial interventions took place through qualitative content analysis of transcripts (Hsieh & Shannon 2005). Think aloud protocols are often coded according to cognitive categories (e.g. decision and hypothesis), but in this instance the aim was to identify thematic categories (e.g. dialogue and encouragement). The categories were developed inductively through a process of being proposed, tested and modified. Two coders

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worked together to devise the content analysis categories, based on independent coding of a sub-set of 10 transcripts. Each transcript was read repeatedly and then split into units coded to tentative category labels. Text units varied in length from a phrase to one or more lines of text.

Initial categories were appraised in terms of category ambiguity, crossover and key examples. While the focus in this paper is on psychosocial categories, a series of thematic categories or codes were developed to code the transcripts as a whole (Boyatzis 1998). Eight categories referred to judgement (a phenomenon, e.g. *motivation*) and nine to interventions (a course of action, e.g. *dialogue*). The category coding scheme was described in a codebook (Boyatzis 1998).

All the transcripts were coded by one primary coder following agreement of the final coding scheme. This coder was blind to participant demographics. Regular meetings took place throughout coding to review ambiguous text units and to fully review sample transcripts. Inter-rater reliability was indicated by 95·3% concordance between two raters coding a sample of transcripts.

Quantitative content analysis queries were run on NVivo7 to assess prevalence, word count and number of references for each content analysis category. Further exploratory analyses comprised matrix queries of category use by participant work setting and experience level (Richards 2005). Analysis of the resulting descriptive statistics was followed up with inferential statistical analysis of group differences using nonparametric tests. Qualitative analysis of category content and original transcripts was carried out using thematic analysis and constant comparison with identify sub-themes and theme relationships (Braun & Clarke 2006).

## Findings

Three intervention categories representing distinct approaches to psychosocial care were identified in the transcripts. *Dialogue* is closest to patient-centred care, based on phenomenological understanding and therapeutic communication. *Reassurance and encouragement* refers to pragmatic use of communication skills to calm anxiety, promote comfort, shape beliefs and prompt motivation. *Structured engagement* is the third psychosocial theme, reflecting nurse-led, directive prompting of service user behaviour.

The tasks asked of participants prompted a transcript structure organized into perception, analysis and task answer phases. References to psychosocial interventions were generally made when discussing what should happen next in Karen's care. These recommendations followed on from the judgements made of her current situation, highlighting the need to contextualize psychosocial interventions in terms of case formulations. Care decisions vary according to which one of several plausible case interpretations is endorsed (Crowe *et al.* 2008, Kerr *et al.* 2007). Consequently, nurses' judgements about Karen are introduced first, followed by the psychosocial interventions they elicited.

### Understanding Karen: case formulation approaches

A mean of 261·5 words per transcript were coded to the judgement categories. The mean number of judgement themes coded was 3·84, with the highest prevalence themes identified in Table 1. *Motivation* was the most extensively used theme, including sub-themes for goal-directedness/energy ('…not taking personal responsibility, kind of just letting other people organise her life for her', Participant 20, P20), daily routine and self-care (personal hygiene, interest in appearance; 'She hasn't changed her clothes for getting into bed, into her night clothes, so she's obviously lacking motivation', P2).

The *hostility* theme was based on having seen Karen talk loudly towards a nursing student in the case video clip. This behaviour was construed in terms of anger ('…responds very aggressively towards a kindly approach from a nurse', P10), and a volatility linked to risk perception ('there's risks in straight away in having someone maybe that volatile there', P27).

Taken together, the judgement categories reflected several plausible narratives or case formulations:

- Phenomenological explanation: frustration, unhappiness, e.g. 'I think at the moment Karen is may be feeling quite vulnerable' (P38).

**Table 1** Percentage prevalence of themes, mean number of words and references to thematic codes among the participant group

| | Prevalence | Words | References |
|---|---|---|---|
| Judgements | | | |
| Motivation | 89·19 | 70·51 | 2·41 |
| Hostility | 67·57 | 30·41 | 1·51 |
| Negative symptoms of schizophrenia | 67·57 | 26·89 | 1·03 |
| Mood | 59·46 | 19·16 | 1·05 |
| Social isolation | 56·76 | 33·16 | 1·35 |
| Recent events | 48·65 | 28·49 | 0·89 |
| Relapse | 43·24 | 28·70 | 1·00 |
| Interventions | | | |
| Structured engagement | 54·05 | 68·35 | 1·73 |
| Reassurance and encouragement | 40·54 | 40·46 | 0·76 |
| Dialogue | 32·43 | 31·16 | 0·68 |
| Multidisciplinary team | 56·76 | 29·62 | 0·89 |
| Involvement of family | 40·54 | 29·89 | 0·62 |
| Admission to hospital | 24·32 | 13·97 | 0·51 |


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- Functional impairment: low motivation, hygiene problems, e.g. 'the problem quite obviously is her hygiene,…it's impacting upon other residents within the hostel' (P18).
- A psychiatric problem: relapse, negative symptoms of schizophrenia, depression, e.g. 'she may have a mood disorder in association with her schizophrenia as well, which may account for the lack of motivation and not feeling very strong and well' (P10).
- A reactive response to a problem: recent event in the hostel or with her family, e.g. '…the sister didn't take her out at the weekend, so she's probably very disappointed over that and is withdrawn' (P33).

These narratives were used to make sense of the case and emerged early in the transcript. Watching the case video, P1 invoked an illness cause (negative symptoms) of Karen's motivation:

> Her room is a mess. She's got negative symptoms all right. I would have thought she's got no energy. She's maybe paranoid.

Illustrating how case formulation influenced intervention recommendations, P1 moved on from this storyline to frame psychosocial engagement in terms of shaping Karen into a daily routine:

> She'll feel better if she cleans herself up…just work on improving her hygiene needs and use positive reinforcement with regard to her looking after herself and keeping her room tidy. (P1)

### Classification of psychosocial interventions

Intervention themes had a similar coding profile to judgement themes, with a mean of 236·43 words coded to intervention categories. The most prevalent categories are presented in Table 1, and can be grouped into psychosocial engagement, family involvement, and referral or interventions not directly focused on the person (multidisciplinary work and hospital admission). A mean of 139·97 words were coded to the three psychosocial intervention categories identified in Table 1. The most prevalent was *structured engagement*, followed by *reassurance and encouragement*, with *dialogue* used by one-third of participants. Seven participants were not coded for any psychosocial intervention.

### Dialogue

This theme resembles a person-centred, phenomenological orientation and non-directive counselling. Transcript extracts coded to *dialogue* referred to understanding Karen's perspective and subjective experience, rather than the nurse having predefined goals:

> And I think maybe avoid you know, for the moment anyway avoid the hygiene and avoid the room, just to find out, or to listen to her what's going on. (P28)

*Dialogue* was a collaborative form of engagement:

> I would sit with her and work through it together as opposed to the nurse writing the care plan. (P25)

The focus of *dialogue* was to facilitate open expression and exploration of Karen's feelings ('I would ask her would she like to come out and talk to me to discuss what is wrong, what's going on for her', P3). In so doing the meaning and reasons for behaviour could be discussed:

> …discuss the irritability side of things and try to ascertain really is it a product of her being unwell or is it just her generally being irritable, has she got something on her mind that's just not kind of, she's not able to express you know. (P6)

*Dialogue* is strategically important as the form of engagement most congruent with patient preferences and mental health policy. The *dialogue* theme was consequently explored through quantitative content analyses and understood in context by reviewing participants' full transcripts.

Using the Wilcoxon signed ranks test, it was observed that word count for *dialogue* was statistically significantly lower than for *structured engagement* ($z = -2{\cdot}4$, $P = 0{\cdot}02$, $n = 37$). But coding for *dialogue* was a marker for a relatively complex model of psychosocial engagement. Eight of the 12 transcripts coded for *dialogue* were coded for *structured engagement* as well and seven coded for *reassurance and encouragement*. These participants exhibited a relatively autonomous mode of engagement, recommending direct nursing work rather than referring on the case through *hospital admission* and *multidisciplinary work*. None of the nurses coded for *dialogue* advocated *admission to hospital*.

The Mann–Whitney *U*-test showed that participants coded for *dialogue* had a statistically significantly longer transcript in general (mean = 930·17), compared with other nurses ($n = 25$, mean = 591·20 words) ($U = 89$, $z = -1{\cdot}98$, $P < 0{\cdot}05$). This parallels a statistically significant word count difference when all intervention categories were combined ($U = 55{\cdot}5$, $z = -3{\cdot}07$, $P < 0{\cdot}01$). Qualitative analysis of transcripts illustrates contrasts in line of reasoning between transcripts coded or not coded for *dialogue*. P28 (coded for *dialogue*) spoke about *hostility* not as a norm transgression but as a sign of an unknown, underlying issue:

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…obviously there's more than that going on with Karen, she certainly is very angry,…there's something triggering this hostility. (P28)

P27 (not coded for *dialogue*) described Karen's *hostility* in normative terms, as having exceeded the threshold for safety risk:

…before it escalates even worse like, because she might start throwing stuff…it's hard to know how bad she might get like. So she's kind of, alarm bells are going off like about her behaviour at the moment.

### Reassurance and encouragement

Compared with the more open-ended *dialogue* intervention, *reassurance and encouragement* involved communication skills to address immediate goals. Reassurance and encouragement are discrete sub-themes linked by a focus on management of emotional responses and beliefs. Encouragement referred to energising and directing motivation through persuasion:

…continue to encourage her to socialise, there's times when she doesn't want to go out on the bus with her hostel mates. (P23)

Encouragement was focused on goals for increased personal independence:

…it's not about telling her to get up and shouting at her because her room is not tidy, it's to help Karen to get to a point where she wants to get up and get the room tidy. (P24)

Mechanisms for shaping beliefs were described, such as feedback and expectation setting, the aim of which was acceptance of normative community standards:

…say to her that it's not appropriate,…frightening to other patients and to nursing staff as well if she's going to shout and not kind of talk things out reasonably and rationally. (P39)

Reassurance referred to emotional support, but in comparison with *dialogue* the reassurance sub-theme involved situational management strategies for listening and talking to manage immediate needs or goals:

…we'll go in and let her, you know, yell and carry on and stay there and just, you know, keep talking to her, not personalising any of the cursing and wait till she calms down a little bit. (P31)

Other pragmatic purposes of reassurance included to open up communication; for example, the nurse in the video should have:

…maybe sat on the side of the bed and had a bit of general conversation first to capture Karen's attention and engage her in some kind of general chat. (P23)

Reassurance was thus seen as promoting a positive relationship, a basis for the nurse's credibility in requesting behavioural compliance:

…maybe bring in a cup of tea and have a chat before, you know, you ask her to clean up her room. (P8)

### Structured engagement

Structured engagement was the most commonly coded psychosocial intervention. In comparison with *reassurance and encouragement*, which addressed behavioural goals through suggestion and persuasion, *structured engagement* referred to directive methods for introducing plans and structure. This psychosocial intervention involved the nurse sorting the patient out, seeking order anchored in normative standards. This theme framed the nurse's role as prompting and coaxing a daily routine and thus acting in the person's best interests:

…we do have to have a stricter more structured programme really. It won't be accepted anywhere and it's not her illness, it's just behavioural, just getting away with it. (P20)

*Structured engagement* involved goals for daily routine and lifestyle ('…she should have things to do where she's not just lying in bed', P30), addressing motivational deficits in a stepwise, behavioural approach:

…working towards, getting her up out of the bed and then after that, working towards maybe cleaning a bit of her room and another bit and carrying on like that. (P5)

Nurse-led strategies for motivating Karen involved positive reinforcement ('you're back to CBT…reward her if she does something well and keeps the room clean for…a week', P20) and a bargaining approach that suggested an exchange-based, conditional relationship:

…have a word with her, insofar as she has got a bed in a hostel and perhaps part of the agreement was that she keeps her room fairly tidy and helps around the house to help keep her place. (P14)

*Structured engagement* was focused on functional needs, with the nurse acting as a guide to normal behaviour. Nevertheless, this risked running counter to collaborative ideals. Whereas encouragement involves talking about normative standards, *structured engagement* refers to explicit direction and setting goals to achieve compliance with these standards:

…go in and actually explain to her that, you know, it is important to keep up your personal hygiene,…it is her space but at the same time if


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there's an offensive smell coming it does need to be addressed as well. (P22)

### Participant characteristics: domain-specific experience and work setting

There was considerable variation between participants in transcript length and psychosocial recommendations. Patterns in psychosocial intervention category use were explored by using nonparametric inferential statistics for group comparison. Comparisons were made across practice setting (acute, $n = 15$; community, $n = 22$) and by experience level (highly experienced nurses: more than 10 years' experience working in that setting, $n = 13$; less experienced nurses, $n = 24$).

Large differences in the mean number of words coded to psychosocial interventions were noted by practice setting and experience level. The difference between highly experienced nurses (mean = 206·76 words) and other nurses (mean = 103·79) was only marginally statistically significant ($U = 97$, $z = 1{\cdot}88$, $P = 0{\cdot}06$). The difference between community nurses (mean = 176·81 words) and acute nurses (mean = 85·93 words) was not statistically significant. But statistically significant differences emerged when comparing less experienced nurses with highly experienced community mental health nurses ($n = 8$, mean = 252 words, $U = 43$, $z = -2{\cdot}31$, $P = 0{\cdot}02$), reflected in statistically significantly higher word count for *dialogue* and *reassurance and encouragement* although not for *structured engagement*.

None of the highly experienced acute nurses ($n = 5$) were coded for *dialogue*, compared with a majority of highly experienced community nurses. Highly experienced community nurses' intervention model was relatively complex compared with experienced acute nurses' relatively straightforward model that emphasized *structured engagement* (see Table 2). Qualitative analysis of transcripts showed greater emphasis among highly experienced acute nurses for risk-oriented depictions of Karen as relapsing in her illness, socially isolated and low in motivation.

## Discussion

### Study limitations

Case simulation enables direct comparisons between participants, but some loss of ecological validity arises from using a simulation at all. This is a concern, given the intention to use a naturalistic research design. A related consideration is whether case simulation respondents can achieve the meaningful identification required for an individuated, empathic understanding (Devine & Kozlowski 1995). There was evidence of this occurring, especially among experienced community nurses, who were particularly fluent in relating to Karen as a person. However, observation of actual nurse–client consultations is required to verify whether this group has a different approach in practice.

The three psychosocial interventions identified as relevant to routine care are discussed below with reference to service users experiencing enduring mental health problems. While the interventions have potential as generic and relevant to other client groups, further work is required to apply them to other client groups. The findings are most relevant to how nursing care is delivered in Ireland, as regulatory environments in other countries may elicit different nursing recommendations.

### Classification of psychosocial interventions

While not described by participants in formal or theoretical terms, psychosocial work was classified into three intervention categories. Karen, the person in the case simulation, was perceived as experiencing low motivation, a situation associated with enduring mental health problems (Lunt 2002),

**Table 2** Prevalence, mean word count and number of references for intervention codes among highly experienced community ($n = 8$) and acute nurses ($n = 5$)

| | Experienced acute nurses | | | Experienced community nurses | | |
|---|---|---|---|---|---|---|
| | Prevalence (%) | Word count | References | Prevalence (%) | Word count | References |
| Dialogue | 0·00 | 0·00 | 0·00 | 62·50 | 86·00 | 1·63 |
| Encouragement | 20·00 | 28·20 | 0·40 | 75·00 | 116·75 | 1·88 |
| Structured engagement | 40·00 | 86·20 | 1·80 | 50·00 | 61·75 | 1·38 |
| Multidisciplinary team | 40·00 | 21·60 | 1·00 | 50·00 | 15·13 | 0·50 |
| Involvement of family | 40·00 | 31·60 | 0·60 | 25·00 | 14·63 | 0·50 |
| Admission to hospital | 40·00 | 21·80 | 1·20 | 0·00 | 0·00 | 0·00 |

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and one which shaped the discussion of psychosocial interventions. Deficits in motivation, which are defined by Ryan and Deci (2000, p. 69) as concerning 'energy, direction, persistence…activation and intention', provided a rationale for recommending *structured engagement*. Equally, there is a role for *dialogue* to establish what Karen finds energising and motivating, and *reassurance and encouragement* to help calm her and work on attitudes to self-care.

The psychosocial interventions reflect a spectrum of collaboration from patient-led to nurse-led care, which parallel the ascending levels of service user empowerment described by Finfgeld (2004). This fits with service users' expectations for nursing assistance on different levels from prompting independent self-care to giving emotional support (Adam *et al.* 2003).

Yet *structured engagement* was the most prominent psychosocial intervention, based on strategies that use extrinsic motivators such as reinforcement, nurse-led goals and bargaining. Goal-setting is recognized as having an important role in rehabilitation (Levack *et al.* 2006), but sole reliance on this intervention depicts the nurse–client relationship as low in consultation and high in compliance-seeking (Godin 2000), a benevolent role of choosing patient goals and inducing structure (Lutzén & Nordin 1993). This is not consistent with the collaborative engagement sought by people with enduring mental health problems (O'Brien 2001, McCann & Clark 2004, Adam *et al.* 2003).

*Reassurance and encouragement* relies on identification with the nurse for change rather than direct requests for compliance. The personal and professional credibility of the nurse is used as a resource to shape or modify expectations, beliefs and mood. This suggests the therapeutic relationship as a medium for pragmatic empathy, practical counselling using communication skills related to de-escalation, active listening and cognitive behavioural techniques (Morse *et al.* 1992). A formalized parallel can be seen in motivational interviewing, which uses empathic listening and communication to encourage change in belief and behaviours (Graeber *et al.* 2003).

Of the three interventions proposed, *dialogue* is the one closest to policy and service user preferences. It is based on perspective-taking and eliciting the service user's preferences, addressing motivational issues by promoting self-determination, intrinsic motivation and personal growth (Ryan & Deci 2000). *Dialogue* is more consistent with situational, subjective explanations of behaviour (e.g. environmental stressors) rather than internalized, fixed attributions (e.g. psychiatric illness). While *dialogue* is consistent with the image of nursing practice as authentic engagement (Barker *et al.* 1999), less than one-third of participants were coded to this theme, a finding consistent with relatively low levels of empathy noted previously among nurses (Reynolds & Scott 2000).

Nurses who recommended *dialogue* as an intervention were commonly coded for *structured engagement* as well. Multiple interventions were seen by these nurses as useful. *Structured engagement* is not inherently oppositional to the service user. Rehabilitation research on other conditions identifies acceptance of paternalism and direction as an initial step to eventual independence (e.g. Moser *et al.* 2005, Proot *et al.* 2007, Resnick 1996). Following activation of self-care behaviours, patients gradually regain agency. Directive interventions are thus disempowering later in the rehabilitation process (Moser *et al.* 2005).

Ideally, this would be reflected in gradual fading of explicit prompting and increasing self-regulation. However, goal-focused rehabilitation programmes can be experienced as 'meaningless and tough' (Borg & Kristiansen 2004, p. 500), and nursing care can be perceived by service users as alienating and disengaged (Moyle 2003).

### Participant characteristics

Considering psychosocial interventions in the light of participant work setting and experience level allowed the findings to be further assessed and applications to be identified. Of the participant sub-groups, highly experienced community nurses were most likely to recommend *dialogue* and to be coded for multiple psychosocial interventions. They appeared to see *dialogue* as compatible with efforts to shape Karen towards compliance with community standards.

Their active approach to psychosocial work supports the contention that implicit, experiential modes of engagement can be person-centred. The case simulation was depicted in the community, allowing participants with extensive experience in this domain to demonstrate a complex schema (Ericsson 2005). In contrast, nurses highly experienced in the acute hospital domain did not elaborate on psychosocial care more than less experienced nurses. This group's responses were compatible with their institutionally based knowledge, where risk management, order and routine are prioritized (Middelboe *et al.* 2001).

While partly supporting experienced nurses' contention that their implicit model is valuable, the findings also show that this model needs to be disseminated more effectively and consistently in terms relevant to practice (Crandall & Getchell-Reiter 1993). Dissemination efforts could contribute to enriched socialization into an experiential mode of practice, while promoting critical analysis of experiential practice.


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### What is already known about this topic

- Enduring mental health problems are challenging to service users on many levels.
- Service users and policymakers endorse person-centred care for enduring mental health problems.
- While there is extensive theory and evidence-based formal interventions to draw on, there is no consensus on the meaning of psychosocial work in practice.

### What this paper adds

- Three psychosocial interventions were identified on a continuum from nurse-led to client-led care, corresponding to directive methods, pragmatic communication skills and empathic dialogue.
- The most prevalent of these informal psychosocial interventions was directive rather than person-centred.
- Highly experienced community nurses emerged as the group most likely to recommend person-centred psychosocial engagement.

### Implications for practice and/or policy

- Tension exists over expectations for psychosocial care among practitioners, policymakers and service users.
- There is a need for consensus in labelling and classifying mental health nurses' implicit and experiential conceptions of psychosocial engagement.
- The psychosocial interventions suggest the basis for a consensus on what is involved in this domain of nursing work, with potential application in care documentation and critical reflection on professional practice.

## Conclusion

This study illustrates a contrast between nurses' recommended psychosocial engagement strategies and the person-centred philosophy of care and shared decision-making in mental health policy internationally. Highly experienced community nurses tended to display a complex approach but a number of others envisioned a minimal role for service user collaboration. One of the first steps in addressing this tension is to achieve consensus on the interventions that comprise routine psychosocial care, so that there is a common basis for discussion. The interventions proposed here have been arrived at inductively, fitting the implicit, experiential knowledge used to guide judgement and decision-making in this subjective domain of nursing care. Adoption of a commonly accepted classification strategy would open possibilities for promoting everyday applications, such as critical self-monitoring, its incorporation in care documentation, and its use in mentorship and clinical supervision.

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## Conflict of interest

No conflict of interest has been declared by the authors.

## Author contributions

PMN and GC were responsible for the study conception and design. PMN and GC performed the data collection. PMN, CP and HD performed the data analysis. PMN was responsible for the drafting of the manuscript. PMN and AS made critical revisions to the paper for important intellectual content. PMN provided statistical expertise. PMN, AS, PT and AH obtained funding.

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