

## **Application of Partnership in Coping system of Recovery to clients with serious enduring mental health concerns**

### **Introduction**

The PinC system of Recovery is used mainly in one-to-one interactions.

However the system can also be used in other forums.

Below is an example of how it can be used in a combination of one-to-one and group interactions that is tailored to help those with severe and enduring mental health concerns.

### **Recovery**

The Partnership in Coping (PinC) system of Recovery is about self-help, empowerment, hope, active participation, self advocacy - connecting with others, self directed coping strategies and having a sense of control. It involves the individual taking responsibility or control and gaining or re-gaining many 'taken for granted' aspects of life that may have been lost or severely compromised by serious and enduring mental health concerns. The system constitutes a fundamental shift in psychiatry which separates the task of controlling symptoms and cure in the usual medical service from the business of leading a better life. This new paradigm of recovery underlines helping people achieve outcomes such as independence, employment, housing, satisfying relationships instead of centring solely on conventional outcomes of treatment compliance and prevention of relapses and re-hospitalisations (Tams 2004, Frese, Stanley, Knees, and Vogel Scibilia. (2001)

## **Outline of Partnership in Coping system of Recovery**

The PinC system of Recovery promotes client self management and reflects a philosophy that involves service-users in decision-making at all stages of their engagement with the services. It focuses on the person's strengths and abilities and constitutes a holistic approach in that it embraces a wide range of concerns, including practical issues being experienced by the person (Shanley, Jubb and Latter, 2003, Jubb-Shanley and Shanley, 2007). While the primary focus of the PinC system was to help the individual achieve specific goals they have set for themselves, a more global aim is to improve their psychosocial wellbeing by increasing an individual's level of hope and coping abilities, to encourage internal locus of control and to promote a greater degree of self efficacy.

### Core Concepts

The term 'Partnership' is the relationship between the client experiencing mental health concerns and the mental health worker in a working alliance, to achieve a common goal. It uses agreed means of working based on the presence of the three core conditions of unconditional positive regard, genuineness and empathy (Rogers 1961). 'Coping' is seen in terms of the client

- 'thinking through' the concern (cognitive approach) e.g. recognising unhelpful thinking styles, and in
- 'acting through' the concern (behavioural approach) e.g., taking medication, avoiding trigger factors.

Alternatively coping strategies involve:

- cognitive avoidance (becoming resigned to the problem) and

- behavioural avoidance (using distractions) e.g. exercise, relaxation, meditation, using humour, and religion).

Despite the negative connotations associated with the term 'coping' as in the expression 'managing to cope', the decision to use the term was taken by service users who were involved in developing the system. They felt it reflected the essence of the approach namely the use of their existing coping strategies to maintain or improve their mental health.

### **Application of a therapeutic programme for people with severe and enduring mental health concerns based on PinC**

PinC can be applied in a one-to-one relationship, in groups or in a combination of both. In the case of helping people with severe and enduring mental health concerns a combination of both individual and group therapy is considered a useful approach.

Clients with severe and enduring mental health concerns may experience episodes of delusions or hallucinations, interference in their thinking (positive symptoms), poor motivation, apathy and social withdrawal (negative symptoms). Also associated with severe and enduring mental health concerns are low self esteem, stigma, social isolation, a sense of hopelessness, anxiety, depression and fear of relapse (Thompson and Mathias 2000).

Research reported by Tarrrier, Yusupoff, Kinney and McCarthy (1997) into the use of coping strategies enhancement in the treatment of hallucinations and delusions in people experiencing symptoms associated with schizophrenia cited improvements in positive symptoms. However no significant changes occurred in negative symptoms and in wider aspects of the client's functioning including their social interaction skills. To address these

'negative symptoms' the creation of therapeutic relationships and peer interaction in the therapeutic programme using the PinC system of Recovery group is aimed at addressing the client's more holistic concerns. According to Whitaker (2000), clients experiencing or beginning to emerge from serious breakdowns in coping such as those experiencing schizophrenia benefit from time limited group sessions. Yalom (2000) recommended that, guiding the group through topic orientated discussion is a means of supporting those who might be psychologically fragile. This provides a safe framework in which to operate and facilitate the development of social contacts and meaningful relationships and for the creation and maintenance of hope. Within the time limit and structured framework the therapeutic programme facilitates the clients playing a large part in decision making processes throughout.

### **The therapeutic Programme**

The therapeutic programme consists of two parts. Firstly each potential client is seen on a one-to-one basis by the mental health worker and secondly he or she takes part in a time limited structured group forum.

#### **One-to- one forum**

The aims of this forum are to (1) select clients that are considered suitable for the programme, (2) establish a therapeutic relationship with each client and (3) to commence the process of the PinC system by helping the client identify his/her mental health concerns and goals. These aims are achieved prior to entering the group. It is anticipated that each client will require 3 to 4 one-to-one therapy sessions.

According to Yalom (2000) the more often clients are seen by a mental health worker before entering the group the less likely they are to terminate prematurely from the group. Dropout rates of people with severe and enduring mental health concerns are particularly high (TARRIER, Yusupoff, Kinney and McCarthy 1997). Contact with the mental health worker will also help with the development of bonds between other members later in the group forum by their mutual identification with the mental health worker.

### **Group forum**

The time limited structured nature of the group is intended to increase efficiency and energise the group sessions in emphasising that the immediate matters at hand and that ultimate responsibility rests within the individual not outside him/her in achieving goals (Yalom 2000).

The intention of the group is dual focussed. The first aim of the group is to help the client achieve the goals set by him/her in the one-to-one sessions by staying in the present with either a 'here-and now' focus or a 'there and now' (recent problem-oriented) focus. The second aim of the group is to assist the client in benefiting from the social interactions within a group that provides a safe environment. Activities within the group may help members with similar mental health concerns to have corrective emotional experiences such as reaching out to others, being of help to other people, comparing own views of self and the world with others, developing the ability to listen and communicate with others, thinking through ways to reorganise a lifestyle if considered practicable or useful and for testing out new behaviours in the group (Whitaker 2000).

## **Recruitment and selection**

It is acknowledged that there is a high attrition rate for people who experience schizophrenia with over 50% of those who commenced therapy leaving prematurely (Tarrier, Yusupoff, Kinney and McCarthy 1997). The use of one-to-one sessions prior to the group work is intended to offset this risk by establishing a therapeutic relationship with each client. This is seen as a useful means of reducing the dropout rate.

Referrals will be taken from agencies such as self help groups, GPs and from Community Mental Health Services.

## **Inclusion Criteria**

1. Experience of episodes of serious and enduring mental health concerns e.g. schizophrenia.
2. Living in the community
3. Currently in a non-psychotic state
4. Possess a moderate degree of motivation to participate
5. Agreement from a medical doctor responsible for the health of the client that it would not be harmful to the client's wellbeing to participate in the sessions. Obtaining this agreement may not be necessary in some situations depending on the system of mental health care, if any, the client is receiving.
6. Approximately equal number of men and women.

## **Exclusion criteria**

1. Currently experiencing an acute episode of schizophrenia

(The inclusion of such a client in the group may be too taxing and too anxiety provoking for other group members to manage).

2. Potential irregular attendees.

3. Extremes of discomfort levels (either high or low discomfort levels).

## **Practical Arrangements for conducting the Group Sessions**

### **Physical setting**

Any room that affords privacy and freedom from distraction

A room big enough to allow members to form a circle so that all can see one another

### **Duration and Frequency of Meetings**

The group will meet as a closed group once a week for twelve weeks. At the end of this period the group will be then reconstituted for a further twelve weeks retaining some members from the previous series and inviting others to join. This strategy is aimed at maintaining a critical mass of 8 -10 members.

The duration of each meeting normally will be 80-90 minutes.

The meeting will be held at a site such as a community hall.

The time of day will depend on the convenience of the participants.

### **Size of group**

Initially 14/15 people will be invited to the one-to-one forum with the anticipation of reduction to 8 - 10 as a stable number.

### **Role of the Mental Health Worker**

Within the PinC system of Recovery the mental health workers' role is to help clients to take responsibility for their own wellbeing, focus on the concerns identified by clients in the one-to-one sessions, help the client to use his/her existing skills in coping and where appropriate to help the client using the group process to expand their repertoire of existing coping skills. More global aspects of the mental health worker's role particularly the group setting are to increase the members' level of hope and coping abilities, to encourage internal locus of control and to promote a greater degree of self efficacy. In this way the mental health worker will help the client to draw on their existing skills and resources (personal, social and environmental etc).

#### **PinC system of Recovery.**

Within the PinC system the individual group member is the prime decision - maker in issues affecting him/her.

The mental health worker will attempt to establish a working alliance with each client. This alliance consists of the bond (therapeutic relationship), goals decided upon and the tasks agreed that will achieve the goals.

Bond is described as the foundation of the working alliance and its development is the main focus of the first of the 8 guided steps in PinC. Success of the ensuing partnership depends on the growth and maintenance of this bond throughout the client, mental health worker engagement. The bond (therapeutic relationship) involves the creation of core conditions of empathy, unconditional positive regard and genuineness. These conditions help create a positive relationship between the partners (mental health

worker and the client) such as mutual trust, acceptance, confidence and feelings of a common purpose (Bordin 1994).

Goals are set in the one-to-one sessions prior to group sessions with the support of the MHW.

Tasks set are the practical details of the actions decided and acted on in the group setting.

Within PinC, the bond, tasks and goals are integrated in a systematic way and in a way that gives clients the major responsibility in undertaking tasks towards achieving their goals.

### **Brief outline of stages of PinC**

#### **Creation of a therapeutic relationship**

The mental health worker will use the principles of client centred therapy (creating the core conditions of unconditional positive regards, empathy and genuineness) in establishing a working alliance with the client. The development of this relationship begins with the first step of the process i.e. one-to-one sessions.

#### **Identification and Prioritisation of concerns**

Issues related to mental health concerns that the client stated they wished to address are identified and prioritised with assistance from the mental health worker in the one-to-one sessions. Prioritisation of concerns is in terms of the degree of desirability to address the concerns and the level of feasibility of action being considered likely to succeed by the client.

## **Establishment of goal**

Goal setting (the formulation of a statement of expected or desired change) is made by the client with the help of the mental health worker. This also occurs in the one-to-one sessions.

The process of establishing goals involves discussion, negotiation and agreement on goals identified by the client. All goals are treated as sincere aspirations of the client. As with all other communications with the client statements of goals are not reframed into professional language.

The client defines goals according to a number of criteria.

- Achievable
- Ownership
- Ideally goals should belong to both the mental health worker and the client
- Specific and able to be evaluated
- Clearly stated goals
- The client is encouraged to consider a range of options in formulating goals from the most obvious to the most innovative.

## **Identification of coping strategies**

The client identifies coping strategies by reflecting in the group setting the previous occasions when they dealt with the same or similar concerns. The group as a whole discuss different coping strategies they have used.

The client and the mental health worker undertake the following:

- discussing the antecedents to previous incident/episode/s the episodes themselves and the consequences following them.
- talking about the ways used to cope with them in terms of their effectiveness.
- identifying as many ways used to deal with the concerns raised (with the help of the group).
- recording the range of actions, i.e., coping strategies, taken by each client and examining each of these.

### **The application of coping strategies**

Each group member will be encouraged by the mental health worker to develop a coping strategy plan that involves using the strategies previously identified as effective to cope with their concerns.

### **Evaluation of Outcome**

Client's goal orientated outcome measure

In order to identify the degree of success of the programme and to maximise the learning from the experience of running this programme the evaluation of the degree to which the goals of each client has been achieved will be established. The feedback will form the basis for discussion with the clients and help the client in determining where to take the issues from here.

Client's psychological wellbeing measures

Global changes in an individual's psychological wellbeing will be measured by comparing clients' characteristics pre and post intervention in terms of hope, coping skills, self efficacy and locus of control.

Clients will be asked by an independent consumer representative to complete questionnaires at the start of the therapeutic programme (in the one-to-one sessions) and in the second last group session. The results will be discussed in the final session. Care will be taken to ensure that the evaluation process compliments the work being done to help the client better use his/her existing coping skills and improves his/her more general psychological wellbeing.

Instruments that will be used are as follows:

The Herth Hope Index (HHI) is a 12 item scale which measures hope in terms of temporality and future, positive readiness and expectancy and interconnectedness with self and others. The instrument has satisfactory reliability and validity (Herth 1992).

The COPE (dispositional) inventory consists of 5 scales that measure problem-focused coping (active coping, planning, suppression of competing activities, restraint coping, seeking of instrumental support); 5 scales that measure emotion-focused coping and 3 scales that measure coping responses (Carver, Scheier and Pozo 1992).

The measure of self efficacy to be used in the study is the Generalised Self Efficacy Scale (Jerusalem and Schwarzer 1992). This scale has 10 items that assesses the strength of an individual's belief in his or her own ability to respond to novel or difficult situations and to deal with obstacles or setbacks.

The Recovery Locus of Control is a 9-item scale developed by Partridge and Johnston (1989). It provides a measure of the internality/externality of the client's perception of control over his or her recovery. Five items reflect internal beliefs and four items reflect external beliefs. Validity and reliability have been established (Partridge and Johnston 1989).

The results of all the measures will form the basis of discussion with the group and may stimulate interest in establishing the relevance of these qualities to themselves.

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