

# Advanced practice nurse's role in alcohol abuse group therapy

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## ABSTRACT

The purpose of this paper is to discuss the importance of conducting groups for alcohol abuse and to present implications for the advanced practice nurse (APN) in leading these groups. The APN is situated to assist in this process not only in a competent and efficacious manner, but in a cost effective fashion. Many studies validate the need and benefit for using group therapy as an intervention for alcohol abuse. The APN can perform this task with positive outcomes, using the American Nurses Association Psychiatric Mental Health Scope and Standards of Practice (ANA 2000) as guidelines for assessing and diagnosing patients, identifying patient outcomes, planning patient care, implementing that plan, and evaluation. Many other sources, such as the USA Department of Health and Human Services *Healthy People 2010* (2000), the USA President's New Freedom Commission on Mental Health (New Freedom Commission on Mental Health 2003), and the USA Report of the Surgeon General on Mental Health (1999), can be referenced to ensure that the patient is provided with the best prevention, as well as treatment.

## INTRODUCTION

The purpose of this paper is to illustrate the significance of the advanced practice nurse's (APN) role in leading alcohol abuse group therapy sessions. Nurse's roles have always been one of compassion and empathy coupled with education and prevention, so why not meld these great qualities and skills to create an empirically based intervention that will not only be successful in theory, but will offer patients a positive outcome?

Many different strategies have been used to treat alcohol abuse. With the advent of managed care, the clinician is forced to condense the length of treatment while at the same time provide the patient with quality outcomes. This poses a challenge for the health care professional, especially when dealing with co-morbidities. This paper proposes that the advanced nurse can use empirically based treatment modalities in an effective manner, while also adhering to the constraints of managed care.

## DISCUSSION

It is important to examine the history of group therapy in order to understand why it still works today and additionally to follow new trends. It is agreed that the origin of group therapy was the early 1900s, treating casualties of World War II. The thought was that more people could be treated in a shorter time period. The next phase of group therapy use was during the movement toward de-institutionalisation of the unremittingly psychologically ill patient. With the shortage of professional staff to run these groups, together with the number of patients requiring this intervention, group therapy was revised. Experimentation with different sized groups with homogeneous members gave rise to the use of techniques that met the requirements of an expansive variety of patient populations and mental health maladies. The third phase of group therapy evolution was precipitated by health care reform. The progression has come full circle back to the need to see more people in less time. This economically based health care delivery system has mandated

change in the traditional approaches, which exists today (Spitz and Spitz 1999).

While many variables impact the capacity of the APN, there is one standard that is used nationally to guide practice. Reference to these standards of care can be found in the Psychiatric Mental Health Nursing: Scope and Standards of Practice, which is published by the American Nurses Association (ANA 2000). These standards consist of assessment of the patient, diagnosis, identification of patient outcomes, planning, implementation, and evaluation, all of which are equally important. The assessment process is highly scrutinised to avoid making an improper diagnosis and thus potentially employing inappropriate interventions. According to the ANA Psychiatric Mental Health Nursing: Scope and Standards of Practice (2000), the advanced practice nurse's role is expanded on by offering psychotherapy, prescribing medications and providing consultation, as directed by state statutes or regulations.

Another document available to guide the clinician in assessing health issues and implementing interventions is Healthy People 2010 (USA Department of Health and Human Services 2000). This manuscript proposes and projects planning efforts in a systematic approach toward public health. It predicts the overall health of a nation by using health indicators chosen for their capacity to motivate action, the accessibility of statistics to evaluate progress, and their significance as community fitness concerns. Two health indicators addressed in Healthy People 2010 can be applied by the APN when performing group therapy and they are: substance abuse and mental health. The USA Health People 2010 (2000) proposes two goals that the APN can use to conduct therapy and these are: to reduce the proportion of persons engaging in binge drinking of alcoholic beverages (pp.26-11) and to increase the proportion of adults with depression who receive treatment (pp.18-19).

The USA President's New Freedom Commission on Mental Health can also be employed to direct the path of alcohol abuse group therapy. This national

document reinforces the notion that mental health issues must be transformed and the APN is positioned to assist with this revision in the health care system. The number one goal of the New Freedom Commission is that: *Americans understand that mental health is essential to overall health* (USA President's New Freedom Commission 2002 p.7). The final report of the President's New Freedom Commission on Mental Health suggests that: "care must focus on increasing consumers' ability to successfully cope with life's challenges; on facilitating recovery; and on building resilience, not just managing symptoms" (2002 p.5). Research has shown that group therapy is effective in achieving this goal.

Additionally, the USA report of the Surgeon General on mental health (1999) can be used by the APN in assessing mental health issues that pose a problem and subsequently providing appropriate care to those in need. The Surgeon General Report is the product of a relationship between two USA Federal agencies, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institutes of Health (NIH). SAMHSA was primarily responsible for organising the progress of the report. Eight chapters are devoted to the development and appropriate treatment of mental illness. This report states that: "Substance abuse is a major co-occurring problem for adults with mental disorders" (USA Surgeon General Report 1999). It further states that: "Evidence supports combined treatment, although there are substantial gaps between what research recommends and what typically is available in communities" (USA Surgeon General Report 1999).

## LITERATURE REVIEW

While many people have indicated an interest in the group therapy process and have studied it extensively, it would seem negligent not to mention two of the most influential pioneers of their time. Hildegard Peplau, a passionate psychiatric nurse, and Irvin Yalom, a psychiatrist, are well known for their contributions to group therapy. When examining Peplau's

*interpersonal theory of nursing* (1991) and Yalom's *group therapy and therapeutic factors* (1995), much similarity is noted. Peplau was the first to identify and 'name' the technique of interpersonal relating and this appears to be a springboard for therapeutic techniques. Peplau used the works of Sullivan and his interpersonal theory in addition to Freud's psychodynamic theory. As a result, she developed her theory of *interpersonal relations in nursing* (1991). The high correlation between her theory and that of psychotherapist Yalom is easily understood. According to Belcher and Fish (1995 p.59), "Peplau identifies needs, frustration, conflict and anxiety as important concepts in nursing situations", all of which have to be addressed for growth to occur. Yalom lists twelve therapeutic factors through which a patient moves during therapy, and they are: "instillation of hope, universality, imparting information, altruism, the corrective recapitulation of the primary family group, development of socialising techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors" (Yalom 1995 p.1).

Just as Peplau and Yalom have expanded models for psychotherapy, Dr. Madeline Naegle, a present-day leader in substance abuse research, has teamed with faculty members from New York University (NYU) to develop a model nursing curriculum on substance abuse education (NYU 2003 pp.20-21). Her model has led to the further development of a program designed to build skills in substance related disorders research and education, which appear to extend Peplau's vision of nurses' abilities, not only to provide care to specific populations of patients, but to recognise these problems early on and to educate accordingly. Furthermore, the problem of alcohol abuse is not solely the patient's crisis, but a family dynamic. Group therapy can address the family dynamics in a cost efficient and efficacious manner.

Therapy and nursing have much in common. Both require more than technical skill to be proficient. Helping patients achieve their highest level of wellness involves the art of listening. They require

the art of listening and observing. Hildegard Peplau knew this to be true. When a patient and a nurse worked together, the outcome was that of increased knowledge and maturity for both. In her book: *Interpersonal relations in nursing: a conceptual framework of reference for psychodynamic nursing* (1991), Peplau defined the phases of the interpersonal process.

As described by Belcher and Fish (1995), Peplau proposed that “nursing is therapeutic because it is a healing art, assisting an individual who is sick or in need of health care” (p.50). Nursing becomes an “interpersonal process because it involves interaction between two or more individuals with a common goal” (p.50). Mutual respect of patient and nurse is the incentive for the therapeutic process. This is achieved through the learning and growing resultant from the interaction. Attaining this goal is met through steps that follow an orderly progression. Through the relationship, “the nurse can choose how she or he practices nursing by using different skill, and technical abilities, and by assuming various roles” (Belcher and Fish p.50). Similarly, the theoretical framework of psychotherapy in organised group therapy has been defined as a treatment method where patients meet with a qualified provider to achieve positive change.

Much research has been directed toward evaluating the most effective treatment strategies for alcoholism. Treatment strategies vacillate between two extremes: (1) sequencing treatment components according to the individuals stage of readiness and varying the approach as needed over time and (2) assigning treatment in a stepped care fashion in which treatment is initiated by using the least intense/costly treatments likely to address the patients needs with the option of moving to higher levels if treatment is unsuccessful (Mattson 2003 p.97). Despite the vagaries of treatments, focus is always placed on the overall goal of treatment. The treatment goal for alcoholism is all but universal; ensure retention of the patient in treatment, appropriate utilisation of resources, and overall effectiveness. When deciding treatment modalities, current argument leads one

to match individuals to treatment. Better drinking outcomes have been reported when the patient’s emotional status was matched to the type of therapy provided. Patients who would be considered highly reactive have been shown to respond more favorably to Cognitive Behavioral Therapy interventions.

Project Matching Alcoholism Treatments to Client Heterogeneity (MATCH) postulated that subjects initially lower in motivation would do better in Motivational Enhancement Therapy compared to Cognitive Behavioral Therapy. This did not occur until the twelfth month of follow up. It demonstrated that readiness to change was found as a strong predictor of drinking status through one year after the end of treatment. Further studies of matching have shown that Type A alcoholics (late onset, few vulnerability markers, less psychiatric comorbidity, fewer alcohol related problems and a good prognosis) had better outcomes in interactional groups. Whereas Type B alcoholics (early onset, rapid progression, familial vulnerability, co-morbid psychiatric disturbance, more severe alcohol related problems and a poor prognosis) benefited most from coping skills group. The majority of the outcome studies involving psychodynamic approaches for treating alcohol abuse and dependence were conducted in the 1960’s and 1970’s (DiClemente et al 2003 p.116). Researchers, Roth and Fonagy (1996) concluded in their review of these earlier studies that “dynamic psychotherapy demonstrated positive results compared to no treatment controls” (p.116). When psychodynamic approaches were compared to less intense modalities, it was found that psychodynamic therapy had a high cost and little or no evidence of unique effectiveness (p.116).

In view of the fact that the majority of patients presenting with substance abuse manifest signs of coexisting psychiatric disorders, it would appear the practical approach would be to treat both disorders simultaneously. This approach to treatment has been in debate, with both perspectives indicating validity. According to Daley et al (1987), whatever approach is used, the clinician must be aware of the dual disorders and adapt their customary interventions

to management and expand suitable plans to treat both disorders. One study done by Burtscheidt et al (2002) indicated higher alcohol abstinence rates on a two year follow up when behavioral therapy was used versus a non-specific supportive therapy. These results did however point out a reduced advantage from behavioral methods when severe personality disorders coexisted, thus amplifying Daley et al's (1987) suggestions that approaches to therapy should be customised to fit the patient.

Matano and Yalom (1991) adapted interactive group therapy for chemically dependant individuals: "The two primary foci of this treatment are the interpersonal relationships within the group in the here and now and conceptualising the group as a social microcosm" (p.117). The authors established five guidelines for the therapist wanting to integrate interactional group therapy for the treatment of chemical dependency: (1) priority of recovery, (2) identification as an alcoholic/addict, (3) careful modulation of anxiety levels, (4) a therapeutic approach to responsibility, and (5) modification of the group process to incorporate into therapy the language and belief of Alcoholics Anonymous (p.273).

The literature describes several types of cognitive therapies used in the treatment of chemical dependencies. Rational Emotive Therapy has been adapted for the treatment of alcoholism. During Rational Emotive Therapy, participants "examine beliefs about drinking and drinking-related expectancies, then challenges those beliefs, which assists the client to create realistic and healthy beliefs, as well as engage in more adaptive self-talk" (DiClemente et al 2003 p.119).

In 1976, Beck developed a cognitive therapy approach that is active and structured. This model "assumes that dysfunctional beliefs regarding the use of alcohol, the anticipated negative withdrawal syndrome and believing that craving is beyond the individual's control all contribute to maintaining the use. Therefore, treatment focuses on assessing situations in which the client is likely to drink and altering faulty beliefs about alcohol", (DiClemente

et al p.119). Included in this type of cognitive treatment are behavioral components such as "activity scheduling, behavioral rehearsal, and relaxation training", (Beck et al 1993). Using cognitive approaches to reframe problematic beliefs and thoughts can play a vital role in sustaining a significant change in drinking behavior.

Whatever therapy is used, it is necessary to follow certain therapeutic guidelines. Spitz et al (1999) suggests that ten guidelines be used when working with substance abuse groups:

- (1) Group goal is to help self and others to abstain from using,
- (2) Be honest about past and present drug use,
- (3) Commitment to refrain from using,
- (4) Mandates regular attendance at the group,
- (5) Do not attend group under the influence of alcohol,
- (6) Initial relapses will be viewed and treated as learning experiences,
- (7) Random urine testing is agreed on,
- (8) No socialising outside of group sessions,
- (9) Family member contact by the group leader is permitted, and
- (10) Confidentiality is a must.

## CONCLUSION

Barriers remain that keep advanced practice nurses from becoming effective group therapy leaders. Most of the barriers relate to the stereotyping of what nursing roles are and should be. All nurses are commonly thought of in their technical role practicing the skills of nursing. Nurses can easily be identified in the role of technician: checking blood pressure, changing dressings, dispensing medications. That is but one aspect of nursing; the art of nursing involves much more. It is the art of nursing where a nurse can demonstrate skills as an active resource for patients and families. "Psychiatric-mental health nursing is a specialised area of nursing practice employing a wide range of explanatory theories of,

and research on, human behavior as its science and purposeful use of self as its art” (ANA 2000 p.10). The advanced practice psychiatric nurse has the capability, through training, to provide among other functions, psychotherapy, including brief, long-term, individual and group. Peplau identified that for nursing when she developed her theory of interpersonal nursing (1952). The nurse is taught to actively listen to patients and through this listening develop a therapeutic process where learning and growing results. Developing goals and progressing in a step-wise fashion, is achieved within this relationship between nurse and patient.

Peplau is not the only reference for the advanced practice nurse acting as therapist. The Psychiatric Mental Health Nursing: Scope and Standards of Practice (ANA 2000) expands on this theory. Clinical practice activities include: “meeting patients’ needs for a stable emotional and social support system” (ANA 2000 pp.12-13). Accordingly, the practitioner utilises “self as a therapeutic resource through one-to-one group interactions, in structured or informal sessions and in the physical as well as the psychosocial aspects of care” (p.13).

## RECOMMENDATIONS

The advanced practice psychiatric nurse practitioner is positioned to enhance positive outcomes in patients’ treatment. By virtue of their advanced training, the practitioner is able to provide comprehensive psychiatric services. Providing group therapy for a population that requires long-term interventions is a challenge in today’s resource restricted medical environment. A skilled group therapist can provide services for a greater number of persons for a longer period of time in a cost effective manner. In the managed care environment of medical practices, group therapy meets the needs of a population with chronic problems.

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