

Running head: NON-PSYCHIATRIC NURSING FACULTY PERCEPTIONS

Non-Psychiatric Nursing Faculty Perceptions of Working with Mentally Ill Patients
A Qualitative Phenomenological Study

A dissertation submitted

by

Ann M. Harms

to

College of Saint Mary

in partial fulfillment of the requirement

for the degree of

DOCTOR IN EDUCATION

WITH AN EMPHASIS IN

HEALTH PROFESSIONS EDUCATION

ABSTRACT

The nursing shortage in 2009 has taken a heavy toll on the psychiatric nursing workforce (Hanrahan and Gerolamo, 2004; Patzel, Ellinger, and Hamera, 2007). Mental health nurses are aging and retiring faster than they are being replaced (Hanrahan and Gerolamo, 2004). It is inevitable that all nurses, even those working in non-psychiatric settings will care for mentally ill patients. This is true also for non-psychiatric nursing faculty who face helping students work with mentally ill persons within their academic and clinical settings.

This phenomenological qualitative study explores the perceptions, attitudes, and beliefs non-psychiatric nursing faculty hold about working with mentally ill patients. Eighteen non-psychiatric nursing faculty participants described their lived experiences regarding mentally ill patients. Each reflected on how they believed their experiences, personal and professional, might have influenced their perceptions of working with mentally ill people, as well as how they believed their perceptions informed their clinical and teaching roles.

These are the four themes identified: 1. Images associated with mental illness (predominantly severe mental illness or substance abuse). 2. Perceptions related to mental illness (perceptions of the mentally ill patients, of the nurses themselves, and or the “system”) and emotional perceptions. 3. Perceived influential factors (influential others, exposure to or experience with mentally ill persons). 4. Perceived impact of perceptions (on behavior, and on emotions).

DESCRIPTORS: PERCEPTIONS TOWARD MENTAL ILLNESS; PSYCHIATRIC NURSING EDUCATION; ATTITUDES; NON-PSYCHIATRIC NURSING FACULTY

Dedication

Education should consist of a series of enchantments, each raising the individual to a higher level of awareness, understanding, and kinship with all living things.

Author Unknown

To my daughter, Olivia.
May you continue to experience the wonders of learning.

Acknowledgements

This has been quite a journey. So many wonderful people have supported me throughout the process. Thank you!

- To Dr. Peggy Hawkins who provided much needed support and guidance throughout the beginning and middle stages of the doctoral and dissertation process. As my initial adviser and dissertation chair, she encouraged me and told me I could do it.
- To Dr. Jeffrey Ehrlich who took over the great task of shaping my “almost done” dissertation and provided me with exceptional support and cheerleading. His non-nursing perspective proved important in translating this work into one that will be understandable for professionals in other healthcare fields.
- To Dr. Patricia Morin who taught me how to synthesize the literature and provided me with wonderful feedback and enthusiastic hugs whenever I was on campus.
- To Dr. Susan Ward who supported me and added her expertise in qualitative research and writing to the dissertation process. She introduced me to the process of scholarly writing by inviting me to write a chapter for her.
- To Dr. Eleanor Howell who allowed me the time it has taken to accomplish this task and encouraged and supported me throughout the process.
- To Dr. Joan Norris who provided ongoing editorial feedback and cheerleading support .
- To Dr. Ann Taylor-Trujillo who understood the angst and joy of the process of working toward a doctorate.

- To my wonderful colleagues, Aris Andrews, Marilee Aufdenkamp, Nancy Bredenkamp, Sharon Hayek, Deb Marr, Jane Parks, and Ali Whittaker whose strong encouragement and support carried me through many discouraged moments.
- To my West Virginia friends who have emailed and telephoned encouragement throughout.
- And to my wonderful daughter, Olivia, my mother, Jeanne, and my family. They have all tolerated my being distracted, absorbed, and often absent, and have given me wonderful loving to make it through.

Table of Contents

Abstract.....	2
CHAPTER I: INTRODUCTION.....	11
Background and Rationale.....	11
Purpose of the Study	14
Assumptions	15
Limitations and Delimitations	15
Definition of Terms	15
Significance of Study.....	17
Research Questions.....	18
Summary.....	18
CHAPTER II: LITERATURE REVIEW	20
Historical Context.....	20
Background.....	20
Extant Literature.....	21
Studies of perceptions of and attitudes toward mental illness.....	22
Nursing faculty perceptions and attitudes.....	22
Nurses' perceptions and attitudes	22
Nursing students' perceptions and attitudes.....	23
Studies comparing attitudes.....	24
Relevance.....	25
Influences on student nurses' perceptions and attitudes.....	26
Impact of perceptions, attitudes and beliefs.....	29

Additional Literature Reviewed.....	30
Theme 1: Images.....	30
Theme 2: Perceptions.....	31
Theme 3: Influences on perceptions and attitudes.....	34
Theme 4: Impact of perceptions.....	35
Summary.....	36
CHAPTER III: METHODS AND PROCEDURES.....	37
Research Design	37
Rationale for phenomenological qualitative study	37
Assumptions of Qualitative Designs.....	38
Theoretical Framework.....	38
Ethical Consideration.....	39
Identification of Sample.....	40
Procedure	41
Quality Review of Data.....	42
Data Analysis.....	43
Summary.....	44
CHAPTER IV: RESULTS.....	45
Demographic Data	45
Data Analysis.....	47
Theme 1: Images associated with mental illness.....	49
Behavioral Images.....	50
Population and Treatment Images.....	51
Specific Memories.....	54

Theme 2: Perceptions of mental illness.....	57
Perception of Self.....	59
Perception of the "System".....	61
Emotional Reactions.....	62
Theme 3: Influential factors.....	64
Influential Others.....	65
Exposure or Familiarity.....	67
Theme 4: Ultimate impact of perceptions.....	68
Results Summary	70
CHAPTER V: DISCUSSION AND SUMMARY	73
Purpose of the Study.....	73
Research Design and Questions.....	74
Presentation of Findings.....	74
Significance of Findings	80
Limitations of this Study	81
Implications and Recommendations.....	82
Future Research	83
References.....	87
Appendices.....	95
Appendix A: Internal Review Board (IRB) Approval.....	95
Appendix B: IRB Change of Protocol Approval.....	96
Appendix C: Invitation to Participate Letter.....	97
Appendix D: Rights of Participants.....	98
Appendix E: Research Questions.....	101

LIST OF TABLES

TABLE	PAGE
1. Highest Degree Held.....	40
2. Years in Nursing.....	40
3. Years Teaching.....	41
4. Data Analysis Using Moustakas' Method (1994).....	43
5. Behavioral Images.....	51
6. Population and Treatment Images.....	52
7. Specific Professional and Student Memories.....	54
8. Perceptions of Working with Mentally Ill Patients.....	58
9. Perceived Influential Factors.....	65
10. Ultimate Impact	68

LIST OF FIGURES

Table		Page
1.	Areas worked.....	46
2.	Areas taught.....	47

CHAPTER I: INTRODUCTION

Non-Psychiatric Nursing Faculty Perceptions of Working with Mentally Ill Patients

Chapter I introduces the reader to the study. It details the purpose of the study as well as the background and rationale. It includes the definitions of the relevant terms and discussion of the limitations and delimitations of the study.

Background and Rationale

The nursing shortage in 2009 has taken a heavy toll on the psychiatric nursing workforce (Hanrahan and Gerolamo, 2004; Patzel, Ellinger, and Hamera, 2007). Mental health nurses are aging and are retiring faster than they are being replaced (Hanrahan and Gerolamo, 2004). Likewise, nursing faculties are older and the ranks are not being replenished fast enough to accommodate the numbers of students wishing to pursue nursing (American Academy of Colleges of Nursing [AACN], 2008).

Trends toward integrating nursing curricula have prompted worries that students do not have access to adequate clinical and lecture hours specifically devoted to psychiatric nursing concepts and experiences (Fox, 1988). The explosion of “basic” nursing knowledge has relegated psychiatric nursing to a “specialty” track at the same time that mental health concepts are being emphasized internationally (World Health Organization, 2001; Galson, 2009), and integrated into non-mental health curricula (American Psychiatric Nurses Association [APNA] & International Society of Psychiatric Nurses [ISPN], 2008).

The *Healthy People 2010* (National Institutes of Health, 2000) initiative highlights mental health as a primary goal for health care. The APNA, in conjunction with the

ISPN in 2008, proposed curriculum guidelines for psychiatric and mental health nursing (P/MNHN). They indicated that psychiatric mental health experiences occur across nursing curricula and should be included across the span of students' educational experiences:

...there are clear indicators that mental health content and learning outcomes may also span across several semesters. For example, experiences with families and/or groups may occur in P/MHN settings but may occur in pediatric, maternity, and/or community as well as in acute medical/surgical experiences. Furthermore, patients with psychiatric disorders who have other physical health problems are in fact treated in acute care medical/surgical settings, which require that students and new BSN/RNs have the requisite skills to provide competent care (p. 2)

The report goes on to say, "Furthermore, there is a belief that psychosocial content is the core for all areas of nursing; thus, areas such as therapeutic communication cannot wait until a specific P/MHN course (p.3)".

Mental health faculties in nursing schools strive to create learning experiences that will prepare students for the mental health concerns of patients they will encounter as nurses. Many experienced educators have not been prepared in mental health (Gilje, Klose, and Birger, 2006). All the while, cutbacks in funding for inpatient mental health facilities and the push toward deinstitutionalization of the mentally ill have decreased the number of clinical sites available for students to gain experience in psychiatric mental health nursing (Melrose, 2002).

The topic of non-mental health faculty perceptions was chosen because it is important that students learn sound mental health concepts and practices (AACN, 2008). It is essential for students to develop comfort in working with people with mental illness, whether within the mental healthcare system, or in the general nursing population. Students are often anxious about working with patients with psychiatric diagnoses or who display behaviors associated with mental health problems (Gilje, et al., 2006; Halter, 2008). Typical pre-clinical comments gleaned in anecdotal conversations with student nurses (2004 – 2009) have indicated worries about inadvertently *setting someone off* with ill-timed or improper communication skills, *destroying someone's hard-earned progress*, again because of poor communication skills, or fear of being physically hurt by an aggressive patient (Gilje, et al., 2006; Halter, 2008). A smaller number of students, again from anecdotal conversations, have indicated that they grew up not believing that mental illness is a *bona fide* illness; that mentally ill patients are simply unwilling to *pull themselves together*. These worries mirror those shared by other student nurses and nurses in the literature (Gilje, et al., 2006). In addition, students and nurses have indicated that they view psychiatric nurses and the practice of mental health nursing negatively (Halter, 2008).

It is inevitable that all nurses, even those working in non-psychiatric settings will care for mentally ill patients. People with mental illness are susceptible to the same physical illnesses as non-mentally ill people. Given the prevalence of mental disorders in the United States (National Institute of Mental Health [NIMH], 2008), many patients treated in non-psychiatric inpatient and outpatient settings have at least one concomitant diagnosis of mental illness (Toft, Fink, Christensen, Frostholm, & Olesen, 2005). Faculty

will likewise encounter psychiatric patients while working with students in non-psychiatric settings. The stigma attached to mental illness is well documented (Day, Edgren, & Eshleman, 2007; Gaebel, Zäske, & Baumann, 2006; Halter, 2008; Hinshaw & Stier, 2008). This bias or concern can be seen dramatically in students preparing for their first day of psychiatric-mental health clinical rotations. Students often express concern about working on psychiatric inpatient and outpatient units. For many, it is their least desired rotation because of the students' beliefs about mental illness and the mentally ill (Happell, 1999; Happell & Gough, 2007).

Psychiatric nursing frequently carries with it an ominous sense. Exceptionally talented and caring nurses who regularly deal with life and death situations often shy away from working with someone with a known mental illness (Björkman, Angelman & Jönsson, 2008; Happell & Taylor, 2001; Rao, Mahadevappa, Pillay, Sessay, Abraham, & Luty, 2009). These attitudes, often reflective of a societal mind-set in general (Chung, Chen & Liu, 2001; Day, Edgren & Eshleman, 2007; Galka, Perkins, Butler, Griffity, Schmetzer, Avirappattu, & Lafuze, 2005), may be conveyed to students.

Purpose of the Study

This phenomenological qualitative study therefore explores the perceptions, attitudes, and beliefs non-psychiatric nursing faculty hold about working with mentally ill patients. The perceptions were garnered by asking eighteen nursing faculty participants to describe their lived experiences regarding mentally ill patients. Each was also asked to reflect on how they believed their experiences, personal and professional, may have influenced their perceptions of working with mentally ill people. An additional focus was on how

these non-psychiatric nursing faculty members believed their perceptions informed their clinical and teaching roles.

Assumptions

The underlying assumptions of this study are that: 1) faculty impact students; 2) mentally ill patients are cared for in every aspect of nursing care, whether or not they are identified as such; 3) perceptions affect attitudes; and 4) attitudes influence patient care.

Limitations and Delimitations

This study was conducted in two private Midwestern baccalaureate schools of nursing, one with two separate campus sites. Included were non-psychiatric nursing faculty with either a masters or doctoral degree teaching didactic, clinical, or both content areas. By design, psychiatric nursing faculty were not included in this research study. Nor were faculty who had had significant previous psychiatric-mental health experience.

Definition of Terms

The following operational definitions were used in this research study:

Attitude – A learned predisposition to respond in a consistently favorable or unfavorable manner with respect to a given object. Attitudes are informed by and inform perceptions.

Mental illness -- The term that refers collectively to all diagnosable mental disorders (NIH, 2000). This term was purposefully not defined further for this research study. Interviewees were asked to imagine their own ideas of mentally ill patients and to describe them. As it turned out, schizophrenia and psychotic

behaviors were the predominant idea of mental illness, although many of the participants discussed various other diagnoses.

Perception -- A person's experience of a phenomenon; how that person takes in information related to the phenomenon. In this study, perception refers to the experience non-psychiatric nursing faculty have in working with mentally ill patients.

Epoche/Bracketing –The first step in phenomenological data analysis. The process of detaching from preconceptions and biases that allows the researcher to truly understand the experience of the study participants (Moustakas, 1994 as cited in Creswell, 2007).

Essence – The essential aspect of an experience. The reduction of the *what* and the *how* of experiences to the *essential* aspects (Moustakas, 1994 as cited in Creswell, 2007).

Horizontalization – The second step in the phenomenological data analysis. The researcher lists every significant statement relevant to the topic and gives it equal value (Moustakas, 1994 as cited in Creswell, 2007).

Personal experiences -- Memories or images that interviewees identified from their histories, i.e., family members, friends, or personal experience with mental illness.

Phenomenon – An observable fact or event (Merriam-Webster online). This is the central concept being examined by the phenomenologist. It is the concept being experienced by subjects in a study, which may include psychological

concepts such as grief, anger, or love (Creswell, 2007). In this study, the phenomenon is working with mentally ill patients.

Professional experiences – Memories or images that interviewees identified from their work-related lives either as students themselves, or as clinicians or faculty.

Structural description – The written description of *how* the participants experienced the phenomenon being studied (Moustakas, 1994, as cited in Creswell, 2007).

Textural description – The written description of *what* the participants in the study experienced related to the phenomenon. It is a description of the meaning individuals have experienced (Moustakas, 1994, cited in Creswell, 2007).

Significance of this study

Gaining insight into the perceptions and experiences of non-mental health faculty is useful because, as stated earlier, patients with mental health concerns present for care in every aspect of healthcare. Nurses will encounter people with emotional or psychiatric difficulties at some point in their careers. Nurses need to be able to work comfortably with these patients. Nursing faculty must be able to not only work with the patients, but also teach student nurses, model behavior, and mold healthy attitudes.

Nursing faculty are in a position to influence the development or refinement of attitudes of nursing students towards people with mental illness. Any level of discomfort or bias has the potential of translating into negative attitudes and behaviors towards patients. It will be useful to know if non-psychiatric faculty harbor feelings and reactions similar to those of the general nursing population, or the public.

Research Questions

The principal question for this study is “How do non-psychiatric nursing faculty perceive working with mentally ill patients?”

Related questions are:

What images come to mind when non-psychiatric nursing faculty think of mental illness or mentally ill patients?

What have the faculty’s individual experiences been with mentally ill individuals, professionally and personally?

How have these experiences colored their perceptions?

How have their experiences influenced their work?

Summary

The purpose of this study is to explore the perceptions, attitudes, and beliefs of non-psychiatric nursing faculty about working with mentally ill patients. Participants were asked to imagine working with someone with a mental illness and then to describe the images, thoughts or feelings that they experienced. They were also asked to consider their experiences, personally and professionally with mentally ill individuals or populations. Finally, they were asked to reflect on how their experiences had influenced their perceptions of mentally ill patients as well as how they believed their perceptions influenced their work. This study is important in the field of nursing education in light of the declining numbers of psychiatric nursing faculty and the brief clinical experiences available to student nurses during their educational process. The integration of nursing curricula and the increasing numbers of mentally ill patients being cared for in non-

psychiatric settings have increased the likelihood that non-psychiatric faculty will work with mentally ill patients, clinically and within their academic roles.

CHAPTER II: LITERATURE REVIEW

This chapter discusses the relationship of the study to the literature. The historical context and setting within which the study is placed are also addressed. An additional literature review conducted following the analysis of the data are be included in this chapter.

Historical Context

Background

Qualitative researchers frequently avoid conducting a full literature review until after data have been analyzed since the reading itself might prejudice the information gathered (Creswell, 2007). The researcher may inadvertently frame the questions or interpret the answers in accordance with previous research findings. Creswell (1994, 2007) indicates his preference for reviewing literature to develop a sense of where his study fits within the broader perspective. He suggests developing a research map. Speziale and Carpenter (2007) recommend conducting a preliminary literature search to insure relevance of the study, saving the more intensive review of the literature to “place the findings within the context of what is already known about the topic (p.97)”. It is therefore important to recognize what is and is not already included in the literature (Munhall, 2001).

The literature was reviewed to accomplish two overarching purposes:

1. To determine what has already been studied related to perceptions of working with mentally ill patients.
2. To establish that nursing faculty perceptions of and attitudes toward working with mentally ill patients are indeed relevant in the field of nursing education.

Extant literature

Specific references to nursing faculty perceptions of working with mentally ill people were not found in the literature reviewed. Nor were there direct references to the concept of working with mentally ill people at all. The search was broadened to include perceptions of and/or attitudes toward mental illness. Because perceptions inform attitudes, that topic was included in the search. Indeed, many of the articles found, while discussing *attitudes*, also talked about the *perceptions* of those being studied. The following terms were searched in the CINAHL, MEDLINE, PsycInfo, and ProQuest Dissertation and Theses databases: perceptions of faculty (nursing faculty and general faculty), of nurses, and of nursing students related to mental illness or mentally ill persons; attitudes toward mental illness/mentally ill of (general and nursing) faculty, of nurses, and of student nurses; and the impact of nursing faculty attitudes on student attitudes and learning. In a further search, “perception of mental illness” was explored using additional databases (Academic Search, International Pharmaceutical Abstracts, and Business Source Abstracts). These yielded 97 references related to various aspects: perceptions mentally ill individuals described of their care and of the stigma they experienced; cultural, religious and class-related perceptions of mental illness; familial perceptions; and perceptions of college students and the general public. Throughout the international literature, quantitative studies were identified that assessed perceptions of, attitudes toward and *stigmatization* of mentally ill patients. Few qualitative studies were identified that specifically addressed *perceptions* of mental illness.

Studies of perceptions of and attitudes toward mental illness

Nursing faculty attitudes and perceptions

While there were no studies found directly concerning nursing faculty perceptions of or attitudes toward working with the mentally ill, one study was found that focused on nursing faculty and students' attitudes toward homelessness. Kee, Minick, and Connor (1999) measured attitudes of 45 faculty and 377 students in their descriptive correlational study that measured knowledge and attitudes toward homelessness. This study was relevant to the phenomenon of working with mentally ill persons because a large number of people with mental illness are homeless. They found overall that attitudes toward homeless individuals were either negative or neutral. In addition, those who had had superficial contact with homeless people reported a more negative attitude whereas those who believed they had helped someone who was homeless had a more positive attitude. They concluded that "More than superficial contact with people who are homeless is needed so that individuality is emphasized and more effective professional health care can be given" (p.3).

Nurses' perceptions and attitudes

Halter (2008) surveyed 200 nurses, 122 of whom responded. Those surveyed indicated that psychiatric nursing was one of the least desirable nursing careers, both from their personal and societal perspectives. Psychiatric nurses were predominantly seen as "unskilled, illogical, idle, and disrespected" (p. 24). Halter believed these descriptors resulted from linking psychiatric nurses with the clientele they served. Societal biases defined those who associated with mentally ill people in the same way

they defined the mentally ill population. Both psychiatric nurses and psychiatric patients suffered from the same stigma. The generalizability of Halter's study (2008) may be limited because the sample was relatively small and the nurses who responded worked predominantly in pediatrics. Pediatric nurse respondents may have been biased toward their own area of nursing and against others. Still, the study underscored the existence of bias toward mentally ill people and those working with them. This may be an important indicator of why student nurses avoid mental health nursing as a career choice.

Happell & Taylor (2001) surveyed 106 nurses working in a general hospital that had a substance treatment unit that provided consultation services within the hospital. They developed a Likert scale questionnaire that addressed items related to attitudes, confidence and perceived knowledge of the care of patients with substance abuse issues. Forty-eight percent of those surveyed had asked for assistance from the consultant. Forty-eight percent had not used consultation services, and three did not answer. The two groups were compared. Nurses who had not used the services responded similarly to nurses who had used consultation using attitude, confidence, and perceived knowledge as the tested variables. The researchers hypothesized that the nurses in that specific hospital may have already been sensitized to substance abuse simply by having the consultants available. They responded more positively to the substance abuse population than nurses in other studies.

Nursing students' perceptions and attitudes

Many studies were found that explored the perceptions, attitudes, and beliefs student nurses hold about mental illness and mentally ill persons. Each of those studies

however also addressed the impact of educational experiences (didactic and clinical) on attitude change. Therefore, those articles will be discussed later in this chapter in the Influences section. Several quantitative and qualitative studies explored the perceptions, attitudes and beliefs student nurses hold about mental illness and mentally ill persons.

Studies comparing attitudes

Several studies made comparisons of attitudes between various groups. Björkman, Angelman, and Jönsson (2008) compared attitudes of psychiatric nursing staff with those of medical nursing staff using two different tools. The Level of Familiarity Questionnaire measured attitudes toward specific mental health diagnoses. Data were collected continuously for three weeks from 120 of the 150 registered nurses and nursing assistants at a Swedish university hospital. The results indicated that sixty-six percent of the respondents had worked with someone with a mental illness, and twenty-five percent had a friend or relative with a mental illness. The attitudinal scale showed that medical nurses had greater levels of negative attitudes towards schizophrenic patients than those with other psychiatric diagnoses. Nursing staff associated schizophrenia with danger and intractability of symptoms. Nursing staff attitudes were comparable to those of the public (Gaebel, Zäske, & Baumann, 2006). Regular contact with someone with a mental illness engendered a more positive attitude.

Magliano, et al. (2004) compared the expressed beliefs about schizophrenia of 190 psychiatric nurses with the beliefs of 110 psychiatrists and 709 relatives of schizophrenic patients using a vignette followed by the Questionnaire on the Opinions about Mental Illness (QO). The researchers found that nurses had similar attitudes as

psychiatrists related to the causes of schizophrenia (heredity, stress, and family conflicts) whereas family members endorsed stress, trauma, and love breakdowns). Nurses and psychiatrists held similar beliefs about the ability of a schizophrenic person to work and to understand criminal intent. Nurses had similar attitudes to those of relatives of schizophrenic patients related to the unpredictability and political rights of these patients (i.e., should not vote; should not have children, etc.).

Rao, et.al. (2009) studied stigma related to diagnoses. Using three vignettes of schizophrenia, brief psychosis, and substance abuse, followed by the Attitude to Mental Illness Questionnaire (AMIQ), they measured the attitudes of 108 health professionals working in general medical and mental health. They found schizophrenia engendered greater stigma than did a brief psychosis. Hospitalization increased stigma more. An active substance abuser provoked more stigma than did one who was abstaining from substances.

Relevance

The second objective of the literature review, to determine the relevance of non-psychiatric faculty perceptions of working with mentally ill, was addressed by launching a search to identify which factors influence perceptions and attitudes of student nurses about working with mentally ill patients. No studies were found directly related to the impact of faculty perception or attitude on student perception, attitude, or performance. Research was found that discussed the changes in attitudes that occurred related to didactic and clinical instruction, and in-service education for practicing nurses. A recurrent theme was that regular and deliberate contact with people with mental illness was important in attitude formation. Brief, superficial encounters were often

counterproductive. Deliberate protracted contact that allowed those in the study to become familiar with those who they were talking about when referring to mentally ill people allowed them to truly experience mentally ill people as individuals.

Influences on student nurses' perceptions and attitudes

The majority of the studies identified in this search addressed the impact that psychiatric mental health nursing theory and clinical education have on student nurse attitudes. Many of the studies involved pre and post clinical attitude assessments. A synthesis of the literature reviewed for this objective is included in the following paragraphs. One study (Rohde, 1996) which will be discussed in more detail below indicated that the perceptions of student nurses were influenced greatly by the expert psychiatric nurses they met during their clinical rotations. Rohde cited Heidegger's (1927/1962) premise that socialization plays an important role in helping one clarify ideas and perceptions. Patricia Benner (1984), also cited by Rohde, reiterated that clinical instruction of students is greatly enhanced by the presence of expert clinicians who are able to familiarize students with what is expected and what is unusual. In other words, expert nurses play a vital role in helping student nurses develop knowledge, attitudes, and perceptions relevant to the patients they care for.

Landeen, Byrne & Brown (1995) conducted a phenomenological qualitative research in which they studied the clinical journals written by 18 third year student nurses during their 13-week psychiatric nursing rotation. They identified six themes throughout the student journals: 1) Meaningful learning, 2) Issues of the novice, 3) Relationship, 4) Control, 5) Self-reflection, and 6) Identification with clients. While the intent of the study was to investigate the usefulness of journaling as a teaching method, a number of

their findings about perceptions and the needs expressed by the students are germane to this study. Students journaled consistently about the usefulness of the learning experience of working with mentally ill patients. They addressed preconceived notions about psychiatric patients that changed during the course of the rotation. They also discussed their initial feelings entering the rotation (anxiety, worry) that generally got better throughout the course. Students expressed a degree of uneasiness about developing relationships with patients and about issues of control (control staff exerted over patients as well as the students' own sense of not being in control) and of themselves identifying with clients and thus creating a connection and decreasing the stigma associated with mental illness.

In a narrative qualitative study of 22 junior U.S. nursing students, Rohde (1996) asked students to “describe how your perceptions and understandings of psychosocial nursing have changed since the beginning of the semester and describe how a specific (or general) clinical experience has changed the meaning of psychosocial nursing for you (p. 348)”. Using the narrative reports given by the students, he tracked the changes in student perceptions following their 13-week psychiatric didactic and clinical rotation. He began with the statement that “the culture of nursing education is a major influence in transforming student nurses’ perceptions of mental illness and nurse educators are the primary facilitators in this process (p. 347).” The students identified three important “relational themes (p. 350)”: 1) *Uncovering others’ sameness through differences*: Students began to appreciate that mentally ill people are more similar than different than themselves; 2) *Coming face-to-face with mental illness*: Students became aware of their own vulnerabilities and histories in light of those of their patients; and 3) *Staff nurse*

influence in the uncovering process: Seasoned psychiatric-mental health nurses played a pivotal role in the perceptions and attitudes of the students. Rhode recognized the importance of the clinical experiences and of faculty and staff nurses in helping student nurses develop their perceptions of mental illness through self-reflection and example, not simply through linear learning (i.e., theory, practice, knowledge), but rather through an “uncovering process” that develop with time and experience.

Additional studies reported the evidence that educational experiences carry significant weight in positively impacting attitudes (Bell, Horsfall, & Goodin (, 1998) ; Evagelou, et.al., 2005; Happell(1), 2008; Happell(2), 2008; Happell & Taylor, 2001; Happell, Robins & Gough, 2008; Hayman-White & Happell, 2005; and McLaughlin, 1997).

Hayman-White and Happell (2005) adapted the *Psychiatric/Mental Health Clinical Placement Survey for First Day of Placement* scale to measure the impact of education and clinical placement on student nurses’ preferences in career and in attitudes towards mental health nursing and patients. They studied 784 student nurses, each placed in one of 21 compulsory clinical sites. Most of the students were in their second or third year of study. They addressed the relationship between attitudes, sense of preparedness, and career preferences of undergraduate nursing students prior to their psychiatric clinical experience and found that few students wanted to pursue careers in mental health. Those who did hope to work in mental health overall had a more positive view of the actual worth of mental health as a profession whereas the other students did not. Students overall did not feel well prepared to begin their rotation.

On the other hand, McCann, Lu, and Deegan (2009) conducted a longitudinal study in Australia over the course of student nurses' entire educational experience, rather than pre/post-mental health content. The researchers studied a non-probability sample of student nurses (90 first year, 46 second year, and 96 third year) measuring knowledge and attitudes toward mental illness using the Attitudes and Beliefs about Mental Health Problems: Professional and Public Views questionnaire. Findings indicated that students' initial attitudes were similar to those of the public. These attitudes did not change dramatically during the second year of nursing education. By the end of the third year, students began to believe in value of therapeutic interventions (as opposed to lifestyle interventions). The researchers questioned whether new nurses were adequately prepared to work with mental health issues.

Impact of Perceptions, Attitudes, and Beliefs

Since a stated problem was that there are dwindling numbers of student nurses choosing to become psychiatric-mental health nurses, the literature was searched to find what influenced career choices for nurses. Various research articles correlated career choice with attitudes toward clients (Happell & Taylor, 2001, Hayman-White & Happell, 2005, Melrose, 2002), career counseling (Robinson & Murrells, 1998), as well as interest and a sense of self-efficacy (Bell, et al.,1998; Nauta, Kahn, Angell & Cantarelli, 2002). Each of these aspects was important in determining career choice. Of note, Bell, et al. (1998) correlated career choice with the student's sense of confidence and competence, believing that if confidence could be enhanced, competence and career choice would follow. Nauta, et al. (2002), studied which of two variables, self-efficacy or interest, was predominant in career choice. The authors discovered that both variables were

reciprocal. Interest sparks motivation to develop efficacy. Self-efficacy (used interchangeably with confidence in this paper) creates more interest. This is important in this study because student nurses who are influenced to try psychiatric nursing and feel successful may also chose it as their field of work.

Additional Literature Reviewed

As indicated at the start of this chapter, the initial literature review was undertaken to determine two things: what has already been studied about nursing faculty perceptions of working with mentally ill patients, and what has been published that would indicate that the topic of non-psychiatric faculty perceptions of mental illness is relevant. Additional literature was reviewed following data analysis and is presented here. The literature reviewed was categorized according to the themes that arose in the interviews.

Theme 1: Images

Three studies (Day, Edgren & Eschleman, 2007; Mann & Himerlein 2004; and Rao, Mahadevappa, Pillay, Sessay, Abraham & Luty, 2009) identified schizophrenia as the most stigmatized of the mental illnesses. In their 2007 study, Day, Edgren, et al. used stigma theory to develop the Mental Illness Stigma Scale. They addressed seven factors related to attitudes toward people with mental illness: interpersonal anxiety, relationship disruption, poor hygiene, visibility, treatability, professional efficacy, & recovery. They validated the results of their tool with college students and the public then compared the attitudes of the college students with those of people diagnosed with mental illness. Their study found schizophrenia to be more stigmatizing than depression, bipolar illness, and general mental illness.

Mann & Himerlein (2004) surveyed 116 college students in a US university to determine what may be associated with stigmatizing attitudes toward mentally ill people. They compared attitudes toward schizophrenia and depression, and found more stigma about people with schizophrenia than depression. They also found that students who believed in the possibility that treatment could be effective had less stigmatizing attitudes. Perhaps that is one of the reasons depression is seen less negatively than schizophrenia since the latter is often more complex to treat. The researchers posited that females overall are more comfortable with schizophrenia and depression than males.

Theme 2: Perceptions

In their qualitative study of perceived need for more training in working with mentally ill elderly, Atkin, Holmes & Martin (2005) interviewed nineteen nurses in three focus groups and discovered that the nurses identified older people with mental illness through their behavior, rather than through their diagnoses. They also indicated they lacked the skills to work effectively with patients with mental illness and that they believed the mentally ill geriatric population were not receiving good care in the general hospital setting. The authors suggested comprehensive psychiatric liaison nursing services to assist the nurses in providing competent care.

Sharrock & Happell (2006) conducted a qualitative grounded theory study of four new nurses (two years post-graduation) asking about their individual experiences with at least one mentally ill patient being treated within a physical health setting. While the authors admitted the sample was small, they indicated that the responses gleaned in their study were consistent with what had been found in the literature. The nurses interviewed

each indicated positive attitudes toward mentally ill patients and toward the importance of mental health care within their scopes of practice. They each also expressed disillusion that the healthcare systems they worked in made the delivery of comprehensive mental health care difficult. The systems were “focused on the physical and organized nursing work into tasks (p. 13).” They lacked confidence in their mental health skills. The authors surmised, “if low confidence persists, the participants may become less open to learning, more rigid in their views and less able to assist patients through hospital experiences.” The study also questioned the skill level and competence of new nurses to deal with complex mental health issues. These findings were mirrored in the present study.

Clark, Parker & Gould (2005) asked 163 generalist nurses to answer a Mental Health Problems Perception Questionnaire that measured the nurses’ sense of effectiveness in working with mentally ill patients who were being treated medically in their rural hospital. Seventy percent of the nurses surveyed felt inadequately prepared and supported to be able to deliver proper care.

Mavundla (2000) discovered four themes in her explorative, qualitative study of twelve generalist nurses employed in a tertiary hospital. The themes were perception of self (positive and negative), perception of patients (wandering, noisy, violent, bizarre, or positive), perception of the environment (staff shortage, overcrowding), and perceived feelings (fear, despair, frustration). Her study most closely follows the direction of this study. She ultimately recommended nursing education confront the problems of generalist nurses working with mentally ill patients by adding coursework related to communication, assertiveness, psychiatric nursing information, and nursing practice. She

also recommended that nurses receive continuous support from their department managers in working with this population.

Ross & Goldner (2009) conducted a “systematic, targeted search and review of the existing body of literature pertaining to stigma, negative attitudes, and discrimination towards mental illness, specifically as viewed through the lens of the nursing profession (p.559)”. This concentrated review of nursing literature discussed two themes: nurses as stigmatizers (negative attitudes toward mental illness – if greater familiarity led to less stigma, nurses wouldn’t judge; fear, fragmented care – focusing on physical not the psychiatric; and lack of resources for good, safe care), and as ‘the stigmatized’ (for being psychiatric nurses, or for having mental illness themselves).

Reed and Fitzgerald (2005) addressed attitudes of nurses in rural general hospital about working with patients with co-occurring mental illness. The nurses indicated that the factors influencing their attitudes were lack of availability of specialized mental health services; perception of dangerousness of clientele; inadequate time, support and education for working with the population; and the stigma of mental illness. They attributed the greatest influence on their attitudes to the nature of the experiences they had had with mentally ill individuals. The nurses also believed that their negative attitudes contributed to avoidance, which in turn led to compromises in care.

Brinn (2000) measured the emotional reactions medical nurses endorsed after reading vignettes of patients with co-morbid mental and physical illnesses. Sixty-four nurses from the general hospital units answered the questionnaire. They endorsed being fearful of patients with mental illness. Their discomfort stemmed from the sense that the

mentally ill population is unpredictable and therefore dangerous. Those who had had more extensive experience with mentally ill individuals felt more comfortable.

Theme 3: Influences on perceptions and attitudes

Addison & Thorpe (2004) found that there is a tenuous relationship between *knowledge* of mental illness (*experiential and cognitive*) and attitude but that the relationship is complicated and not particularly predictive of cause and effect. The authors cited the conflicting evidence in their review of the literature as well as in their study. They did assert, “accuracy of knowledge appears to play a part” (p. 232) in attitude formation toward mental illness.

Alexander & Link (2003) conducted a telephone survey to determine the correlation between contact with homeless individuals and stigma towards them. Of the 1999 people surveyed, 1507 completed two measures related to perceptions of mentally ill people (dangerousness, and their experiences with mentally ill individuals) and then responded to a vignette depicting a character with history of mental illness. They reported finding that the perception of dangerousness decreased, as did the need for social distance with those who endorsed more contact with someone with mental illness (family member, coworker, friend, or seeing someone in public).

Corrigan, Green, Lundin, Kubiak & Penn (2001) studied 208 community college students to determine the impact of familiarity with and social distance from mentally ill people on the respondents’ attitudes toward the mentally ill. They found that as familiarity increased, perception of dangerousness decreased as did the amount of social

distance. They surmised that greater knowledge and/or experience with the mentally ill population may lessen stigma, at least in the arena of perceived dangerousness.

Gureje, Olley, Ephraim-Oluwanuga & Kola (2006) conducted a survey in three Nigerian states to investigate whether belief about causation of mental illness influenced attitudes toward mentally ill people. Eleven thousand one hundred and sixty three people from the general population responded to the modified version of the World Psychiatric Association Programme to Reduce Stigma & Discrimination Because of Schizophrenia questionnaire. 15.4 percent endorsed a religious-magical cause, while 84.6 percent endorsed a biopsychosocial cause. They found that those who endorsed the biopsychosocial belief of causation evidenced less stigma. They cautioned, however, that the correlation is not a simple one and that more factors may come into play in causing stigma.

Theme 4: Impact of perceptions

Nurses in Reed and Fitzgerald's study (2005) believed that their ability to care was affected by their perception of safety, time, and education. Their fear of saying something wrong added to their perceived (and actual) lack of knowledge would lead to negative attitudes. Negative attitudes in turn led to avoidance of caring for the patient's psychiatric needs and thus compromised care.

Summary

The majority of the studies found in the initial literature review were quantitative in design. There were scales available to determine attitudes toward mental illness and mentally ill patients as well as psychiatric nurses. Several qualitative studies addressed

the *lived experiences* of student nurses as they moved through their mental health rotations. No studies were found that specifically addressed nursing faculty perceptions or attitudes toward mental illness.

The secondary literature review conducted after the data were analyzed yielded research related to the additional thematic information gleaned from the interviews. Perceptions and attitudes about specific diagnostic categories of mental illness, specific images and nursing reactions were found.

CHAPTER III: METHODS AND PROCEDURES

Chapter III contains discussion of the methodology and procedures used in this study. In addition, the sample size, data collection procedures, and interview questions are discussed.

Research Design

Rationale for phenomenological qualitative study

A phenomenological qualitative design was used to understand non-psychiatric nursing faculty perceptions of working with mentally ill patients. “Qualitative research aims to address questions concerned with developing an understanding of the meaning and experience dimensions of humans’ lives and social worlds.” (Fossey, Harvey, McDermott, & Davidson, 2002, p. 717). Perceptions and attitudes are indeed dimensions of human lives and social experience, as is mental illness.

As indicated in Chapter II, previous researchers have addressed perceptions and attitudes of various populations toward mental illness, mentally ill patients, and psychiatric nursing. It is important to note that perceptions form attitudes and that attitudes influence perceptions.

Two factors were considered in deciding to undertake a qualitative study with this population. First, masters and doctorally prepared nursing faculty have been educated beyond initial nursing education in the provision of care for patients across the spectrum. They are responsible for further developing attitudes of the students they teach. Their attitudes carry weight and hence influence with their students. Faculty attitudes are intertwined with their own perceptions of the phenomenon of working with people with

mental illness. Second, developing an understanding of what non-psychiatric nursing faculty experience when they are faced with mentally ill patients while working within their field of expertise provides a depth of awareness not previously available. A qualitative study affords deeper and richer understanding of the phenomenon experienced by those participants.

Assumptions of Qualitative Designs

Phenomenology focuses on the lived experience of a subject. It allows the researcher to pay mindful attention to what and how the interviewee embraces the subject at hand; what he experiences in relation to the phenomenon. The phenomenon to be understood in this study is what non-psychiatric nursing faculty perceive when faced with working with people with mental illness. The study seeks to understand what it is like for them to address mental health issues, whether teaching or practicing, and to understand what they believe about the mentally ill individuals. It seeks to also understand how they believe their experiences inform their perceptions, attitudes and reactions to mentally ill people.

Theoretical Framework

Several bodies of literature informed the context in which this study was undertaken. Patricia Benner (1984) applied the Dreyfus model (as cited in Benner, 1984) to nursing and formulated a framework that traced the development of nursing skill and expertise from novice to expert practitioner. She relied on the theories of Heidegger (1962) and Gadamer (1975) to discuss the role of experience in redefining preconceived notions. Rohde (1966) described Heidegger's depiction of the process of perception-

formation thus: “Perceptions are built on past experience and are understood in the form of shared meanings and common understandings or misunderstandings” (Heidegger as cited in Rohde, 1996, p. 348). In addition, Gadamer (as cited in Rohde, 1966) “viewed perceptions, understandings, and misunderstandings as historical phenomena that lay the foundation for new experiences” (p. 348). This study of the perceptions of non-psychiatric nursing faculty of working with mentally ill patients has been sensitized by this body of literature in framing the process of assessing perceptions.

Ethical Considerations

Interviews for this study have been conducted at two private Midwestern baccalaureate schools of nursing. Approval was sought through the Institutional Review Board (IRB) of the College of Saint Mary (Appendix A). The study qualified as an *expedited* study since the likelihood of harm to the participants was minimal. Following College of Saint Mary approval, permission was sought from the IRB of the second institution where interviews were to be conducted. There were differences in the requirements of the two institutions related to the use of a signed consent form. The second IRB gave approval as an *exempt* study and objected to obtaining signatures as that increased the likelihood that names could be associated with data. An amended application was made to College of Saint Mary IRB for a waiver of consent (Appendix B) Both IRBs approved the use of a written consent form given to each participant prior to the interview. Copies of the consent form are located in Appendix D in addition to the letters of correspondence with participants (Appendix C).

Identification of Sample

A purposive sample of sixty-one non-psychiatric nursing educators from two private Midwestern baccalaureate schools of nursing was identified. The sample included both faculty who had lecture and/or clinical teaching duties. Seventeen educators from the first school and two from the second responded to the invitation email. One interview was completed at the second school. Participants were prepared with masters and doctoral degrees and each was actively teaching at the time of the interview. None of the participants had taught psychiatric nursing.

Table 1: Highest Degree Earned

Masters Degree	11
<hr/>	
Doctoral Degree	7

Table 2: Years in Nursing

1-3	None
<hr/>	
4-7	1
<hr/>	
8-15	3
<hr/>	
16-25	4
<hr/>	
26+	10

Table 3: Years Teaching

1-3	2
4-7	6
8-15	1
16-25	2
26+	7

Procedure

The interviews were conducted as informal dialogues (Bailey, 1996), using reciprocal communication techniques (Groenwald, 2004). The interviewer refrained from offering opinions or guiding the conversation, but did ask questions as appropriate to continue a thread in the interview. Fifteen of the participants were interviewed in their offices; two in the researcher's living room; one in her living room, and one by phone. The locations were chosen for the convenience of each of the participants, although, the phone interview was conducted predominantly to accommodate logistical difficulties experienced by the interviewer. The dean of the school of nursing was approached to determine if interviews needed to be accomplished after working hours. She allowed faculty to be available during work time.

Each participant was given a copy of the consent form to keep (Appendix A). During the initial interviews, the study was verbally explained which proved to be an inadequate technique. Participants responded more comfortably when given a copy of the questions and instructions to refer to during the tape recordings.

Each audio taped interview lasted between 20 and 45 minutes. The audiotapes were transcribed verbatim and returned to the interviewees to check for accuracy. Audio

tapes are stored in a locked cabinet in the interviewer's office. Typed transcripts are kept in a locked file in the interviewer's password-protected computer. The data will be kept for a period of three years.

The computerized program NVivo8 was used to categorize and store the data. The NVivo8 material specific to this project is stored in a password-protected file of the researcher's jump drive and backed up on the university server (also password-protected). Each interview was read and reread to gain an understanding of the content and meaning. Field notes were recorded during and following the interviews. These notes were then hand written onto the typed transcriptions of the interviews. The notes included brief observations of each setting as well as specific observed behaviors.

Quality Review of Data

The researcher employed several techniques to ensure the data quality, transferability, and relevance. Bracketing was employed to identify the researcher's personal feelings and reactions initially and throughout the study process. Any identified actual or potential biases were deliberately set aside. In addition, the researcher conducted the semi-structured interview process in a manner that encouraged participants and clarified responses without adding content or opinion to the process. Interviews were conducted until saturation of content was reached. There were no new perceptions or reactions expressed.

Respondents received copies of the verbatim transcripts of their interviews and verified that the transcription was accurate. Data from the interviews were consistent with the secondary literature review done after data analysis.

Data Analysis

The data were analyzed according to Moustakas (1994). The steps of this phenomenological analysis are shown in Table 4.

Table 4: Data Analysis Using Moustakas Method (1994)

Step	Explanation	Actions Taken in This Study
Bracketing (<i>Epoche</i>)	Identifying personal beliefs and experiences and setting them aside in order to not bias the work.	Reflection on previous experiences and opinions. Journaling throughout the research process. Discussions with others. Frequent returning to the literature.
Horizontalization	Each statement within each interview has equal value.	After reading and rereading interview transcripts, significant statements were listed. Each statement was given equal value and was coded and stored as <i>free nodes</i> in the NVivo8 software program.
Units of Meaning (<i>Themes</i>)	Developing themes or meaning units removing repetitions and overlaps (Moustakas, 1994).	Themes were identified and statements were entered into the appropriate thematic nodes (<i>tree nodes</i>) in the NVivo8 software.
Textural Descriptions (<i>What</i>)	Describing what the participants experienced as well as the meaning they ascribed to the experience.	Descriptions of what the participants experienced in relation to the phenomenon were recorded, including verbatim statements.
Structural Description (<i>How</i>)	Describing the context within which the experiences occurred.	Verbatim descriptions of the circumstances and settings in which the phenomenon occurred were recorded.
Composite Description of textural and structural experiences (<i>Essence</i>)	Reducing textural and structural descriptions to form a description of the essential nature of the phenomenon.	The textural and structural descriptions were viewed together to develop an understanding of the core meaning of the experience.

Summary

The process and methodology of the research study were explained in this chapter. A phenomenological qualitative study was undertaken to determine the perceptions of eighteen non-psychiatric nursing faculty of working with mentally ill patients. Data were analyzed according to the steps identified by Moustakas (1994) using the NVivo8 software and the field notes made during the interview process. Field notes were included in the reflection process.

CHAPTER IV: RESULTS

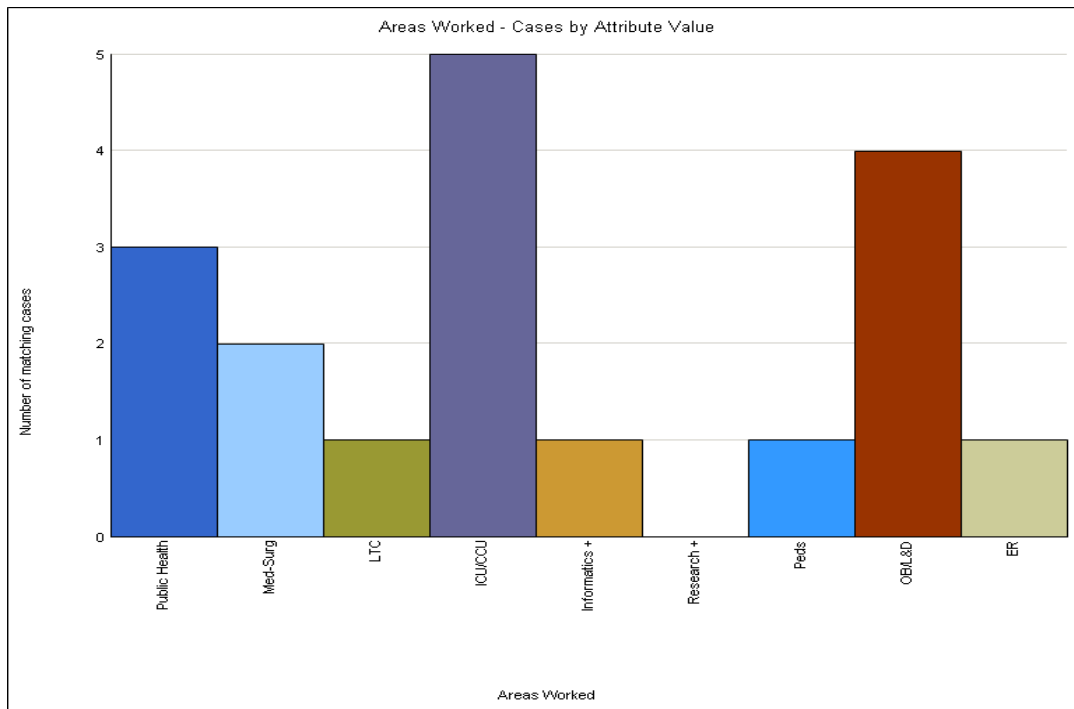
This chapter presents the demographic data as well as the results of the data analysis. A summary of significant findings is included.

Demographic Data

Eighteen non-psychiatric nursing faculty were interviewed for this research study in order to understand their perceptions of working with mentally ill patients. As indicated in Chapter III, the sample was a purposive sample recruited from two private Midwestern schools of nursing. Eleven of the interviewees held master's degrees and seven were doctorally prepared. Information about the characteristics of the interviewees follows.

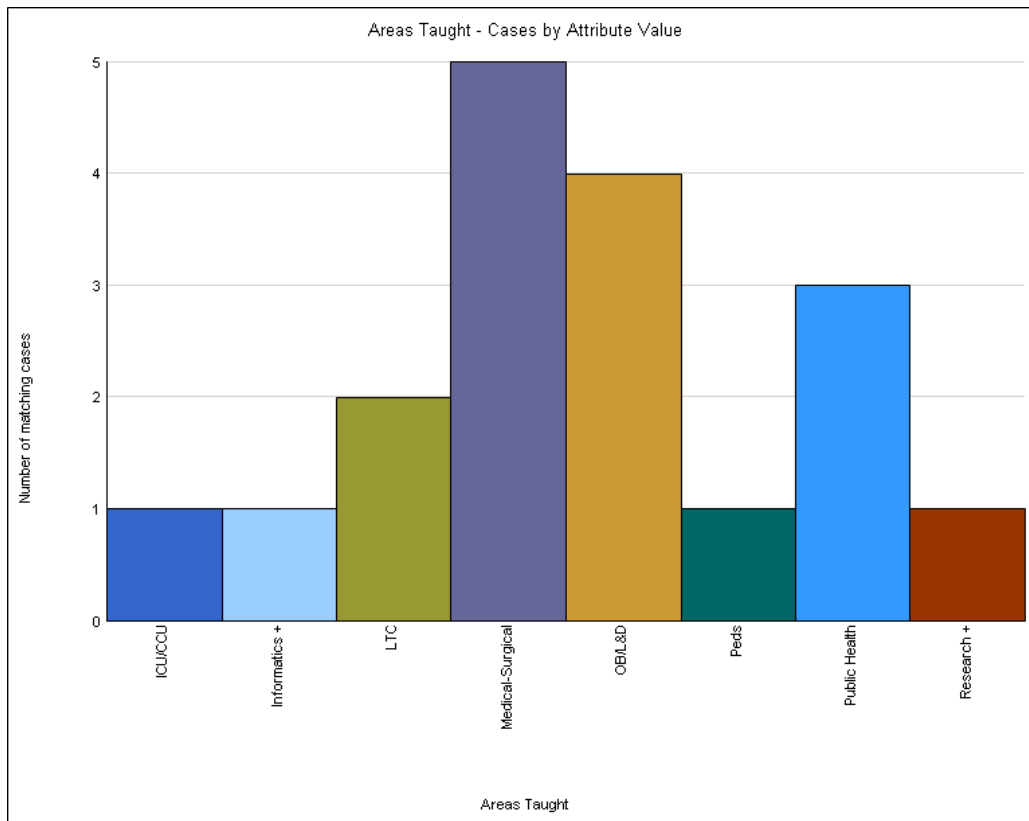
The number of years interviewees worked in nursing ranged from six to fifty-one, with eleven (sixty-one percent) having more than thirty-one years of nursing experience. Four (twenty-two percent) had been nurses between fifteen and twenty years, while three (seventeen percent) had been nurses fewer than fifteen years. Seven (thirty-nine percent) of the non-psychiatric faculty had taught nursing at least twenty-nine years; four (twenty-two percent) taught ten to twenty years and another seven (thirty-nine percent) taught seven or less years. Nursing educator experience ranged from two to forty-one years.

Figure 1: Areas worked



The predominant areas of nursing experience were broad. While the data were only identified for one area of practice each, a number of the nurses had worked in more than one setting. The principle or most recent practice area was counted. The majority of the interviewees (twenty-eight percent) had ICU/CCU experience, followed by Obstetrics/Labor & Delivery (twenty-two percent) and Public Health nursing (seventeen percent). The other areas represented were Medical-Surgical, Long term Care, Informatics, Pediatrics, and Emergency Room nursing (thirty-three percent each).

Figure 2: Areas Taught



As with the areas of nursing experience, the predominant or current area of teaching was recorded. Faculty in particular who had been teaching many years had had varied teaching experiences. Likewise, many were currently teaching in more than one area. The predominant teaching areas were Medical-Surgical (twenty-eight percent) followed by OB/Labor and Delivery (twenty-two percent) and Public Health (seventeen percent).

Data Analysis

Bracketing was accomplished by personal reflection about previous experiences both as a registered nurse and as an educator. Journaling throughout the process proved to be an important factor in keeping the focus clear.

Horizontalization – As the transcripts were read, each statement was viewed as

important and potentially relevant to the purpose of the study. Each pertinent statement was coded into the NVivo8 program, initially as a *free node* (one that had not yet been assigned a specific meaning or context). The purpose of this coding was to identify and store “brainstormed” content to be later categorized. This yielded 34 categories.

Meaning Units (Themes) – The free nodes were synthesized and resynthesized, ultimately divided into the four *tree nodes*, which made it possible to categorize and store statements appropriately. In the NVivo8 program, tree nodes can be identified as *parent nodes* (broad themes) that include *child nodes* (specific categories within themes) to allow more direct specificity. The parent nodes were defined as *Images associated with mental illness; Perceptions of mental illness; Influential factors* and *Ultimate impact*.

The child node information will be discussed within each of the parent nodes:

1. Images associated with mental illness
 - a. Behavioral images
 - b. Images of populations and treatments
 - c. Images of specific memories
2. Perceptions of mental illness
 - a. Beliefs
 1. About the nurses’ selves
 2. About mentally ill patients
 3. About the “system”

- b. Emotions engendered
3. Influential factors (Positive and Negative)
- a. Influential others – specific people who influenced their perceptions
 - b. Exposure to or experience with mental illness or mentally ill people that influenced their perceptions
4. Impact of perceptions
- a. On teaching
 - b. On clinical practice

Textural and structural descriptions were developed by detailing specific quotations from the interviewees regarding their perceptions and experiences of working with mentally ill patients.

Theme 1: Images associated with mental illness

The first theme cluster involved the images that came to mind for interviewees when they considered working with mentally ill patients. These images constituted the *textural descriptions* (what the faculty described as their experiences and perceptions). The *structural descriptions* are the context within which the images took place (i.e., in a hospital, home, school, etc.). The prominent images were further categorized as *behavioral images, populations and treatments, and specific impressions*. Even though these are now seasoned nurses, the emotional impact of their student experiences quickly became a focus of their reactions.

Behavioral images

Responses reflecting the behavioral images that emerged are listed in Table 5 below followed by quotations that further exemplify each.

Table 5: Behavioral images

Suicidal/Self-Harm (threatened, attempted, or successful)	Psychotic Behaviors or Symptoms (hallucinations, delusions, erratic behavior)	Challenging Behaviors (manipulation, noncompliant,	Agitated or Aggressive Behaviors
8 sources (44%) (9 references)	4 sources (22%) (5 references)	5 sources (28%) (7 references)	3 sources (17%) (5 references)

Many of the behavioral images relayed were of situations involving either suicidal or self-harming acts, or included images of suicidal threats and attempts as well as successful suicides and self-harming actions. Eight (forty-four percent) of the interviewees discussed these images. Many of the images were disturbing to those who described them. One young faculty member discussed an experience she had had early in her career:

I was 23 years old. I remember very clearly this girl who had overdosed on tricyclics, which is one of the worst things. She was on a vent and she was being dialyzed. She wanted to die so badly that she pulled her...she extubated herself three times. And she actually did die. She coded when we could not get her intubated again. And she was going into renal failure anyway. And she died.

Other experiences were aversive, as the one described by an older faculty member who

had experience at the state mental institution:

Seeing the women that had totally scarred themselves because they'd pulled out the pierced earrings over and over and over again

One interviewee reported feeling frustrated, confused, and used when a patient she was working with implied over and over that he was suicidal:

He'd call us in on the call light and say "I want to tell you I want to give my favorite pair of jeans to my cousin", and, umm, he did that throughout the course of the evening. And we were ...it was the 3-11 and I was a fairly new nurse. I think I was the charge nurse that night...And we were spinning our wheels a lot because we really didn't know what to do. We didn't really know what our moral obligation was and our professional obligation. It felt like he was just occupying our time by making us run around. But, it was frustrating and scary at the same time.

Population and treatment images

Since mental illness was not defined at the outset of this study, there was room for participants to offer their own impressions of what should be called mental illness. The second child node referred to images of populations. The interviewees addressed psychiatric diagnoses as well as certain vivid treatment images.

Table 6: Population and treatment images

Population/Treatment	Number of sources	Percentage
Schizophrenia	9	50%
Substance Abuse	9	50%
Mood Disorders	9	50%
Treatments (Electric Shock Therapy, Lobotomy)	6	33%
Restraint/Show of Force	4	22%
Vulnerable populations	3	17%
Dementia or Alzheimer's Disease	3	17%
Homeless	2	11%
Abuse Victims (Domestic or Sexual Abuse)	2	11%

Patients with schizophrenia, mood disorders, and substance abuse were most frequently identified as mentally ill (fifty percent each). Schizophrenia was seen as an illness that is less understandable and less clear to work effectively with.

“Schizophrenia... I think because we at least think it's less common we don't know how

to deal with those people whose drugs aren't working presently or [who] have chosen not to take the drugs.”

While participants spoke of Alzheimer's disease and dementia, they were at times reluctant to categorize the disorders as mental illness: “I have always gone kind of back and forth with dementia. I am a little uncomfortable having dementia being considered...” Moreover, later in the same interview, “I really am actually uncomfortable that we teach it [dementia] that way and that it's in that category because I think that sets students up with a perception of it. But, the other side of it is the behaviors that you see with dementia are actually best treated probably more in the psychiatric realm than they are med/surg or whatever realm.”

Treatment images were often described in uncomfortable terms. Electric shock therapy was mentioned most often (eight references), not always negatively. Two of the interviewees indicated that they witnessed positive results from ECT. Others were less positive.

ECT... You know there'd be the physician, and then his med students, and then the nursing students and you'd walk down the hall and the people would just be cringing. It was a terrible experience.

Other treatment images included physical show of force or the use of restraints. Faculty who had been educated in earlier years were more likely to indicate memories like the one described above as a result of having clinical rotations in “old state hospitals” and with less sophisticated treatments and medications.

Specific memories

Specific memories were categorized according to *professional* memories, memories as a *student nurse*, and *personal* memories. The professional and student categorizations are indicated in table 7.

Table 7: Specific Professional and Student Memories

	Student Memories			Professional Memories		
Positive Learning Experience	Uncomfortable	Neutral	Comfortable	Uncomfortable	Neutral	
	6	13	1	4	6	4

Seventy-two percent (thirteen) of the interviewees indicated uncomfortable memories from their *student* experiences, while thirty-three percent (six) talked about learning experiences that ultimately felt positive. The discomfort related evenly to feeling threatened and intimidated by the patients or a specific patient and to feeling very uncomfortable with the conditions the patients lived in. One instance that engendered discomfort was described by an instructor who recounted her experience as a student in which her male patient became agitated because she chose to wear a dress rather than her usual slacks on one of the days of clinical. The second was described by another seasoned faculty person who described her impression upon entering the psychiatric hospital for the first day of her clinical rotation: "...we're talking about the late 60s. So

that was before the deinstitutionalization and they literally were in huge rooms. And that whole concept of warehousing individuals...” One professor with more than 25 years experience put it quite clearly that her clinical student experience was a negative one:

When I went to the [state hospital]...freaked me out! And we were there and we spent the whole day there. And we would leave and we would go “Oh my God!” There was no discussion about it or anything. It was just kind of a watch your back. You know truly they told us that and it was eww. It was frightening to me. It was really frightening. Bizarre behavior. I had a lady who had had a lobotomy. And the different outbursts and just hahhh...

Positive learning experiences were also addressed. Those student experiences were the ones in which faculty and/or staff were able to turn whatever happened during the rotation a positive part of the learning. In addition, the interviewees saw those experiences as *empathy building*.

Three interviewees attributed their discomfort when they were students to either feeling unprepared for what they experienced or uncertainty of their own boundaries. One retained that worry about her limit-setting abilities into her current clinical and teaching practice: “I’m just so gullible and so easily manipulated that I didn’t like that feeling.”

The *professional* impressions (related to nursing, teaching, or other relevant work-related experiences) were similar to those experienced as students although they tended to carry more intense themes. An instructor described her clinical experiences in the community:

So, I went to this home and the young woman was there. And we sat down, she had answered the door and I could hear some noise in the other room. And this man called out "Who's there." And she said "A nurse." And he came around the corner with a rifle pointed at me. And this...you know what I was thinking was "This (Pause) poor young woman is suffering and will suffer all of her life because of this man...and I've got a mentally ill man pointing a gun at me. So, I just said to him you know "Why do you think I'm here." And he said "I don't give a shit why you're here. You get out of here." And I said "Okay, I'm leaving." And I left... and I went to the police department and... (laugh) decompensated a little bit; decompressed. And they sent out a police officer. (Sigh)

Personal memories related to family, individual, co-worker, or acquaintance of the nurse faculty member. These experiences were related as important factors for the interviewees. One of the interviewees talked about a neighbor whose husband, a professional, had been hospitalized psychiatrically:

But later the wife...I saw her out walking one day and asked her how he was. And she said he was doing really well and he just would go off his medication sometimes, thought he didn't need them...even as educated as he was. And she said "You know, the thing that is really difficult is that you're one of the few people who asked about him. Now, when he had his open heart a year ago, everyone asked. Now, even just because I'm related to him...you know, just my husband..." That had stuck with me.

And another who had experienced the loss of an associate discussed her desire to

understand why it had happened:

It has to do with a colleague at [university] who committed suicide. And so, all of those unanswered questions that just didn't fit for that physician... Yeah, I had lots of conversations with a faculty member on campus trying to understand what's the latest theory? What's the latest knowledge?

Others described family members with affective disorders, substance abuse, or indicated their own difficulties with depression. Each believed her experiences made her more empathetic.

Theme 2: Perceptions related to mental illness (How the subjects experienced mental illness)

The second theme was related to the perceptions respondents had of working with mentally ill individuals. The comfortable or uncomfortable perceptions related to each faculty person herself (how she believed she was or was not able to work effectively with mentally ill patients), to mentally ill patients, to the "system" (healthcare and mental healthcare), and to the emotions engendered while considering working with mentally ill patients. Interviewees indicated varying degrees of satisfaction with their own perceptions. Perceptual responses were either indicative of past or current impressions. As much as possible, they were categorized accordingly.

Table 8: Perceptions related to working with mentally ill patients

	Past Perceptions		Present Perceptions	
	Comfortable	Uncomfortable	Comfortable	Uncomfortable
Beliefs				
About self	Interested (1)	Gullible (2)	Open-minded (7)	Judgmental (3)
		Helpless	-Due to	Not current in
		Unprepared	experience or	knowledge
			exposure	Worry/Anxiety
			-Due to maturity	-About saying the
			Empathetic (3)	wrong thing
				-About boundaries
				(4)
				Vigilant (3)
About patients	Interesting (2)	Dangerous	Interesting (3)	Unpredictable (1)
	Fun to talk to (1)	Different (2)	Same/continuum	Dangerous
			(3)	
About the system	XXXXXX	XXXXXX	Better research	Underfunded (2)
			(1)	Not enough
			Less stigma (1)	resources (2)
				Other nurses not as
				compassionate (6)
				Need more
				continuing
				education
Emotions	Empathy	Fear	Compassion	Uncertainty
		Frustration	Empathy	Anxiety
		Anger		Sadness
		Sadness		

Perceptions of self

Interviewees expressed *beliefs* about their own sense of competence, about patients with mental illness, and about the mental healthcare system and societal responses to mental illness. The predominantly expressed *belief about self* in the past was a sense of being gullible (2), unprepared and fearful or intimidated. The current *belief about self* was more often positive than negative. Ten believed they were currently more empathetic and open-minded. Seven directly related their empathy to their prior experiences or to their own level of maturity. One stated, “Oftentimes, things are completely out of their control. They didn’t ask for this illness. They didn’t ask for these genes or whatever it may be. And so, that was very powerful in shaping...I have a great empathetic response...” Another indicated her own life and professional experiences have made her more empathetic and less likely to judge others. Others (two) expressed empathy for the families of mentally ill individuals.

Three faculty members indicated that they felt comfortable, not only being with mentally ill people, but also doing basic interviewing and assessment. “I’m comfortable referring and knowing where to refer. I’m comfortable with medication reconciliation and knowing the majority of the meds, at least to a degree and knowing the side effects at least to a degree.” One also expressed that she enjoyed learning to know people’s stories.

While nursing faculty identified themselves as empathic and open-minded, they also expressed an ego-dystonic awareness of judging others. Whether true or not, these faculty expressed a conscious effort to not judge, although, at times found it difficult. “In

my deepest heart I want not to be stereotypical and prejudicial. In my deepest desires, that is the person I want to be. I do struggle with judging people.”

Faculty were also often unsure of what to do in order to be effective and therapeutic. This lack of self-confidence and a sense of efficacy was a theme throughout the career span, as students and as nurses and faculty members. Three focused on feeling “out of the loop” with current knowledge similar to how they would feel working with any population or situation not in their specialty. One stated: “I want to know the latest brain research.” Another stated:

I don't know what to do. It just makes the situation more complex and more overwhelming but my knowledge is less than it is if it's two med-surg diagnoses. So, there is always a little bit more aspect of the unknown. I don't know the meds as well. I can't anticipate the patient's reactions as well. I don't have the same ability to interpret the patient's behavior, characteristics, or to determine if it makes a difference, what's part of one illness or anticipate a reaction

While this anxiety was relatively common, not all believed it was bad to venture out of one's comfort zone:

But I think as a professional sometimes moving out of our comfort zone does make us grow and I think that that's why all nursing students go to psych. I think it's the best thing we can do for them. And I do think it makes you less afraid.

About patients

Fewer faculty expressed beliefs specifically about *patients* than about self or the

system. While many of the cited memories and emotional and/or behavioral reactions certainly may point out beliefs about patients, these were not explicitly described. Interviewees did comment on their belief that people exist on a continuum of health and that mentally ill people are more similar to non-mentally ill people than not. “I would certainly be able to say to the students they’re normal people. They have a disease process.” Another aspect is that everyone exists on a continuum of health and ill-health”

I just feel like we’re all in this path together. I mean stepping over that line into mental ill health. That’s real easy to do. I’ve always been acutely aware that there’s very...any of us can find ourselves there. There’s nothing that immunizes any...It’s not an us and them. To me, we all have different issues that we have to deal with.”

Other descriptors of mentally ill persons were interesting, surprising, and unpredictable. “You know comments that they make or things that they do or say. It is just like I can just hardly believe that they are actually doing and saying and acting in that way. So, it’s kind of such a reality check for me.”

Perceptions of the “system”

System refers in this study to several levels of the structure within which nurses practice. It includes the broad system of healthcare and mental healthcare in the United States, i.e., financing and organizing, as well as the narrower conceptualization of relationships with peers or colleagues and the impact of their beliefs or behaviors on interviewee’s perceptions. Beliefs about the *system* generally indicated a sense of frustration and disappointment with funding (two), accessibility (two), and the lack of

continuing education for non-psychiatric nurses and physicians. One faculty member questioned the wisdom of closing the mental institutions and sending so many patients out into the community. "...when I see those people that are homeless and that aren't coping. Those are the times when I feel that in our desire to return people to the community, I think it became an outlandish desire and I think we have done a great disservice to the chronically mentally ill by removing the [state hospitals]." Another wondered if patients, especially depressed women, were being medicated with antidepressants rather than being referred for psychotherapy.

Further addressing the system of mental health care, two of the interviewees offered the following two comments:

I think they're incredibly underserved. I think that our system is broken.

Sometimes I feel powerless to manage their disease.

Moreover:

I think there needs to be more money put into mental illness in the United States.

I think it's ridiculous. I think we're way too low on that. And I think that continuing ed for physicians in the ER and nurses in the ER I think mental illness should be required. And I think probably some continuing ed with med-surg people should occur.

Emotional reactions

Emotional reactions ran the gamut from enjoyment and empathy to fear and uncomfortable disdain. Only two interviewees expressed *past emotions* that were

comfortable, indicating they enjoyed working with the psychiatric patients, particularly depressed patients, or people who had abused substances. Patients with these diagnoses were described as interesting and easy to talk to and relatively high functioning at the time, they worked with them. “But really I enjoyed working with the substance abuse people and the people that were in for depression. I enjoyed those conversations I had with them. I liked it.”

Uncomfortable past emotional reactions were characterized as anger or irritation (two), overwhelmed (four), sadness (one), fear (two), and hatred (one). Overwhelmed and uncomfortable were the most frequently mentioned reactions, largely related to either not knowing what to do or not being comfortable with skills or knowledge. The fear reactions were related to apprehension about being hurt or being stalked by a mentally ill person. One nurse practitioner who had done physical examinations on the psychiatric unit as a part of her clinical job was uncomfortable and sometimes fearful of running into patients when she was in the community with her family. She had had experiences where patients approached her to say hello and to comment on how pretty her daughter was. This made her more uncomfortable than when medical patients she had treated did the same thing.

Others described instances when they were student nurses and worked with patients who had poor boundary awareness (i.e., flirting) or were cursing. These episodes made them feel frightened and vulnerable to physical assault.

One faculty member expressed deep sadness when she described an incident where she was both frightened and saddened when an aggressive patient was put into restraints after a “show of force”:

And it seemed to me they nearly tackled that elderly man to the ground, and in doing so a pair...a pack...a folder of pictures fell out of his back pocket. And, um, gosh I feel like I could cry talking about it. It just made me feel really badly because here is a man with a LIFE, and a HISTORY...that felt like basically it was being negated by...I don't know if he was being objectified. Nothing about who he really was as a person was kind of felt like it was being acknowledged.

The *hate* emotion was in reference to working with a suspected pedophile. The interviewee indicated she believed she was able to provide him with the physical cares he required, but emotionally, she distanced herself from him.

Nine of the interviewees indicated they continue to feel uncomfortable, and continue to question what it is they should be doing to be therapeutic. The discomfort ranged from continued fearfulness (three) to feelings of sadness (four) and powerlessness (one) and frustration with not being able to measure success (one). One interviewee stated “It makes...I feel very...a lot of times I have sadness types of feelings for these patients when we're getting ready to send them home. A lot of times they're homeless, we get them a cab voucher and say ‘Bye.’”

Theme 3: Influential factors (Comfortable and Uncomfortable)

The third theme related to the factors which faculty believed had influenced their perceptions and attitudes. Influences were more comfortable, i.e. leading to more

positive perceptions, and less comfortable, i.e. leading to more negative perceptions, and were subdivided into four child node categories: *influential others* (specific people or groups of people that left an impression related to mental illness) and *exposure and familiarity* (the degree of contact with mental illness).

Table 9: Perceived Influential factors (Positive and Negative)

	More comfortable	Less comfortable
Influential others	10	9
Exposure or experience	7	0

Influential others

Influential others contributed almost equally to comfortable and uncomfortable reactions in the faculty. Those *influential others* who left comfortable or positive impressions varied somewhat. Three cited their psychiatric nursing faculty colleagues (three sources/seven references). One commented:

My experience as an instructor, I mean we work together with groups and everything and you hear people whose specialty is mental health defend it and say different things. They're people that you trust and believe more so than just a textbook or whatever. But it makes it more real. And maybe more acceptable. And "Okay, maybe I'll believe you this time." Um...I think it's just slowly making its way into my beliefs.

Three interviewees referred to their psychiatric instructors during their student nurse experiences (three sources/three references):

...my instructor was so good about explaining and helping us understand what was going on. She used to take us to a coffee shop [for post conferences]. They were always a lot longer than they were supposed to be because it was just so interesting and she made it so exciting and such a good learning experience to learn about...So, by the end of the semester, instead of being scared to death with some of these strange manifestations, it was more like, "Wow. That's cool." You know, what's going on here? I think I've carried that over into my nursing career...

Others felt admiration for and learned from the psychiatric nursing staff, either when they

were students or as faculty (three sources/four references). Two credited their mothers for their comfort level with and respect for people with mental illness. One mother was a psychiatric nurse practitioner, the other a special education teacher.

I was steeped in it, yes. And, we would talk about reasons behind behavior, even my own. So not just...so I think that that in itself is a psychiatric health mentality. There's always a reason behind a people's actions. There's thoughts behind those... that leads to that. So I guess that's the sort of thing, looking deeper at a human being as opposed to they're here for kidney stones.

Finally, one interviewee described a nursing home administrator she had worked with and another described a public health nurse colleague who worked with infants and young children at risk. Both were positive influences that the interviewees believed impacted their perceptions of mental illness and vulnerable populations at both ends of

the generational spectrum.

Influential others who engendered an uncomfortable or negative expectation were nurse colleagues, physicians (“I come from a time telling doctors ‘This woman is really depressed.’ And they’ll say, ‘Of course she’s depressed. She’s old.’”), family members who were unwilling to face mental illness within the family itself, or societal beliefs and biases that stigmatize people with mental illness.

Exposure or familiarity

The delineation between this category and the categories in the first theme related to the images associated with mental illness was in some ways an artificial one. Many of the comments fit into both categories. Answers included in this section represent those faculty members who specifically identified more experience that is extensive with mentally ill individuals as more positively influential than short-term contact. Eight sources with twelve references reported that experience and familiarity with mental illness tended to increase comfort and decrease fear.

I think if you never have worked with a certain kind of population or situation I think a lot of times, adults or people or kids, whatever, we’re just afraid of the unknown. So I think the more that you work with the clients you’re afraid of or the situations, I think the better off you are and the more you learn. And the more you learn the more you know and the less afraid you are.

The same faculty member went on to indicate a wish that all non-psychiatric nurses could come to value their psychiatric educational experience. “I think some med-surg nurses should have more experience with it. I think sometimes there are still nurses

in practice that are afraid or think ‘just get over it’ and ‘grow up’.

Another faculty person cited her master’s and doctoral programs (not in psychiatric nursing) with introducing her more to the biological aspects of mental illness and treatment therefore increasing her interest and understanding. Yet another, a child of a military family, travelled a lot growing up. Her experience allowed her “continuous exposure to new and different” people that made little room for fearful responses.

Theme 4: Ultimate Impact of perceptions

The fourth theme related to how the faculty members responded when asked explicitly how they believed their perceptions and experiences affected their practices. They replied describing both behavioral and attitudinal results.

Table 10: Ultimate impact

Behavioral Impact

Prepare to work with (10)

Engage with

Seek support/Refer

Advocate (3)

Avoid

Behavioral impact

Ten (fifty-six percent) indicated they would spend time preparing themselves

and/or students in anticipation of working with a patient with mental illness. Preparation included both seeking knowledge and in anticipation of patient needs as well as preparing mentally to face a challenge.

I try my best to discuss those kinds of situations with staff and with students [together, using staff as teachers] so that they can see what's appropriate and what's not appropriate. When people handle situations very well, it's like "Oh now look what they did! What did they say? What did they do and how would you do it?"

Of the seven who discussed whether or not they assign students to patients with Mental illness, five (twenty-eight percent) indicated they would assign students to patients with mental illnesses during clinical rotations. They also specified that any reluctance they might have to assigning mentally ill patients related more to the developmental level of the student as well as the complexity of the patient's illness (es) than to an unwillingness to work with the mentally ill person.

Three nursing faculty responded that they advocate, either directly or indirectly for mentally ill patients. Two in particular discussed their choice of fields within nursing in response to what they are passionate about. That passion was not specifically mental health, although, since the mentally ill generally fit within vulnerable populations, both spend energy advocating legislatively and socially for them.

Those who preferred not to work with patients with mental illness reported being less likely to engage with psychiatric patients under their care. “If I have to take those patients, yes, [I will] and I usually take the patients that we’re sedating. We might have them restrained...As they start coming out there, then I will get the ones that like the psych interactions.” A nurse specializing in intensive care stated, “I can say safely that meds are given, oxygenation, fluids, and all that physical stuff is good. Their emotional needs, we don’t address...we all run from it.”

Avoidance of working with mentally ill patients manifests itself through the nurse maintaining physical and/or emotional distance. Another avoidance technique was focusing only on physical needs and intervention or medicating patients with prn’s rather than using communication to address behaviors or emotions.

Results Summary

Composite Descriptions

Evaluation of the data collected elicited the following tentative relationships between the images and perceptions of mental illness and mentally ill persons, perceived influences on those perceptions, the comfort level of the non-psychiatric nursing faculty in working with the mentally ill, and the subsequent impact of the perceptions on attitudes and behaviors of non-psychiatric nursing faculty.

Images associated with mental illness were concentrated primarily on significant psychiatric diagnoses and challenging behaviors. Specific memories (as students and professional nurses) were often uncomfortable but were also seen a significant learning experiences.

Questions about perceptions of mental illness and mentally ill persons yielded information about what nursing faculty believed about their ability to work with this population. Many believed they were compassionate and empathetic, but at the same time not well equipped to deal with the emotional and behavioral needs of their patients.

Nursing faculty indicated that previous experience and role models made a difference. Both positive and negative experiences tended to give the respondents a chance to learn about mental illness and to evolve their comfort levels. Most often, discomfort came from not feeling able to speak to the emotional needs of the mentally ill patient (i.e., related to time constraints, lack of up-to-date knowledge, and/or discomfort with own specialized communication skills).

Faculty indicated that their perceptions had an impact on their willingness to engage with mentally ill patients on an emotional level. When faced with caring for patients with mental illness, each would ensure that physical needs were taken care of. Many would refer emotional needs to a specialist.

An interesting observation not explored specifically related to the issue of “maturity” vs. “new knowledge”. While many “older” nurses believed they had eased into their understandings and feelings of safety or comfort by virtue of their age and experience (a combination of maturity and perhaps wisdom), the relatively newer/younger nurses believed that their more recent educational experiences helped them to become more accepting and open than those of previous generations, and therefore, they had the advantage experientially. It is true that many of the nurses educated in earlier years dealt with patients whose treatments were often less advanced

and, therefore were confronted with perhaps more frightening experiences. It would be interesting to understand the full impact of their experiences weighed against their level of experiences since graduation. It is also important to note that several of the newer nurses attended the university in which they taught and learned from the psychiatric nursing faculty who are the peers often consulted by the “older” faculty.

CHAPTER V: DISCUSSION AND SUMMARY

Chapter V pulls the pieces of the research study together to make sense of the data in a way that allows the reader to use the information in practice or to conduct further research. A *composite description* of the textural and structural descriptions provides an understanding of the essence of the phenomenon. With that in mind, this chapter presents a discussion of the purpose of the study, the research design, interpretation of results, significance, and limitations of the findings, and further correlation to the literature, as well as implications for education and future research.

Purpose of the Study

The purpose of this study is to discern the lived experience of non-psychiatric nursing faculty in working with mentally ill patients. It originated from observations of the researcher that student nurses entering their psychiatric rotations expressed similar fears and concerns related to their impending clinical experiences. These concerns were generally dispelled during the first week or two of the rotation, but few students were ultimately choosing psychiatric nursing as a career. A review of the literature was undertaken during which it was learned that when asked, student nurses often express concerns about working with mentally ill patients, and that psychiatric nursing is indeed often one of the least preferred career choices. Given the nursing shortage, and the aging population within the psychiatric nursing workforce, added to changes within nursing education itself (integrated curricula, fewer inpatient clinical resources) and the inevitability that non-psychiatric nurses (and nursing faculty) will work with mentally ill patients in non-psychiatric settings, the researcher began to question how non-psychiatric nursing faculty perceive mental illness. Eighteen faculty members at two private

Midwestern schools of nursing were interviewed to determine their perceptions. The range of years in nursing was six – fifty-one, while the years teaching nursing ranged from two – forty-one. In this study, perception is defined as how a person takes in information about a phenomenon; how that person experiences the phenomenon. Perception is closely related to attitudes in that the latter are derived from the former. Nursing faculty perceptions took the form of memories, emotions, and beliefs about mental illness and mentally ill patients. Further discussion focused on what the interviewees believed influenced their perceptions toward mental illness and the mentally, and then, how the perceptions affected their individual practices, clinically and academically.

Research Design and Questions

This phenomenological qualitative research study sought to address the following questions:

- What images come to mind when non-psychiatric nursing faculty think of mental illness or mentally ill patients?
- What have the faculty's individual experiences been with mentally ill individuals, professionally and personally?
- How have these experiences colored their perceptions?
- How have their perceptions influenced their work?

Presentation of Findings

Four major themes emerged from the interviews of non-psychiatric nursing faculty. Within each theme are subthemes that will also be discussed. The first theme related to the images each respondent associated with mental illness. Participants were

each given time to collect their thoughts and to reflect on or imagine situations in which they were dealing with someone with mental illness. The subthemes that relate to the first theme are behavioral images, populations and treatments, and specific memories.

The behavioral images subtheme most often identified were descriptions of problematic actions observed in mentally ill individuals. The behaviors were suicide behavior (attempted and successful), self-harming behaviors (cutting, self-mutilation), manipulation (taking advantage), non-compliance, or aggressive acts (requiring chemical or physical restraints). The images engendered uncomfortable memories at times.

The second subtheme consists of those diagnostic and treatment images each faculty member described. Since the researcher did not specify diagnoses and severity of illness, participants were given full rein to identify their own representations of mental illness. The psychiatric diagnoses most frequently identified by participants in this study were schizophrenia, mood disorders (bipolar illness and depression), and substance related disorders. Other diagnostic categories were classified as “vulnerable populations”, dementia, or Alzheimer’s disease, homelessness, and domestic or sexual abuse victims. These identifications were similar to those found in the literature where schizophrenia (Björkman, et al., 2008; Day, et al., 2007; Mann & Himerlein, 2004) or the dangerousness that is perceived to accompany schizophrenia (Gaebel, et al., 2006; Reed & Fitzgerald, 2005; Alexander & Link, 2003; Corrigan, et al., 2001) The treatments cited by respondents were of restraints (physical and chemical) and the “show of force” used to subdue a patient who is considered out of control.

The third subtheme was related to specific memories identified by the interviewees. The memories discussed were rich and detailed. Most (thirteen) of the

respondents had experienced uncomfortable student situations with six of those thirteen believing the experiences were good learning experiences ultimately. Six of the eighteen respondents identified uncomfortable professional memories while four talked about positive memories that reinforced for them a shared sense of humanity with the mentally ill individuals. Given that the length of nursing experience ranged from six to fifty-one, it is interesting to note how important the nursing school experiences have been for them.

The second theme, perceptions identified three subthemes: faculty perceptions of themselves in relation to mentally ill patients, perceptions of mentally ill patients, and perceptions of the mental healthcare system and of other providers in general. Most of the nursing faculty believed themselves to be open-minded and empathetic, but also identified a dissonance between how open they hoped to be and how open they actually felt. Most also indicated a perceived lack of skill in working with the population. This was consistent with findings in the study done by Atkin, K., Holmes, J., and Martin, C. (2005) who studied general nurses working with mentally ill elderly. Those nurses consistently believed they did not have sufficient knowledge and skills. It was difficult to ascertain whether the sense of lack of skill in the faculty population was due to perceptions specifically of mental illness itself, or to mental health nursing not being their chosen field. Interviewees made interesting and differing distinctions concerning empathy and comfort. On one hand, several of the more experienced respondents attributed their comfort and acceptance to their longevity and their maturity. Two of the more recently educated nurses believed their level of comfort with and acceptance of mentally ill patients was enhanced by the recent nature of their experiences and the attitudes and teaching qualities of their instructors.

Mentally ill individuals were believed predominantly to be on a continuum of health. Some of the terms used to describe patients with mental illness were interesting, “same as us but with an illness”, unpredictable, and sometimes dangerous.

Dangerousness, again, was one of the factors in the literature cited above that described perceptions of people with schizophrenia.

Interviewees discussed their views of the mental healthcare system in the United States and their sense of how other nurses and physicians respond to mentally ill patients. While two asserted that society has become more open to mental illness, most criticized the lack of funding and available resources for treating mental illness. Six believed that most nurses and healthcare professionals are not typically well-enough educated or informed to provide good care to mentally ill patients. This is consistent with the findings of Atkin, Holmes & Martin (2005) whose qualitative study of general nurses working with older people with mental illness in the general hospital. Using three focus groups to explore the perceptions of the general nurses’ of their training needs with this population they found that general nurses perceived themselves lacking in important skills for recognizing and managing mental illness.

The third theme explored those factors that faculty believed were influential in the development of their perceptions and attitudes about mental illness. They believed they were influenced by the attitudes and actions of others (psychiatric and non-psychiatric faculty, family members, other nurses, and physicians). Those who described psychiatric instructors as enthusiastic about the field and about working with the patients expressed an enhanced comfort level regardless of the field of nursing they chose. The influence of “others” appears to be related to the attitude and demeanor of the influential person as

much as to the message they imparted.

Familiarity and experience appears to have offered the most influence on perceptions. This is borne out in the literature as well (Bell, et al., 1988; Björkman, Angelman & Jönsson, 2008; Corrigan, Green, Lundin, Kubiak & Penn, 2001; Happell, 2008). McLaughlin (1977) found that contact improves attitudes. Madianos, Alevisopoulos, Koukia & Rogakou (2005) found that exposure is important (didactic and clinical) in improving attitudes.

Many studies focused on using enhanced educational experiences to increase confidence, competence, attitudes, and career choice. As discussed earlier, Bell, et al. (1998) advocated clinical experience as a means of increasing confidence and thus performance and choice. Overall, the belief that increasing skills in communication, assessment, reflection, and feedback would decrease anxiety and stigma was made clear. Students must become more aware of mental health issues in every clinical setting. They must learn that the mentally ill are not limited to the psychiatric unit.

The final theme identified how the nursing faculty believed their perceptions ultimately informed their practices, clinically and academically, and their attitudes toward mentally ill patients. The subthemes identified in this section are: Prepare to work with; Engage with; Seek support/Refer; Advocate; and Avoid. Faculty, regardless of attitude or preference, sought to prepare themselves and students whenever faced with working with mentally ill patients. Self-preparation included learning the latest research related to mental illness as well as learning the specifics of the patient. They also sought to prepare themselves emotionally to work outside of their comfort range.

Some faculty willingly chose to work with mentally ill patients, but most

preferred that acute psychotic symptoms be ameliorated first. This is likely similar to any nurse working outside her field of expertise. The identification of “psychiatric patient” was not in and of itself as problematic as the behavioral manifestations observed or anticipated. The faculty who chose to assign students to patients with known mental illness did so with the belief that students must learn to work with the whole spectrum of patients. Assignment of mentally ill patients hinged upon the educational and maturity level of the student being assigned.

Many interviewees indicated they relied on mental health nursing colleagues to consult with when mental health issues arose (sub-theme three). Happell & Taylor (2001) discussed the use of consultation as a means of working effectively with mentally ill patients. They studied the consulting practices of nurses working with patients who abused substances. While they found that forty-seven percent of the one hundred six nurses surveyed indicated they would and did seek consultation, forty-eight indicated they did not. They found little significant difference in the attitudes between the groups, although all scored higher than most nurses on attitudes, confidence, and perceived knowledge.

The fourth sub-theme related to advocacy. All hoped they were teaching without bias and that they were advocating for holistic care of all patients. Several consciously limited their practices to advocating (legally, locally, and legislatively) for this at-risk population.

The sub-theme of avoidance was threaded throughout the interviews. Avoiding behaviors were identified on a continuum. Some were willing to work with an aggressive, threatening, or behaviorally “scary” individual only if the patient was

subdued physically and/or chemically. Others indicated a tendency to focus only on the more comfortable physiological issues, while deliberately avoiding the emotional or behavioral one. Still others admitted asking others to work with the a mentally ill patient, while others would administer prn benzodiazepines rather than taking additional time to address behavior nonpharmacologically.

Corrigan, Green, Lundin, Kubiak & Penn (2001) used three written measures related to familiarity, dangerousness, fear and social distance to ascertain the perceptions of two hundred eight community college students to determine the impact of familiarity on social distancing. They discovered that familiarity with mental illness decreased the belief that mentally ill people were dangerous. The authors indicated that perception of less danger might lead to less social distance (i.e., less avoidance). Greater knowledge about or experience with mentally ill persons may decrease stigma, at least in terms of perception of danger. Several faculty indicated a worry about physical safety, immediate or later related to poor interpersonal boundaries that many mentally ill patients exhibit. This worry contributed to a desire to distance physically and/or emotionally from mentally ill patients.

Significance of Findings

The findings of this study are significant in that they shed light on the complex perceptions non-psychiatric nursing faculty have of working with mentally ill patients. Mental illness is not confined to patients admitted to psychiatric units. All patients bring with them emotional issues whether diagnosable or not. Faculty, even those without bias, are confronted with situations that test their skills and knowledge. Faculty must be aware

of their own attitudes and the impact these have on students' learning and perceptions about the population.

Limitations of this Study

One significant limitation of the study was the use only of interviews and memos for data gathering. There are richer ways to obtain information related to perceptions, i.e., vignettes with reactions, card sort, drawings, etc.

There were several limitations in conducting this study. The initial research proposal indicated that subjects would be interviewed until saturation was reached. If the first university did not yield enough participants, then a second or a third would be approached. Faculty interviewed represented a homogeneous group (minimum masters prepared, teaching in Bachelor of Science program). Seventeen faculty members were interviewed and saturation of data was achieved within the first school. In retrospect, it may have yielded much richer information to draw from a broader number of schools.

Another possible limitation was that each of the faculty interviewed knew the researcher as a peer. This allowed relatively easy access and a quick trust level, but, again, a broader mix of educators might have been wise. With these points in mind, an attempt was made to expand the scope by soliciting faculty from a second institution. Two educators responded initially, but only one was able to follow through with an interview.

Another limiting factor was that no men were interviewed. The number of male nurses is increasing as is the numbers of male faculty, but there were none available in either of the institutions studied.

Implications and Recommendations for Education

It is important to understand what nursing faculty believe or perceive about working with any population. They are in a position to affect the attitudes of nursing students and thus the care of patients. It was interesting to note the amount of ambivalence suggested in faculty who wanted to be caring and helpful but had to overcome their negative perceptions/attitudes. It suggests that even with good intentions some faculty may not be comfortable or effective in working with psychiatric patients. At least some of those attitudes can be expected to be communicated to students in subtle ways. This study implies that non-psychiatric nursing faculty need additional support and education in helping them address the needs of mentally ill patients they meet in practice or with students. While many feel comfortable with their own empathy and ability to use resources available to them to work effectively with mentally ill patients, many do not.

Empathy is teachable (Ancel, 2006). Several studies have explored the use of various measures to help faculty in this area. Bylund, Brown, diCiccione, Levin, Gueguen, Hill, et al. (2008) developed and tested a train-the-trainers program where non-psychiatric physicians were instructed in teaching communication skills. This format could be useful for non-psychiatric nursing faculty, not only in developing their own comfort level, but also in assisting students in communicating with psychiatric patients. In addition, faculty could make use of simulations to practice and teach communication skills to students. Nursing educators are increasingly using simulations to teach clinical content to students. Adding psychiatric patients to the mix may help increase comfort.

Psychiatric nursing faculty would assist with this teaching, thus integrating mental health into non-mental health rotations.

Future Research

Psychiatric/mental health concepts must be threaded throughout the nursing curricula. This is a fundamental tenet of an integrated nursing education program. Based on the reluctance of some of the participating faculty members to work with the mentally ill population, it is important to do further research to determine what nursing faculty need to help them overcome any negative experiences and influences in order to effectively assist students in medical surgical settings to understand and support psychiatric patients.

References

Adams, C.E., Murdock, J.E., Valiga, T.M., McGinnis, S. & Wolfertz, J.R. (n.d.). Trends

in registered nurse education programs: A comparison across three points in

time – 1994, 1999, 2004. National League for Nursing. Retrieved from

<http://www.nln.org/aboutnln/nursetrends.htm>.

Addison, S.J. & Thorpe, S.J. (2004). Factors involved in the formation of attitudes

towards those who are mentally ill. *Social Psychiatry & Psychiatric*

Epidemiology, 39, 228-234.

Alexander, L.A. & Link, B.G. (2003). The impact of contact on stigmatizing attitudes

toward people with mental illness. *Journal of Mental Health*, 12, 271-289.

American Academy of Colleges of Nursing [AACN] (2008a). *Nursing Shortage Fact*

Sheet, Author.

American Academy of Colleges of Nursing [AACN] (2008b). *Draft: Revision of the*

Essentials of Baccalaureate Nursing Education. Retrieved from

<http://www.aacn.nche.edu/Education/pdf/BEdraft.pdf>.

American Psychiatric Nurses Association [APNA] & International Society of Psychiatric

Nurses [ISPN], (2008).Essentials of psychiatric mental health nursing in the BSN

Curriculum: Collaboratively developed by ISPN & APNA. Retrieved from

[http://www.apna.org/files/public/revmay08finalCurricular Guidelines for Undergraduate Education in Psychiatric Mental Health Nursing.pdf](http://www.apna.org/files/public/revmay08finalCurricular_Guidelines_for_Undergraduate_Education_in_Psychiatric_Mental_Health_Nursing.pdf).

Ancel, B. (2006). Developing empathy in nurses: An in-service training program.

Archives of Psychiatric Nursing, 20, 249-257.

Atkin, K., Holmes, J. & Martin, C. (2005). Provision of care for older people with co morbid mental illness in general hospitals: General nurses' perceptions of their training needs. *International Journal of Geriatric Psychiatry*, 20, 1081-1083.

Bell, A., Horsfall, J. & Goodin, W. (1998). The mental health nursing clinical confidence scale. A tool for measuring undergraduate learning on mental health clinical placements. *Australian & New Zealand Journal of Mental Health Nursing*, 7, 184-190.

Benner, P. (2001). *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. Prentice Hall Health, Upper Saddle River, New Jersey.

Björkman, T., Angelman, G. & Jönsson, M. (2008). Attitudes towards people with mental illness: A cross-sectional study among nursing staff in psychiatric and somatic care. *Scandinavian Journal of Caring Sciences*, 22, 170-177.

Brinn, F. (2000). Patients with mental illness: General nurses' attitudes and expectations. *Nursing Standard*, 14,(27), 32-36.

Bylund, C.L., Brown, R.F., di Ciccone, Levin, T.T., Gueguen, J.A., Hill & Kissane,

- D.W. (2008). Training faculty to facilitate communication skills training
Development and evaluation of a workshop. *Patient Education & counseling*, 70,
430-436.
- Chung, K.F., Chen, E.Y.H. & Liu, C.S.M. (2001). University students' attitudes towards
mental patients and psychiatric treatment. *International Journal of Social
Psychiatry*, 47, 63-72.
- Clark, C., Parker, E. & Gould, T. (2005). Rural generalist nurses' perceptions of the
effectiveness of their therapeutic interventions for patients with mental illness.
Australian Journal of Rural Health, 13, 205-213.
- Corrigan, P.W., Green, A., Lundin, R., Kubiak, M.A., & Penn, D.L. (2001). Familiarity
with and social distance from people who have serious mental illness. *Psychiatric
Services*, 52, 953-958.
- Creswell, J.W. (2007). *Qualitative Inquiry & Research Design: Choosing Among Five
Approaches*. Thousand Oaks, London, New Delhi, Sage Publications.
- Day, E.N., Edgren, K. & Eshleman, A. (2007). Measuring stigma toward mental illness:
Development and application of the Mental Illness Stigma Scale. *Journal of
Applied Social Psychology*, 37, 2191-2219.
- Evagelou, H., Adali, E., Koukia, F., Katostaras, F., Priami, M. & Toulia, G. (2005). The

- influence of education of nursing students on the formation of attitudes toward psychiatric illness. *ICUs Nursing Web Journal*, 23, 1-9, Retrieved from
- Fossey, E., Harvey, C., McDermott, & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian and New Zealand Journal of Psychiatry*, 36, 717-732.
- Fox, J.C. & Chamberlain, J. (1998). Preparing nurses to work with the chronically mentally ill. *Community Mental Health Journal*, 24(4), 296-309.
- Gaebel, W., Zäske, H. & Baumann, A.E. (2006). The relationship between mental illness severity and stigma. *Acta Psychiatrica Scandinavian*, 113, 41-45.
- Galka, S.W., Perkins, D.V., Butler, N., Griffity, D.A., Schmetzer, A.D., Avirroppatur, G. & Lafuze, J.E. (2005). Medical students' attitudes toward mental disorders before and after a psychiatric rotation. *Academic Psychiatry*, 29, 357-361.
- Galson, S.K. (2009). Surgeon General's perspectives on mental health matters. *Public Health Reports*, 124, 189-191.
- Gilje, F.L., Klose, P.M.E., and Birger, C.J. (2006). Critical clinical competencies in undergraduate psychiatric-mental health nursing. *Journal of Nursing Education*, 46(11), 522-526.
- Groenewald, T. (2004). A phenomenological research design illustrated. *International*

Journal of Qualitative Methods, 3(1). Article 4. Retrieved from

http://www.ualberta.ca/~iiqm/backissues/3_1pdf/groenewald.pdf

Gureje, O., Olley, B.O., Ephrain-Ohwanuga, O. & Kola, L. (2006). Do beliefs about causation influence attitudes to mental illness? *World Psychiatry*, 5, 104-110.

Halter, M.J. (2008). Perceived characteristics of psychiatric nurses: Stigma by association. *Archives of Psychiatric Nursing*, 22, 20-26.

Hanrahan, N.P. and Gerolamo, A.M. (2004). Profiling the hospital-based psychiatric registered nurse workforce. *Journal of the American Psychiatric Nurses Association*, 10, 282-289.

Happell, B. (1999). Who wants to be a psychiatric nurse? Novice student nurses' interest in psychiatric nursing. *Journal of Psychiatric and Mental Health Nursing*, 6, 479-484.

Happell, B. (2008a). The importance of clinical experience for mental health nursing -- Part 1: Undergraduate nursing students' attitudes, preparedness and satisfaction. *International Journal of Mental Health Nursing*, 17, 326-332.

Happell, B. (2008b). The importance of clinical experience for mental health nursing – Part 2: Relationships between undergraduate nursing students' attitudes, preparedness, and satisfaction. *International Journal of Mental Health Nursing*, 17, 333-340.

- Happell, B. & Gough, K. (2007). Undergraduate nursing students' attitudes towards mental health nursing: Determining the influencing factors, *Contemporary Nurse*, 25, 72-81.
- Happell, B., Robins, A. & Gough, K. (2008). Developing more positive attitudes towards mental health nursing in undergraduate students: Part 1. *Journal of Psychiatric & Mental Health Nursing*, 15, 439-446.
- Happell, B. & Taylor, C. (2001). Negative attitudes towards clients with drug and alcohol related problems: Finding the elusive solution. *Australian & New Zealand Journal of Mental Health Nursing*, 10, 87-96.
- Hayman-White, K. & Happell, B. (2005). Nursing students' attitudes toward mental health nursing and consumers: Psychometric properties of a self-report scale. *Archives of Psychiatric Nursing*, 19, 184-193.
- Heller, B.R., Oros, M.T. & Durney-Crowley, J. (N.D.) The future of nursing education: Ten trends to watch. Retrieved from <http://www.nln.org/nlnjournal/infotrends.htm>
- Hinshaw, S.P. & Stier, A. (2008). Stigma as related to mental disorders. *Annual Review of Clinical Psychology*, 4, 367-393.
- Hung, B.J., Huang, X.Y. & Lin, M.J. (2009). The first experiences of clinical practice of

- psychiatric nursing students in Taiwan: A phenomenological study. *Journal of Clinical Nursing*, 18, 3126-3135.
- Kee, C.C., Minnick, M.P. & Connor, A. (1999). Nursing student and faculty attitudes toward people who are homeless. *American Journal of Health Behavior*, 23, 3-12.
- Landeen, J., Byrne, C. & Brown, B. (1995). Exploring the lived experiences of nursing students through self-reflective journals. *Journal of Advanced Nursing*, 21, 878-885.
- Magliano, L., DeRosa, C., Fiorillo, A., Malagone, C., Guarneri, M., Marasco, C., Maj, M. & the Working Group of the Italiano National Study on Families of Persons with Schizophrenia (2004). Beliefs of psychiatric nurses about schizophrenia: A comparison with patients' relatives and psychiatrists. *International Journal of Social Psychiatry*, 5, 319-330.
- Mann, C.E. & Himerlein, M.J. (2004). Factors associated with stigmatization of persons with mental illness. *Psychiatric Services*, 55, 185-187. Retrieved from <http://qs.psychiatry online.org>.
- Mavundla, T.R. (2000). Professional nurses' perception of nursing mentally ill people in a general hospital setting. *Journal of Advanced Nursing*, 32, 1569-1578.
- McCann, T., Lu, S. & Deegan, J. (2009). Bachelor of nursing students' beliefs about prognosis and outcomes for people with schizophrenia: A longitudinal study.

International Journal of Mental Health Nursing, 18, 72-79.

McLaughlin, C. (1997). The effect of classroom theory and contact with patients on attitudes of student nurses towards mentally ill people. *Journal of Advanced Nursing*, 26, 1221-1228.

Melrose, S. (2002). A clinical teaching guide for psychiatric mental health nursing: a qualitative outcome analysis project. *Journal of Psychiatric and Mental Health Nursing*, 9, 381-389.

Merriam, S.B. (1988). *Case study research in education: A qualitative approach*. San Francisco: Jossey-Bass Publication.

Merriam-Webster Online Dictionary. Retrieved from

<http://www3.merriamwebster.com/opedictionary/>

Moustkas, C. (1994). *Phenomenological Research Methods*. Thousand Oaks, London, New Delhi: Sage Publications.

Munhall, P.L. (1994). *Revisioning Phenomenology: Nursing and Health Science Research*. New York: National League for Nursing Press.

National Institutes of Health & The Substance Abuse & Mental Health Services

Administration (2000). *Healthy People 2010*. Retrieved from

<http://www.healthypeople.gov/>

National Institute of Mental Health (2008). *Statistics*. Retrieved from

<http://www.nimh.nih.gov/topics/statistics/index.shtml>.

Nauta, M.M., Kahn, J.H., Angell, J.W. & Cantarelli, E.A. (2002). Identifying the antecedent in the relation between career interests and self-efficacy: Is it one, the other, or both? *Journal of Counseling Psychology*, 49, 290-301.

Patzel, B., Ellinger, P., and Hamera, D. (2007). Tomorrow's psychiatric nurses: Where are we today in providing students clinical experiences? *Journal of the American Psychiatric Nurses Association*, 13, 53-60.

Rao, H., Mahadevappa, H., Pillay, P., Sessay, M., Abraham, A. & Luty, J. (2009). A study of stigmatized attitudes towards people with mental health problems among health professionals. *Journal of Psychiatric & Mental Health Nursing*, 16, 279-284.

Reed, F. & Fitzgerald, L. (2005). The mixed attitudes of nurses to caring for people with mental illness in a rural general hospital. *International Journal of Mental Health Nursing*, 14, 249-257.

Rohde, D. (1996). Uncovering a world of mental illness: An analysis in perceptual transformation in undergraduate nursing students. *Archives in Psychiatric Nursing*, 10, 347-354.

Ross, C.A. & Goldner, E.M. (2009). Stigma, negative attitudes, and discrimination

- towards mental illness within the nursing profession: A review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 16, 558-567.
- Sharrock, J. & Happell, B. (2006). Competence in providing mental health care: A grounded theory analysis of nurses' experiences. *Australian Journal of Advanced Nursing*, 24, 9-15.
- Speziale, H.J.S. and Carpenter, D.R. (2007). *Qualitative Research in Nursing: Advancing the Humanistic Imperative*. Philadelphia: Lippincott, Williams & Wilkins.
- Surgenor, L.J., Dunn, J. & Horn, J. (2005). Nursing student attitudes to psychiatric nursing and psychiatric disorders in New Zealand. *International Journal of Mental Health Nursing*, 14, 103-108.
- Toft, T., Fink, P., Christensen, K., Frostholt, K. & Olesen, F. (2005). Mental disorders in primary care: Prevalence and co-morbidity among disorders. Results from the functional illness in primary care (FIP) study. *Psychological Medicine*, 35, 1175-1184.
- Wolkenstein, L. & Meyer, T. (2009). What factors influence attitudes towards people with current depression and current mania? *International Journal of Social Psychiatry*, 55, 124-140.
- World Health Organization. (2001). *The world health report 2001 – mental health: New understanding, new hope*. Author.

Zolnierek, C.D. (2009). Non-psychiatric hospitalization of people with mental illness: systematic review. *Journal of Advanced Nursing*, 65, 1570-1583.

Appendix A



January 30, 2009

College of Saint Mary

7000 Mercy Road

Omaha, NE 68106

Dear Ms. Harms:

The Institutional Review Board at College of Saint Mary has granted approval of your study titled, *Non-psychiatric Nursing Faculty Perceptions of Working with Mentally Ill Patients*.

Since you have already provided your Consent Form, I have placed it on CSM letterhead and have embedded the approval date stamp so that you may make official copies of your consent forms directly from this document. You will find it attached to this email.

The Committee has assigned approval number CSM 08-77. The approval will expire in one calendar year, January 30th, 2009.

Attached is the "Rights of Research Participants" form. You are required to make copies and give a copy to each research participant.

Sincerely,

Dr. Melanie K. Felton

Melanie K. Felton, Ph.D.

Associate Professor

Chair, Institutional Review Board

mfelton@csm.edu

Appendix B



May 7, 2009

College of Saint Mary

7000 Mercy Road

Omaha, NE 68106

Dear Ms. Harms:

The Institutional Review Board at College of Saint Mary has granted approval of your request for a Change of Protocol: Waiver of Consent for your study titled, *Non-psychiatric Nursing Faculty Perceptions of Working with Mentally Ill Patients*.

As per your Change of Protocol request, you will need to submit a copy of the document that you will be using to inform the participants. Since you will not be requiring a signature, of course the signature section would be removed. If you would like to prepare a more narrative information sheet, you could follow a format similar to our Online Consent format. A copy will be provided for your consideration.

Once you have submitted the informational document in the format of your choice, you will receive an updated letter of authorization to begin your research.

You will continue to use the assigned approval number of CSM 08-77. The approval will expire in one calendar year, January 30th, 2010.

Attached is the "Rights of Research Participants" form. You are required to make copies and give a copy to each research participant.

Sincerely,

Dr. Melanie K. Felton

Melanie K. Felton, Ph.D.

Associate Professor

Chair, Institutional Review Board

mfelton@csm.edu

Appendix C

Dear Colleagues,

I am writing to invite you to participate in a qualitative research study of non-psychiatric nursing faculty's perceptions of working with mentally ill patients. This study is being undertaken to meet the requirements of the Doctorate in Education Program at the College of Saint Mary.

You are being asked to take part in this study because you teach nursing students and you do not teach or have not taught psychiatric-mental health content.

Data collection will involve audio-taped interviews during which you will be asked open-ended questions from a prepared questionnaire. Transcription of the interviews will be shared with you for verification of the content and meaning(s) you intended. The audiotapes and transcripts will be destroyed at the conclusion of the researcher's doctoral studies.

There are no known risks associated with this study. The expected benefits associated with your participation again are twofold. The information about your experiences working with mentally ill patients will provide me with a baseline for further study. The process of the interview and the study will provide me with feedback on my learning experience as a qualitative researcher.

Thank you,

Ann M. Harms MSN, APRN-CNS, Principal Investigator

Appendix D

**NON-PSYCHIATRIC NURSING FACULTY PERCEPTIONS OF WORKING
WITH MENTALLY ILL PATIENTS**

IRB approval:

College of Saint Mary #CSM08-77

Thank you for agreeing to participate in this qualitative research study of non-psychiatric nursing faculty's perceptions of working with mentally ill patients. This study is being undertaken to meet the requirements of the Doctorate in Education Program at College of Saint Mary.

You are being asked to take part in this study because you teach nursing students and you do not teach or have not taught psychiatric-mental health content. Since mentally ill patients are cared for in all areas of nursing, this study will help me understand what that experience is like for faculty who have not chosen mental health as a primary nursing specialty.

Data collection will involve audio taped interviews during which you will be asked open-ended questions from a prepared questionnaire. Each interview will take no longer than 60 minutes (most likely 30 minutes) and will be scheduled at a time that is convenient for you. Transcription of the interview will be shared with you for verification of the content and meaning(s) you intended. A follow-up interview may be requested if necessary to clarify information. The audiotapes and transcripts will be kept confidential. No names or identifying information will be placed on the transcripts. Audiotapes will be destroyed at the conclusion of the study.

There are no known risks associated with this study. Likewise, you are not expected to gain an immediate benefit other than an opportunity to clarify your own values and perceptions of working with the mentally ill.

Thank you in advance for agreeing to participate in this study.

Researcher: Ann Harms MSN, APRN-CNS

Phone Number: 402-461-5057

Creighton University School of Nursing

Advisor: Peggy Hawkins, PhD, RN, BC, CNE

Phone Number: 402- 399-2658

College of Saint Mary



AS A RESEARCH PARTICIPANT ASSOCIATED WITH COLLEGE OF SAINT MARY YOU HAVE THE RIGHT:

1. TO BE TOLD EVERYTHING YOU NEED TO KNOW ABOUT THE RESEARCH BEFORE YOU ARE ASKED TO DECIDE WHETHER OR NOT TO TAKE PART IN THE RESEARCH STUDY. The research will be explained to you in a way that assures you understand enough to decide whether or not to take part.
2. TO FREELY DECIDE WHETHER OR NOT TO TAKE PART IN THE RESEARCH.
3. TO DECIDE NOT TO BE IN THE RESEARCH, OR TO STOP PARTICIPATING IN THE RESEARCH AT ANY TIME. This will not affect your relationship with the investigator or College of Saint Mary.
4. TO ASK QUESTIONS ABOUT THE RESEARCH AT ANY TIME. The investigator will answer your questions honestly and completely.
5. TO KNOW THAT YOUR SAFETY AND WELFARE WILL ALWAYS COME FIRST. The investigator will display the highest possible degree of skill and care throughout this research. Any risks or discomforts will be minimized as much as possible.
6. TO PRIVACY AND CONFIDENTIALITY. The investigator will treat information about you carefully and will respect your privacy.
7. TO KEEP ALL THE LEGAL RIGHTS THAT YOU HAVE NOW. You are not giving up any of your legal rights by taking part in this research study.

**8. TO BE TREATED WITH DIGNITY AND RESPECT AT ALL TIMES.
THE INSTITUTIONAL REVIEW BOARD IS RESPONSIBLE FOR ASSURING THAT YOUR RIGHTS AND
WELFARE ARE PROTECTED. IF YOU HAVE ANY QUESTIONS ABOUT YOUR RIGHTS, CONTACT
THE INSTITUTIONAL REVIEW BOARD CHAIR AT (402) 399-2400.**

***ADAPTED FROM THE UNIVERSITY OF NEBRASKA MEDICAL CENTER , IRB WITH PERMISSION**

7000 Mercy Road • Omaha, NE 68106-2606 • 402.399.2400 • FAX 402.399.2341 • www.csm.edu

Appendix E

NON-PSYCHIATRIC NURSING FACULTY PERCEPTIONS OF WORKING WITH
MENTALLY ILL PATIENTS

Thank you for agreeing to participate in this research study. Below are the questions I will be asking you when we talk.

QUESTIONS:

1. Please take a few moments to imagine either patients you have worked with who are mentally ill, or imagine the prospect of working with mentally ill patients in your practice or teaching.
2. What images come to mind when you think of mental illness or acutely mentally ill patients?
3. If you are comfortable, please talk about your previous experiences with the mentally ill.
4. How do you believe these experiences have influenced your perceptions of mentally ill people?
5. How do you believe these experiences have influenced your work with people who are mentally ill?