The psychiatric educational experiences of advance beginner RNs.

Summary The nursing profession is in an extraordinary position to improve educational experiences of prospective nurses, particularly within psychiatric nursing. To acquire an enhanced understanding of the nurse's instructive learning process and skills regarding psychiatric nursing, this study described and explored the experiences of advance beginner nurses employed in mental health facilities. It also denoted the registered nurses' (RNs) educational preparedness to function in their new professional role. Reflection of the nurse's personal experiences was acquired by using a qualitative study with a phenomenological approach. Colaizzi's Frame work [Colaizzi, P., 1978. Psychological research as the phenomenologist views it. In: Valle, R., King, M. (Eds.), Existential Phenomenological Alternative for Psychology. Oxford University Press, NY, pp. 48-71] guided the mode of data analysis by enlisting 15 advance beginner nurses to participate in in-depth, audio-taped interviews. Results from this study indicated a need for educational improvements to accurately reflect trends of psychiatric patient care in order to emphasize interpersonal relationships as well as multi-diagnosis and co-morbidity. Additionally, increased contact with diverse patient populations and responsibilities congruent with other clinical placements in managing the patient's overall care were noted to be critical. This study suggests that some nursing educational programs can improve their curriculum, methods of teaching and approach used to introduce students to psychiatric mental health nursing.

KEYWORDS

Psychiatric nursing education; Phenomenological study; Advanced beginner nurses

Introduction

It is vital that undergraduate nursing students receive quality education to prepare them for a profession full of diverse experiences and complex learning situations (Thornton and Chapman, 2000). RNs are required to synthesize and analyze information from a multitude of sources. They become accustomed to making decisions quickly, taking risks, prioritizing care needs and acting as part of a multidisciplinary team. RNs are required to trust their knowledge, be creative, adaptive, flexible and competent.

To facilitate this learning, quality clinical experiences afford students opportunities to test and refine their skills and knowledge, and make judgments regarding the suitability of their learning (Arnold
et al., 2004). To become a competent RN this learning becomes operationalized not only in the university classroom but also the clinical setting (Thornton and Chapman, 2000). For this reason, the 'real' world of professional practice cannot be ignored.

There is a dearth of literature in the United States (US) that focuses on the experiences of recent psychiatric nurse graduates. Current literature focuses on nursing students or nurses in acute care not specifically relating to the mental health specialty (Duchscher, 2001). The purpose of this study was to describe and explore the lived experiences of advance beginner nurses employed in mental health facilities and their educational preparedness to function in their new professional role.

Literature review

The uniqueness and importance of clinical practicum to student learning and attitude development in mental health nursing is well documented in the literature (Arnold et al., 2004; Martin and Happell, 2001; Mullen and Murray, 2002). Currently, some nursing programs are integrating psychiatric curriculum under a comprehensive model (Haas and Hermanns, 2003) thereby limiting the visibility and importance of psychiatric nursing (Happell, 2000). As such, students within these programs do not have a separate psychiatric mental health nursing course. Psychosocial principles are however incorporated into other nursing clinical courses (Haas and Hermanns, 2003). This has occurred at both the Associate Degree (E. Taglarini, Personal Communication, March, 2005) and Baccalaureate (Haas and Hermanns, 2003) levels of nursing education.

Currently, the US has three basic undergraduate nursing education programs. These include a three-year hospital-based diploma program, a two-year associate degree program, and baccalaureate degree programs (four-year traditional, five-year co-operative, and 11-18 month accelerated programs) (Lambert et al., 2004; AACN, 2005). Graduates of all three programs sit for the same NCLEX-RN licensing examination.

Psychiatric education for nurses is further compromised given the decreased number of psychosocial questions on the NCLEX-RN licensing examination. The new NCLEX-RN Test Plan became effective April 2004 which decreased the number of psychosocial questions from 12% to 22% to only 6% to 12% of the total content (Post, 2004a). The results of the NCLEX have serious consequences for schools of nursing and their graduates given the emphasis on curriculum to support passing the NCLEX-RN examination. A balanced approach to all nursing clinical areas is required when educating students to provide a general
comprehensive view of skills. However, this may be impeded if educational institutions direct their course of study based on the licensing examination. It is not sound educational practice to have the NCLEX or any exit examination steer the curriculum (Post, 2004a).

The de-emphasis of psychiatric mental health nursing and clients with mental illness diagnoses, comes at a time when we know that one-fourth of art health disabilities are related to psychiatric mental health and substance-abuse disorders (Post, 2004a). Mental illness related problems are a major source of disability and morbidity for children, adults, and the elderly. The Surgeon General's report (USDHHS, 1999) alerted the nation that more than 54 million Americans have a mental illness in any given year, although fewer than eight million seek treatment. It is a major concern that the percentage of questions devoted to the "psychosocial integrity" category is being significantly reduced.

Evidence-based data support the need for this country's two million plus nurses and its new graduates to be able to identify emotional disorders and behaviors indicative of mental illness and provide care and/or resources for care (Post, 2004a). Without sound knowledge and focused clinical experiences, future nurses will not be prepared to recognize and effectively intervene with patients who have psychiatric conditions. At a time when the Institute of Medicine recommends raising the profile of behavioral and social science education in the nation's medical schools, it is imperative that nursing education not minimize or delete content and clinical experiences related to psychiatric mental health nursing (Post, 2004a). An adequate compulsory component for psychiatric nursing education is essential since it is inevitable that all nurses will be caring for patients with a mental illness, regardless of the type of health care setting in which they are employed (Happell and Phung, 2005; Poster, 2004b).

Durkin (2002) noted that the most influential factor with regard to nurses choosing psychiatric nursing has been their clinical practice exposure in school, with varied experiences and proper role models during the course. This is a necessity as psychiatric nursing is one of the least popular specialty choices (Durkin, 2002; Martin and Happell, 2001) as the care of individuals with mental illness is not preferential among nurses (Durkin, 2002). Also several studies identified psychiatric nursing as disadvantaged due to non-favorable images portrayed in the media (Wells et al., 2000). Psychiatric nursing involves intellectual and physically demanding work that focuses on helping individuals who some treat as social outcasts (Durkin, 2002).
Nursing education must address changes in the health care delivery system and be responsive to shifts in the population, scientific advances and the special needs of the disadvantaged and vulnerable. In order for nurses to provide quality care to patients with mental illnesses they must have a strong foundation in psychiatric mental health nursing. Therefore it is imperative that schools of nursing continue to make an investment in psychiatric mental health education.

Relevance to nursing

Nursing educators identify that the clinical component of psychiatric nursing education is to experience a realistic perspective of the specialty (Mullen and Murray, 2002). This enables the students to gain an understanding of the illness experience from the patient's point of view. Furthermore, the clinical experience allows students to initiate capturing the interplay of their own assumptions and biases within a therapeutic and dynamic relationship (Armstrong and Pieranunzi, 2000). The learning that occurs within the clinical environment is paramount in developing the qualities and abilities characteristic of competent professionals (Daigle, 2001; Shipton, 2002). "The importance of preparing nurses capable of 'doing', as well as 'knowing', has meant that clinical education has remained a significant component of nursing curricula" (Becket and Neuwirth, 2002, p. 89).

Due to the expanding practice expectations of advance beginner nurses and the increased complexity of the clinical environments, the nature and quality of clinical learning experiences continue to increase in significance (Adams, 2002).

Within this study, shortcomings in the preparation of undergraduate students of nursing for commencing practice in mental health nursing are described and comments are given on issues affecting the quality of their educational preparation.

Methodology

Overview of methodology

The purpose of this study was to describe and explore the experiences of advance beginner nurses employed in mental health facilities and their educational preparedness to function in their new professional role. Colaizzi's methodological framework (1978), a qualitative design using descriptive phenomenology guided this study. This framework offered a unified view of objective and subjective realities and more effectively described the complexity of the nurses' lived experiences. Therefore, the goal of the nurse's communication was to bring to
written and verbal description, distinct, critical components of the phenomenon (Colaizzi, 1978).

Description of the method

Colaizzi (1978) sets forth a procedural modification to unveil the meaning of participants' lived experiences through their responses to research questions relating to the phenomenon under study. The following steps occurred in this procedural process:

(1) Interviews conducted with each nurse were transcribed verbatim and read to gain an understanding of their personal experiences.

(2) After reviewing the transcripts, significant statements/phrases relating to the experiences under research were extracted.

(3) For every significant statement extracted, meanings were formulated based upon the nurses narrative.

(4) The meanings were organization into clusters or themes.

(5) The themes were used to describe the nurses experiences.

(6) The descriptions were returned to the individual nurses for confirmation of validity.

(7) Any new relevant data acquired from the nurses validation was incorporated into the final description.

During this process, bracketing occurred to minimize interference with the pure and clear transfer of the phenomenon into the researcher's consciousness (Drew, 2001). This endeavor was necessary to prevent assumptions from shaping the data collection process, to discover any possible bias, and to prevent interposing the researchers understanding and constructions on the data. This allowed discovery of phenomenon through experiential perspectives of the nurses thus alleviating any researcher imposed impressions and recollections. To facilitate this process, the researcher maintained a reflective diary which was initiated preceding any interviews. There was continuous reflection and self-questioning to bring personal perceptions, presuppositions, and biases to the surface of consciousness.

Research questions

The phenomenon of focus was described using information from the following questions. "Describe your educational preparedness to
fulfill your new professional role?" "What was the essence of your psychiatric educational experience?" "What feedback would you give your educational institutions regarding your psychiatric educational experience? Responses to these questions generated a framework to understand issues, which have evolved due to disparate methods in teaching and provisions for learning during clinical practice within educational institutions.

Sample

A purposeful sampling of 15 nurses was used to allow selection of the population that fit the criteria. As a result, hospitals with psychiatric units, independently operated mental health facilities, and psychiatric state hospitals within an approximate 60-mile radius of the researcher's residence were targeted for acquisition of the sample for this study. The facilities were contacted by telephone, email, or fax through their nurse recruiter, nurse manager, director of nursing, or their designee. Communication occurred with appropriate management or administrative personnel. I identified the nature of the study and inquired if any prospective nurses met inclusion criteria. If the organization had prospective participants, institutional review board (IRB) data were completed. Upon approval from the IRB, the organization gave my contact information to the nurses and they in turn responded if they had an interest to participate. Upon contact with me screening measures were completed. The RNs met with me and provided consent to participate voluntarily in the study. Code numbers were used on all forms except the informed consent document. Each nurse was provided a code number for identification during correspondence. All participants were informed of their ability to withdraw from the study at any time without repercussions.

Criteria for selection

The RNs graduated from programs accredited by the National League for Nursing Accrediting Commission (NLNAC) or by the Commission on Collegiate Nursing Education (CCNE). The population consisted of nurses with an Associate's Degree in Nursing or a Baccalaureate Degree in Nursing (traditional 4 year program) with a maximum of two years of nursing practice after graduation. Also, no RN had more than one year of practice within the field of mental health. Nurses with more experience typically have contact with diverse patient populations, obscuring their ability to identify knowledge of psychiatric nursing skills through education or experiential measures. Therefore, RNs with previous mental health experience including dual diagnosis, prior to entering their nursing profession, were not included in the study. Nurses from Diploma Nursing Programs were excluded since their
presence in higher education has significantly lessened. As such, the results from this research would provide wider applicability with the two dominating undergraduate educational degrees (ADN and BSN).

Information on age, employment facility, employment status, shift work, and time employed are in Table 1. The group of 15 RNs encompassed few traditional age college graduates from nursing school with 13 Caucasian and two African-American women. There were four RNs with a BSN and 11 had an ADN.

Data collection methods

In-depth interviews were conducted during the months of July, August, September, and October 2002, and the participants determined the setting. Each nurse was provided an interview number to assist in identifying the audio-tape for transcription. A demographic sheet was also obtained prior to the audio-taping to assist in identifying and contacting the nurses for validation of accuracy of transcribed information. The interviews were formatted to be open-ended and they averaged 45 min. Most transcriptions were completed within 48 h of the interview and all participants had a transcription and description packet returned to them within a seven day time frame for review. Fifteen individual interviews occurred.

Analysis procedure

Data was collected from audio-taped interviews and from notes that recorded affective, contextual and verbal material. The data was subjected to hand analysis using Colaizzi's (1978) seven-step method described under the description of method section.

Rigor and trustworthiness

In qualitative research, rigor and transferability are assessed using four objectives: credibility, transferability, dependability, and confirmability (Lincoln and Guba, 1985). Credibility was supported by returning the transcriptions and descriptions of the RNs experiences for confirmation and review. This provided an internal check, which revealed accurate descriptions of nurse's experiences. Transferability is evidenced by the ability of the data to elicit subjective judgments about contextual similarities in other practice settings. Saturation of concepts occurred prior to at the interviews being completed. As such, repetitive similarities were noted in the data. Dependability was demonstrated with the use of audio-taped interviews and I transcribed the data myself to remain close to the data. Also, debriefing occurred with a senior researcher, whereby ongoing analysis
and findings were regularly presented to the dissertation committee members for evaluation. Confirmability was evidenced since all data was traceable to its source and logic was used to organize the interpretation into its structurally coherent and corroborating wholes. The audit trail provided a clear and distinct decision trail concerning the study from its inception to the end.

Results

Psychiatric educational experiences of advance beginner RN's

Although 14 of the 15 nurses had psychiatric clinical rotations and all of them had classroom theory regarding psychiatric nursing principles, some described a feeling of insufficient knowledge to work in the mental health specialty. The 14 RNs, who had psychiatric clinical rotations, identified enjoying this clinical more than any other during their educational program. However, they asserted the need for improved quality in select areas. There was a kaleidoscope of feelings and perceptions emanating from the RNs experiences. The predominant themes were: significance of patient interactions; quality of assignments for educational purposes; methods of learning (regarding psychopathology of mental illnesses, therapeutic responses); professional boundaries; value of treatment teams; and challenges of psychopharmacology.

Significance of patient interactions

This term was used to signify the time spent with patients on the unit having one-to-one contact. The primary concerns expressed by the RNs were: (a) having the ability to only care for one patient during their clinical; (b) lack of time spent with patients on a one-on-one basis; (c) intensely focusing on acquiring data to complete assignments versus spending time connecting with the humanistic part of understanding the patients' views of their mental illness. One nurse cited, "I did not have the opportunity to spread myself out and talk to other patients that had different types of problems. I was so focused on getting information to complete my assignment". The nurses communicated great concern for not being able to develop and implement many skills taught in the classroom. Many nurses expressed being intrigued, wanting to do more than "sit in on groups". They viewed having contact with diverse patient populations as invaluable, particularly since the dynamics between individuals varied according to their individual characteristics. Also, RNs expressed disappointment because as students, they were not assigned a larger realm of responsibilities for providing patient care, at times viewing their contact as "formal and restrictive". For some, this resulted in
their limited ability to cope with such responsibilities as nurses.

Another nurse cited "nursing faculty can talk to you all they want about the textbooks but until you actually live it (italics added) and meet and talk to people face to face ... everyday I learn something new". Various nurses expressed having confidence interacting in a setting with patients who had varied psychiatric illnesses; yet, some contributed this to life experience and not educational interventions.

Quality of clinical assignments for educational purposes

To facilitate the learning process, students were given various assignments with a great deal of focus on therapeutic communication. Due to the lack of patient contact, the nurses benefited from other venues of practicing their therapeutic communication skills. The nurses' preferred learning modes were role-playing, process recordings and reviewing case studies.

Nurses viewed role-playing as being very helpful in building their confidence and strengthening their communication techniques since their exposure to varied patients was limited. They identified the relevance of role-playing during clinical pre and post conference, particularly with increased anxiety during the initial weeks. Process recordings were viewed favorably as one nurse stated, "They were a pain ... but I see the purpose and how you can learn to develop communication techniques". Other RNs also commented positively regarding its use with self-evaluation of communication patterns and responses. In addition, nurses emphasized the importance of examining individual patient cases holistically and then analyzing individual areas. This enabled them to compare standard symptoms within the Diagnostic Statistics Manual (DSM) IV versus the client's presenting symptoms.

Methods of learning: areas requiring increased emphasis

Psychopathology of illnesses

Since the acquisition of knowledge and skill are essential to nurses as professionals, these RNs believed more emphasis should be placed on understanding basic psychopathology of mental illness. Participants identified that increased time and learning should be placed on issues of co-morbidity with substance abuse, personality disorders and forensics. One participant noted, "I walked out not really understanding many things. I wish I understood more of the pathophysiology of mental illness. What triggers schizophrenia, bipolar illness? What chemical induces these illnesses?"
The RNs identified that helping patients with psychiatric illnesses brought a sense of satisfaction though they wanted increased knowledge regarding psychobiological aspects of the disease process. They communicated a sense of enjoyment when talking to their patient. The RNs identified that as students they lacked interest in solely focusing on task completion emphasized in other nursing clinical rotations and enjoyed opportunities to form relationships with their patients. Promoting understanding of what causes patients illnesses and the best manner of promoting health and treatment was viewed as critical.

Therapeutic responses

When a nurse is exposed to patients having varied psychiatric illnesses and diverse backgrounds, challenges can arise in using therapeutic communicating strategies. Complex situations occur when one is required to manage emotionally charged comments while maintaining a professional demeanor with both verbal and non-verbal communication. One nurse recounted, "I know I shouldn't take some things patients say personally but I've been called everything from a 'B' to a black 'N'". An older nurse related, "I am an older middle aged woman. I don't think that there is anything that a patient could say that would upset or shock me". The RNs responses to comments made by patients varied. However, they all concurred that discussing these issues with students would be beneficial to lessen the shock if confronted with similar situations in practice. Furthermore, RN's recognized the benefits of collegial support and time for ventilation. This was necessary due to the multitude of issues encountered in their specialty and the sense of isolation felt from other clinical areas.

Professional boundaries

Within psychiatric nursing, the use of therapeutic skills is essential. Since communication consumes a large portion of the psychiatric nurse's intervention, it is imperative that boundaries are distinctly clear for the patient as well as the nurse. Establishing and maintaining boundaries creates a relational space whereby the patient and nurse are able to explore treatment issues within the safety of the therapeutic relationship. These RNs conveyed that there is a wealth of intricate communication that develops between a patient and a nurse, and as a student, issues and feelings easily surface that are not readily recognized. Upon reflection, several RNs identified instances of blurred boundaries due to sharing of personal information. Understanding the boundary and power differential within the nurse-patient relationship is critical Preparing nurses to
maintain professional boundaries is a pre-requisite to enabling safe connections in meeting the needs of the patient, enhancing opportunities for therapeutic interventions, and strengthening the nurse-patient relationship. If role confusion occurs, sabotage of professional boundaries could occur given the intimacy of caring actions displayed by the nurse and long-term relationships formed with patients.

Value of treatment teams

Within psychiatric nursing, the RNs noted differences in interactions between disciplines which were unique compared to other clinical nursing courses. This specifically related to the use of treatment teams. Preferably, a treatment team approach that generally includes, a nurse, physician, social worker, psychologist, and creative arts therapist, is used in making patient care decisions. Most of the RNs within this study had not participated in treatment teams within the clinical setting. Also, discussion regarding treatment teams did not occur within their class setting. All of the RNs advocated that students need exposure to this process, particularly with familiarizing themselves with "psychiatric terminology". In addition, one RN recounted, "There's more dialogue. You're part of a team. They really value the nurse's perspective. The role of the nurse is far more professional" Perease (2002) imparted that students have "to be able to talk the talk of the treatment team, to be able to understand and use the language of the DSM IV, and to understand the principles of psychiatric rehabilitation" (p. 153).

Challenges of psychopharmacology

There has been a tremendous growth of psychopharmacologic agents used in the treatment of various psychiatric disorders. RNs must be knowledgeable about common usages, side effects, medication blood serum levels and interactions of medication. RNs in this study identified pharmacology knowledge and understanding as a limitation since most were not able to give medication to their assigned patient. Three of the nurses were able to combine both the lived experience of giving medication and making medication sheets. One nurse recounted, "After gaining employment I had a gentleman with oculogyric crisis and I was the only nurse on the floor. I didn't know what was happening". Several RNs cited that adverse reactions connected to many psycho-pharmacologic agents were not reviewed or witnessed while in their clinical educational program.

RNs also denoted a challenge in giving medication to many psychiatric patients which was not noted on medical-surgical units. One RN
identified, "on medical-surgical units most of the patients readily take their medication. On a psychiatric unit, you get many more non-compliant patients, or patients that ask a lot of questions about what they are taking". As such, it is essential that students are aware of common patient responses particularly with non-compliance. Additionally, all of the nurses cited that they were granted the opportunity to provide patients with medication in their other clinical rotations. Why not psychiatry?

Implications

Higher education

This study provided insight into the lived experiences of advance beginner nurses employed in mental health settings, relating their views on their educational preparedness to work in their practice. The results identified areas that require modification given the acute, complex, co-morbid patient care issues nurses are confronted with today. Nurse educators must be proactive in educating nurses regarding current principles and practices regarding mental disorders given its presence in our community's and healthcare settings. Special needs of the vulnerable and disadvantaged populations having mental disorders must be addressed in curricular and clinical formations in order for nurses to gain quality education. Themes identified in this study will guide educators to re-examine older formats of teaching. Additionally the need to have a strong foundation in psychiatric nursing is clearly noted particularly when forging a difference in care for the 54 million Americans affected every year by mental illness.

Research

Information obtained by these nurses will add to the current body of knowledge for professional nursing practice. It identifies critical target areas requiring modification if we are to improve nurse's educational preparedness to work in the mental health specialty. More research is required with the inclusion of men and potential differences in educational preparation. Future research could focus on the impact of various clinical rotation settings, program types-ADN, BSN: traditional 4 year program, co-operative program or the accelerated program--and institutional setting--private, public, state. Research should also explore the integration of psychiatric curriculum throughout all nursing courses within nursing programs. There is limited documentation in the US regarding psychiatric nursing integration into the curriculum however its impact on student's educational preparedness to work as competent professionals within this specialty demands further review.
Accepted 19 August 2005

References


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Table 1

Participant Demographics

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Employment Facility</th>
<th>Employment Status</th>
<th>Shift Work</th>
<th>Time Employed</th>
</tr>
</thead>
<tbody>
<tr>
<td>19-29</td>
<td>AS</td>
<td>FT</td>
<td>D</td>
<td>2 mo</td>
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<tr>
<td>19-29</td>
<td>IPF</td>
<td>FT</td>
<td>SP</td>
<td>8 mo</td>
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<tr>
<td>19-29</td>
<td>AS</td>
<td>FT</td>
<td>N</td>
<td>2 mo</td>
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<tr>
<td>19-29</td>
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<tr>
<td>30-40</td>
<td>SH</td>
<td>FT</td>
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<td>2 mo</td>
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<tr>
<td>30-40</td>
<td>IPF</td>
<td>FT</td>
<td>SP</td>
<td>5 mo</td>
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<tr>
<td>30-40</td>
<td>SH</td>
<td>FT</td>
<td>D</td>
<td>9 mo</td>
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<tr>
<td>30-40</td>
<td>SH</td>
<td>FT</td>
<td>E</td>
<td>2 ½ mo</td>
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<tr>
<td>41-51</td>
<td>SH</td>
<td>FT</td>
<td>E</td>
<td>1 ½ mo</td>
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<tr>
<td>41-51</td>
<td>IPF</td>
<td>FT</td>
<td>D</td>
<td>9 mo</td>
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<tr>
<td>41-51</td>
<td>SH</td>
<td>FT</td>
<td>N</td>
<td>7 mo</td>
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<tr>
<td>41-51</td>
<td>IPF</td>
<td>PT</td>
<td>D</td>
<td>9 mo</td>
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<tr>
<td>41-51</td>
<td>AS</td>
<td>FT</td>
<td>E</td>
<td>1 mo</td>
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</table>
Table 1 presents demographic data for each of the 15 participants which are coded to indicate their age group (years), type of facility they are employed (AS = acute care setting, SH = state hospital, IPF = independent psychiatric facility), employment status (FT= full-time, PT= part-time), primary shift worked (D = days, E evenings, N = nights, SP = split shift, 11 am - 7 pm), and the amount of time employed at the facility on their psychiatric unit (mo = month, yr = year).

Disclaimer: This information is not a tool for self-diagnosis or a substitute for professional care.

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