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Mental health nursing education

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MENTAL HEALTH NURSING EDUCATION

BY

Judith Ann Kopka

A Master’s Thesis Project

submitted to Cardinal Stritch University College of Nursing

in partial fulfillment of the requirements for the degree

Master of Science in Nursing

Cardinal Stritch University

Milwaukee, Wisconsin

November, 2002
CARDINAL STRITCH UNIVERSITY
College of Nursing

THESIS DEFENSE
COMMITTEE APPROVAL FORM

(date) Jun 11 2002

We hereby recommend that the project prepared by Judith Ann Kopka entitled “Mental Health Nursing Education” be accepted as fulfilling this part of the requirements for the Degree of Master of Science in Nursing.

Committee:

Chairperson

Accepted:

Dean
ABSTRACT

MENTAL HEALTH NURSING EDUCATION

By

Judith Ann Kopka RN, BSN

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Dr. Ruth Waite Ph.D., Chairperson
ABSTRACT

The purpose of this inquiry was to gain information on how mental health nursing is being taught in Wisconsin. Research has suggested that nursing students who are exposed to mental health clients demonstrate less bias, stereotyping and fear, and an increased knowledge and comfort level with mental health clients. The trend toward an integrated nursing curriculum reduced or eliminated the opportunity for nursing students to work with persons with a psychiatric diagnosis. This lack of contact may influence the number of nurses choosing mental health as a career, potentially decreasing the quality of care for this population. The literature also proposed that since psychiatric inpatient stays are getting shorter, nurses are exposed to clients with mental health disorders in a variety of settings; thus it is important for all nurses to have psychiatric nursing knowledge.

A two-part mixed design survey was developed addressing mental health theory and clinical hours, clinical locations and application of mental health concepts in a separate or integrated nursing curriculum. Respondents were asked to share rationale for program type and concerns for teaching mental health nursing today. Surveys were addressed to Deans/designees of all 30 Collegiate Commission on Nursing Education and National League for Nursing accredited nursing schools in the state of Wisconsin. The response rate was 76%. Results indicated that the majority of students (integrated curriculum 100% and separate curriculum 64%) worked with a client with a psychiatric disorder whose primary reason for entering the healthcare system was not for mental health treatment. This exposure occurred in a variety of nonpsychiatric settings including hospital, outpatient and community clinical sites. The majority of respondents (73%) reported a separate mental health curriculum. Despite the diversity of
opinion around how mental health nursing should be taught, the consensus of respondents indicated that mental health nursing is deemed of value in the nursing curriculum.
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Chapter I

Introduction

Statement of the Problem

Psychiatric nursing is at a crossroads. The integrated curriculum concept is jeopardizing the continuity of the discipline. There is a need to study how psychiatric nursing is being taught because this will affect the future of the discipline, the care of mental health clients and the practice of countless students. Mental health clients are an underserved population who deserve the best nursing care possible. Educators have an obligation to provide the knowledge and experience to facilitate adequate nursing care.

In 1989, Hildegard Peplau wrote:

Every psychiatric nurse should become involved in encouraging basic schools of nursing to include adequate content and clinical experience in psychiatric nursing, in all generic programs, so that all nursing students are well prepared to nurse psychiatric patients and to stimulate their interest in graduate education in psychiatric nursing. (p. 27)

In the 21st century, this is more applicable than ever. Psychiatric nursing has been a hard won specialty. To lose it now would be a great loss to the profession. Beginning with the Crimean War, nursing has evolved parallel to the needs of society and as such has been influenced by societal and political factors. Nursing and history are inexorably linked, so a brief discussion of the history of mental illness in America will help clarify the challenges facing the mental health nursing today.

Historically, Nightingale did not include insane asylums within the scope of nursing reform. The first hospital to provide training of psychiatric nurses was Mclean hospital in 1882. By 1935, there were 70 more schools offering training in mental health nursing. The National
League for Nursing in 1893 and the American Nurse’s Association in 1897 both supported the view that psychiatric nursing be considered within the scope of the profession. This was accomplished gradually over the course of years, affected by politics and trends that will be discussed later in this work. Mclean’s program closed in 1968 in response to the trend of including specialties in generalized nursing programs (Peplau, 1989).

An era of moral treatment of the mentally ill was introduced at the turn of the 19th century. Prior to this, patients were the responsibility of families. Dorothea Dix and Horace Mann introduced the concept that providing care in a controlled environment could treat mental illness. Public and private asylums were built in response. These were soon overcrowded and underfunded. Results of this care in asylums revealed that while it was possible to restore health to some patients, the treatment was not effective in preventing patients from becoming chronically ill. The financial problems and overcrowding became worse during the Depression and World War II. The hospitals provided custodial care, but neglect and abuse were not uncommon (Surgeon General’s Report on Mental Illness, 2000).

World War II was pivotal in changing the perception of mental illness from that of a defect to a more compassionate view. The great numbers of returning soldiers requiring mental health care generated monies as well as empathy. In 1946, the National Mental Health Act became law. Government funds became available to prepare psychiatric nurses. A result of this was the establishment of graduate psychiatric nursing curricula as well as increasing the focus on psychiatric care in undergraduate nursing programs. By 1955, all schools included a basic clinical and theoretical experience in nursing mental health clients (Peplau, 1989).

The history that follows indicates the beginning trends of the fully integrated curriculum of today. Peplau (1989) reported that grants from the National Institute of Mental Health from
the 1950s to the 1970s promoted inclusion of psychiatric mental health and behavioral concepts in clinical nursing. This may have backfired and eliminated critical components of the discipline. The trend towards integrated curriculum reduced or eliminated direct exposure of students to psychiatric patients. Peplau (1989) proposed that this lack of exposure may contribute to decreased interest in the profession and recommended that adequate content and clinical experience in psychiatric nursing are included “so that all nursing students are well prepared to nurse psychiatric patients…” (p. 27)

Research has supported this concern. Research has linked the exposure of nursing students to mental health clients with decreasing bias, stereotyping and fear while increasing knowledge and comfort level in working with these clients. This has influenced the student’s consideration of psychiatric nursing as a potential career option. McLaughlin (1997) studied 72 nursing students at three different stages of a psychiatric clinical rotation. The results indicated a more positive attitude towards treatment of the mentally ill and reduction in fear. Proctor & Hafner (1991) also studied nursing students attitudes toward the mentally ill, and found a brief placement in a psychiatric setting significant in the development of a more compassionate attitude and reduction in fear and prejudice. Rushworth & Happell (1998) linked this change in attitude to an increase in student’s choice of psychiatric nursing as a profession.

Peplau (1989) raised the concern that the future of psychiatric nursing is in jeopardy. Dumas (1994) also expressed concern for the future of psychiatric nursing “We have allowed the so-called integrated curriculum to eliminate courses called psychiatric nursing. In some undergraduate programs psychiatric nursing has been totally removed. We are lagging in the development of an adequate database for assessing the needs in our field” (p. 12).
Background

Data from the 2000 Surgeon General’s Report on Mental Illness indicate that one in five Americans will experience a mental disorder in the course of a year. The National Institute of Mental health has broken this down into the following figures for four of the major psychiatric illnesses: major depressive disorder, 19 million, manic-depressive illness, 2.3 million, schizophrenia, 2 million, and anxiety disorders, 16 million. These statistics include only the adult population of age 18 or older. The total of these four diagnoses alone is 39.3 million people. The Surgeon General’s Report stated that approximately 10 percent of the United States population use mental health services in any year. Another five percent seek help from another source, such as schools, religious or self-help groups. The report also states that critical gaps exist between those who need service and those who receive service. Clients in need of mental health services may seek help from clinics or be treated in any acute care setting. Thus, nurses are likely to have exposure to those diagnosed with a mental disorder in the course of practice, not just in a mental health facility.

McGihon (1994) addressed the changes affecting mental health nursing today. Length of stay is shorter due to managed care and other influences. Inpatients are sicker. McGihon (p.32) stated “The discharge acuity of a (psychiatric) patient today often is higher than the admission acuity of a patient a decade ago”. At the same time, nurses have increased responsibilities. The nursing shortage has also affected mental health nursing.

Legislation of the 1970’s promoted the least restrictive conditions for mental health patients. This resulted in more patients with mental illness being in the community. Clients with a mental health diagnosis can be found in a variety of health care settings. Peplau (1989, p. 26)
acknowledged this in her 1989 article “With deinstitutionalization and the failure to both prepare communities and to provide follow-up care, the mentally ill are once again visible.”

Nurses practicing in inpatient mental health setting are working with increased acuity. Nurses in other hospital settings may care for a patient with a mental health disorder in addition to an acute medical need. Nurses in community or outpatient settings may have exposure to mental health clients at point of entry or at any point along the continuum of care. The large numbers of clients with a psychiatric disorder in the population, as well as the trend towards decreased length of stay means sicker clients are out in the community. This raises the question, “Are nurses prepared to care for the mental health patient in any setting?”

Purpose of the Study

The purpose of this study is to examine how mental health nursing is being taught in associate degree and baccalaureate nursing programs. Persons diagnosed with mental illness are prevalent in society. An integrated curriculum may provide limited opportunity for nursing students to work with this population. Nursing research has linked this lack of experience to decreased comfort and knowledge and increased stigma of the mentally ill. The lack of exposure may also influence the number of nurses choosing mental health as a career, potentially decreasing the quality of care to this population. A gap in research exists in how mental health nursing is being taught today. A literature search revealed no studies on the theoretical content, clinical exposure and methodology of mental health nursing curricula. In addition, the literature does not provide information on how students are prepared to cope with the increasing acuity and decreased length of stay of hospitalized psychiatric patients. A study of mental health curricula could provide information on how nurses are prepared to care for clients with mental health needs in a community or clinical setting. Research directed toward these inquiries could
advance nursing practice by identifying the curriculum discrepancies, similarities and
educational preparation of nurses in the area of mental health.

Peplau's Interpersonal Nursing Theory will be used as the framework of this study.

Guiding assumptions of her original theory are the following:

1) The kind of person each nurse becomes makes a substantial difference
in what each patient will learn as he is nursed throughout his experience with
illness.

2) Fostering personality development in the direction of maturity is a
function of nursing and nursing education; it requires the use of principles and
methods that permit and guide the process of grappling with everyday
interpersonal problems or difficulties. (Peplau, 1952, p. xiii)

Forchuk (1993, p.6) identified these additional assumptions:

3) Nursing can take as its unique focus the reactions of clients to the
circumstances of their illness or health problems.

4) Since illness provides an opportunity for learning and growth, nursing
can assist clients to gain intellectual and interpersonal competencies, beyond
those that they have at the point of illness, by creating nursing practices to evolve
such competencies through nurse-patient interactions.

A foundation of Peplau's theory is that psychodynamic nursing is at the core of all
nursing practice, not just mental health. If this is critical nursing knowledge, it is important to
our profession to examine how mental health is being taught.

What this study hopes to accomplish is to gain information on the current methodology
and content of mental health nursing curriculum. Scant literature exists to document this. In a
review of the literature, many articles discuss the current changes and trends in nursing and/or care of the psychiatric patient. Some of the most significant were cited above. These will be discussed further in Chapter Two. Data supports the benefits of a mental health student experience but the literature does not support that this is being done. The outcome of this study will be data exploring the concept of integrated versus separate mental health curriculum and how clinical exposure to the mental health client is being incorporated.

In summary, studying psychiatric/mental health nursing education is important to the discipline of nursing for the following reasons:

1) Nursing literature has supported the need to maintain psychiatric nursing as a specialty as well as incorporate aspects of it throughout practice. It would be a loss to professional identity and scope of practice, as well as to the clients we serve, to lose this focus.

2) Mental illness is prevalent, and clients with these disorders are underserved in America. It has a significant financial as well as emotional impact. The National Institute of Mental Health reported the cost of mental illness in the United States as $148 billion in 1990, the last year these statistics were recorded. It is second only to heart disease in DALYs (Disability Adjusted Life Years) in calculating disease burden (Surgeon General’s Report on Mental Illness 2000).

3) Psychosocial aspects of care are relevant to all aspects of nursing and a component of “Person” in the metaparadigm of the discipline of nursing. It is key nursing knowledge to study how this psychosocial aspect is being taught.
Research has demonstrated a positive link between clinical mental health experience and perception/stigma of the mentally ill which in turn influences career choice at an undergraduate or graduate level.

All of the above, as well as other factors to be addressed in Chapter Two, reinforce the need to examine how mental health nursing is being taught. Education today will have a multilevel influence on the profession in the future. If the factors contributing to the current practice of psychiatric nursing are not explored, nursing may find itself in the dilemma described by Dumas at the Seventh Annual Convention of the American Psychiatric Nurses’ Association in 1993: “The currents of change are already buffeting long-held traditions and those who are unable to manage change and those who cannot manage to change will find themselves ‘lost in familiar places’” (1994, p.13).

Research Questions

The major research question is “How is mental health nursing being taught in accredited schools of nursing?”

Related subquestions are:

1) How is mental health nursing being incorporated into the curriculum?

2) What factors are currently influencing mental health nursing education?

3) Do nursing students have the clinical opportunity to work with clients with a diagnosed mental illness?
Significance of the Study to the Discipline of Nursing

Results of a literature search revealed the following themes: 1) numerous articles suggesting innovative teaching methods for various components of psychiatric nursing, 2) the curriculum approach and teaching methods of a specific nursing school or course, 3) the history of psychiatric nursing curriculum, and 4) research on factors affecting the outcome of a psychiatric nursing course, including theoretical and/or clinical components. Esparza, Rickelman, & Fox (1996) discussed the implications of the shift toward wellness and primary health care and proposed expanding the curriculum to address both mental health and mental illness over the lifespan. Revitalizing the curriculum was proposed to be critical to prepare empathic, competent practitioners and to attract graduate students to the field. Research of mental health nursing curriculum supported the positive impact of a separate mental health clinical and didactic curriculum. While authors acknowledge the current challenges of providing mental health education, no research on the effectiveness or prevalence of an integrated versus separate curriculum was found. Gaining knowledge in this area to improve psychiatric nursing practice is the purpose of this inquiry.

Limitations of the Study

A sample of convenience was used that relies on the truthfulness of the respondents. Nursing undergraduate schools in the state of Wisconsin were surveyed. Schools accredited by the Commission on Collegiate Nursing Education (CCNE) and the National League for Nursing (NLN) in this state were included. A second limitation was the lack of generalizability of this research. The sample of convenience precludes this. Randomization would add to validity of results, but the process of identifying all undergraduate nursing schools nationwide and then choosing the sample population by randomization exceeds the scope of this research.
No tool exists that addresses the research questions adequately. Therefore, a third limitation was the self-design of the study tool. However, the tool achieved validity through peer and expert review by psychiatric nursing practitioners and educators. A fourth limitation was potential transcription error. The researcher controlled this by a cross check process of data entry. A fifth limitation was the potential inadequate response rate yielding limited data. The two-step follow-up process addressed this.

*Operational Definitions*

*Mental Health/Psychiatric nursing* is defined by the American Psychiatric Nurses Association as the “Promotion of optimal mental health, the prevention of mental illness, health maintenance, management of, and/or referral of mental and physical health problems, the diagnosis and treatment of mental disorders and their sequelae, and rehabilitation.” (American Psychiatric Nursing Association, 1994) This definition remains unchanged and will be used for this study.

*Mental illness* is defined by the Surgeon General’s Report on Mental Health as “the term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.” (Surgeon General’s Report on Mental Illness, 2000) and will be so used here.

*Integrated curriculum* refers to aspects of mental health nursing being incorporated throughout nursing school, including clinical practicum.

*Separate mental health curriculum* refers to a separate course, including a practicum, focusing on psychiatric diagnoses, treatment and mental health nursing as defined above.
Method

The research was a quantitative descriptive study. A self-report questionnaire was mailed to the Deans or their designees of accredited undergraduate nursing programs in Wisconsin. This was a nonrandomized, cross sectional sample of convenience of all schools in the above state listed as accredited on the National League for Nursing and CCNE World Wide Web pages on February 23, 2002. A two-step follow up process was done to maximize return rate consisting of a reminder postcard mailed two weeks after the initial mailing, and a second survey mailed two weeks after that to participants who had not yet responded. An instrument with dichotomous and open-ended questions was mailed to respondents. Face validity of the self-designed survey tool was achieved through expert and peer review. Descriptive analysis of the data was done using the Statistical Package for the Social Sciences (SPSS) Version 10.0.

Assumptions

An underlying assumption is that the data is accurate. The methodology is congruent with the concepts being studied. The sample size and population are adequate for the scope and purpose of this study related to population homogeneity of variables of interest. (Polit & Hungler, 1999). A further assumption is that mental health/psychiatric nursing is being taught in undergraduate nursing programs. Truthfulness of the participants is likewise assumed.
Chapter II

Review of the Literature

The literature has demonstrated a connection between psychiatric nursing education and students' perceptions of the mentally ill. Education variables affecting this perception include content of theory component, mentoring and the influence of a role model, as well as location and type of clinical practicum. Nursing students' variables include personality and prior exposure and preconceived notions about the mentally ill. The research has also supported a relationship between a psychiatric practicum and the selection of mental health as the chosen specialty area of practice. This review of the literature will discuss these findings. The most significant findings will be discussed in chronological order.

The effect of mental health nursing education on nursing students


In 1977, Creech studied student nurses' attitudes towards mental illness following a twelve-week psychiatric clinical rotation in a state mental hospital. The respondents were 95 second or third year student nurses from three diploma schools. This affiliation had specific goals and classroom, practicum, lab and conference components. A 64-item Likert-scale derived from two tools measured attitudes. These tools were Cohen & Struenings (1962) Opinions about Mental Illness (OMI) and Ellsworth's (1965) Opinions about Mental Illness Scale.

Five scales on the OMI include the following: 1) Authoritarianism-indicates a tendency to regard mentally ill persons as an inferior class, threatening and requiring coercive handling; 2) Benevolence- indicates humanism or religion based paternalism rather than professionalism; 3) Mental Hygiene Ideology- positive attitude toward mental illness and belief it can be treated; 4) Social Restrictiveness- the mental patient is a threat and needs to be restricted;
and 5) Interpersonal Etiology- indicates a belief that mental illness is related to interpersonal experience, especially upbringing. The Opinions about Mental Illness Scale reflects the staff members attitudes toward psychiatric patients in three areas: 1) Restrictive Control- reflects need for control, restriction and possible punishment; 2) Protective Benevolence- suggest kindness but can reflect aloofness and distance; and 3) Nontraditionalism- staff with this characteristic were perceived by patients to be sensitive, open, understanding and reliable. Reliability and validity of the tools were addressed as well as the rationale for combining them to maximize empirical and mathematical factors.

Results supported a positive change in attitude about mental illness after the twelve-week psychiatric affiliation. These changes were in a favorable direction in the areas of authoritarianism (p<.001), mental hygiene ideology (p<.01), social restrictiveness (p<.001), interpersonal ideology (p<.01) and nontraditionalism (p<.001). These attitudes would be manifested as less restriction of patient’s behavior, decreased coercion, increased belief in interpersonal factors as causality and increased belief that warmth, honesty and engagement with patients are important. Variables contributing to the positive change were identified as a program stressing interpersonal processes with student- instructor individual time and mental illness information. Creech (1977) acknowledged a need for further research on the relationship of attitude change and behavior. The longevity of the changes was not addressed in this study. The sample size was moderate (n=95) for the large number of nursing students in the United States but provided valuable information and was one of the original (and often cited) works exploring this phenomena.

Clarke (1988)

Clarke (1988) studied students’ attitudes towards treatment of the mentally ill at three different
points in their education. Fifty-one nurse trainees were given the Attitudes to Treatment Questionnaire (1982) and the Wilson-Patterson Attitude Inventory (WPAI) (1975). The Attitudes to Treatment Questionnaire (ATQ) contains 19 items about psychiatric nursing. Respondents rate their level of agreement on a 5-point scale with such statements as “Physical treatments on the whole are more effective than any other kind.” and “It is important to have a ward organized with strict rules.” A higher score indicates a more traditional, medical approach. The maximum score is 95, with higher scores indicating a more conservative belief system. The ATQ test-retest reliability was reported to be between 0.68 and 0.74. The WPAI is a scale developed to measure conservatism. The number of items on the WPAI or examples of these questions were not provided. The WPAI has published internal consistency coefficients of 0.85 to 0.95.

It was hypothesized that: 1.) Students at a more advanced level of training (third year in a three year nursing program) would show more liberal (less physically oriented) attitudes towards treatment than those at the beginning of training; 2.) There would be no difference in attitudes towards treatment among students at different stages of training; and 3.) There would be a positive correlation between conservatism and a preference for physical modes of treatment. (p.488.)

Results supported the first hypothesis with the three groups differing significantly overall in their ATQ scores using one way analysis of variance (ANOVA) (p<01). First year students were less liberal than the other two groups. Hypothesis two was not supported by Spearman rank order coefficient overall (p<.05.) There was no significant relationship between conservatism and attitudes toward treatment that had been predicted. However, the relationship between conservatism and attitudes towards treatment was significant for third year students.
Higher scores on conservatism were associated with less liberal attitudes to treatment. The authors theorized that the difference in results was related to the student’s exposure to different types of nursing providing increased options. There was no difference in conservatism across the three groups. In conclusion, the study indicated that a change in students’ attitudes towards treatment occurs with training, becoming more liberal with experience. Conservatism, as measured by the WPAI, was not affected. Hypothesis three was not addressed, and this was a drawback of the study.

A major limitation of the study was the cross-sectional design. Because a same group longitudinal study was not done and the sample size was small (n=51), results are not generalizable. The sample consisted of 17 student nurses in their first year of training, 17 at the end of their second year of training and 17 at the end of their third year of training. The students involved were asked for their names and this may have skewed results. Information on the type and length of training would add information for comparison with other studies.


Bairen & Farnsworth (1989) also studied the impact of a psychiatric nursing course on favorably changing nursing students’ attitudes toward mental illness. The Opinions about Mental Illness Scale (OMI as described above) was the instrument used. Reliability and validity coefficients were not given but supported in prior studies. The hypotheses were:

1) Scores would decrease on the “Authoritarianism” factor after completion of the psychiatric nursing course. This hypothesis was supported (p<.000).
2) Scores would increase on the “Benevolence” factor. Scores decreased and the result was significant (p<.001). The hypothesis was not supported.
3) Scores on the “Mental Hygiene Ideology” would increase after completion of the course. The hypothesis was supported. (p<.000)

4) Scores on “Social Restrictiveness” would decrease after completing the psychiatric nursing course. The hypothesis was supported (p<.016).

5) Scores would increase on the “Interpersonal Ideology” factor upon completion of the course. These scores decreased but not significantly so (p>.05).

The design was a one-group comparison before and after completing a psychiatric nursing course in an associate degree school. Respondents were 185 students who were sophomores in the suburbs of a large metropolitan city. The nursing course consisted of five hours of class and 15 hours of clinical per week for four weeks. Subject anonymity was provided. An abbreviated version of the OMI was given before the first class and on the last day of class. The OMI was developed by Cohen & Struening in 1962 and was described previously. The abbreviated version used in this study was reported to have face validity by a panel of experts who chose five of the most discriminating items from each of the original five sets. Three of the hypotheses were supported in the proposed direction as reported above, one was significant in the opposite direction, and one was not supported. Authoritarianism decreased, Mental Hygiene Ideology increased and mean scores on Social Restrictiveness decreased as proposed. Mean scores for the factors on Interpersonal Etiology and Benevolence decreased and the difference was significant for Benevolence. Implications by Bairen & Farnsworth included the interpretation that students a) do not view the mentally ill as an inferior class requiring coercion; b) do not have a paternalistic/moralistic attitude; c) hold a positive view of mental illness, believing in its ability to be treated; and d) do not believe the mentally ill pose a threat and need to be restricted in society.
Limitations included an acknowledged need for replication to support that the changes were solely the result of the course. Future research to explore the stability of these attitude changes was suggested. Rationale for the brief version of the OMI or how this affected results was not addressed. The sample was not randomized.

Slimmer & Martinkus (1990)

A limitation of the previous works was the lack of specificity about clinical location and how different locations may influence results. The following study by Slimmer and Martinkus (1990) incorporates these variables. The purpose of this study was to investigate the effect of clinical learning site on students' attitudes toward mental illness. Forty-five senior nursing students at a baccalaureate program were randomly assigned to a Veterans Administration (VA) Medical Center or a private hospital. The research questions were these:

1) Do students perceive a significant difference between the environment of a private hospital psychiatric unit and the environment of a VA medical center psychiatric unit?

2) Does the clinical learning site of a psychiatric nursing practicum have a significant effect on students' attitudes toward mental illness and psychiatric nursing (p.128)?

A pretest-posttest quasi-experimental design was used. The independent variable was the clinical location, and the two dependent variables were students' attitudes toward psychiatric nursing and mental illness. Three self-report questionnaires were used to collect data. The Environment Rating Scale (ERS) was developed by Wendt (1987), based on factors associated with affective learning. The Attitude toward Mental Illness Scale (AMI) (Wendt 1987), was adapted from Cohen & Struening's 1962 Opinions about Mental Illness Scale and the 1982 ANA Standards for Mental Health Nursing Practice. The Attitude toward Psychiatric
Nursing Scale (APN) (Wendt, 1987) was based on Wilson & Kneisl’s (1983) Psychiatric Nursing Ideology Scale.

The ERS includes 45 items in five categories: physical environment, relationship environment, personal development environment, system maintenance environment and learning environment. The AMI consists of 29 items grouped into five components as previously described: authoritarianism, benevolence, mental health continuum, social restrictiveness and interpersonal etiology. The APN represents four ideological paradigms in psychiatric nursing. Thirty-two questions represent orientation to the medical model, milieu therapy, psychotherapist counselor, and community mental health. Reliability and validity of the three instruments were obtained through Rasch analysis by five psychiatric nursing instructors and pretesting on 33 students. Internal consistency was reported as follows: AMI item and person separation reliability were .99 and .77, ERS item and person separation reliability were .97 and .95, and the APN statistics were both .60.

Results indicated a positive answer to the first research question (p<0.000). The students at the private hospital perceived a more supportive and therapeutic learning environment. The second question referred to clinical learning site affecting attitudes towards mental illness and psychiatric nursing. The results supported overall positive change in attitudes to both, but this was not related to clinical location. Hypothesis two results were non-significant (p>0.05). Although students at both sites showed a more positive attitude to mental illness (AMI) mean pretest 93, posttest 99.4 (VA hospital) and 83.6 pretest and 91.2 posttest (private hospital), the means also indicate students start out with a positive attitude and the clinical experience improved these attitudes. The results indicated a general positive change in three of the ideological views towards psychiatric nursing (community mental health, milieu therapy and
medical model), and no change in psychotherapist role perception. These changes were not significantly correlated with clinical site.

An implication for nursing is in the realm of affective learning. The staff competency and support, not locations, was the most important criterion. This supported Klausmier and Ripples (1971), attitude learning theory as used in the study, which identified exemplary role models as a significant factor in attitude development. Further studies to be discussed in the next section support the importance of a mentor to having a positive psychiatric nursing experience. Limitations acknowledged by the author include that the specific program evaluative research was not meant to be generalizable. Other factors affecting attitude change need to be identified and tested. Future research on specific variables contributing to positive change would add further data. A further limitation was that the effect of the didactic component of the psychiatric nursing course as well as the clinical practicum was not addressed.

Proctor & Hafner (1991)

Proctor & Hafner's (1991) work is the most frequently referred to by researchers exploring the phenomena of student nurses' attitudes toward mental illness. The premise for the study is that most nurses will be working with clients with either a diagnosed psychiatric disorder or some manifestation of significant emotional distress. The training received as a student will influence the attitude towards and care of these patients (p. 845.)

The authors assessed attitudes to treatment, conservatism and some aspects of personality structure pre and post psychiatric education. The psychiatric training included 35 hours of classroom lectures followed by a two-week field placement incorporating one-week in a psychiatric hospital. The hypotheses were: 1) personality structure and conservatism would predict attitudes to treatment; 2) these attitudes would change in a positive way after placement
in a psychiatric hospital; 3) changes in attitude to treatment would not be accompanied by changes in personality.

The data collection method used three self-report questionnaires administered to 51 students in their second year of a three-year diploma nursing school. The first two were the Attitudes to Treatment Questionnaire (ATQ) (Caine 1982) and the Wilson-Patterson Conservatism Scale (WPCS) (Wilson & Patterson 1968) as described earlier. The Defence Style Questionnaire (DSQ) (Andrews 1989), measured psychological defense mechanism on three scales: Mature, Neurotic and Immature. Higher scores indicate more use of defenses. Open-ended questions were included to encourage comments about the psychiatric clinical placement. Proctor & Hafner rated reliability and validity of the scales adequate, but statistical correlations were not provided.

Results of the study were given for the pre- and post-training phases. The Attitudes to Treatment results were also provided for the post lecture but preclinical stage of training. The first hypothesis that personality structure and conservatism would predict attitudes towards treatment was partly supported. Conservatism but not personality were positively correlated per report, but statistical significance was not reported. Results indicated that student nurses were moderately conservative, and this correlated with a traditional attitude. The second hypothesis that attitudes to treatment would change was weakly but positively supported (p<.003). The direction of change was towards a more contemporary approach, which was considered positive. In contrast to the study by McLaughlin (1997), no significant change occurred after the lecture/classroom component of the program. The third hypothesis was also supported. Scores on the Defence Style Questionnaire remained stable over the study period, indicating that the changes in attitude were not related to personality structure. None of the scores changed
significantly after completion of the clinical.

The open-ended questions indicated an initial fear of the patients as in prior studies. This diminished in the majority of the students after exposure. Some strongly negative attitudes persisted. No evidence was found that indicated a general reinforcement of stereotypes such as dangerousness towards the mentally ill. Receptiveness of the staff to students and treatment team collaboration were other positive factors identified in the open-ended questions. Most frequent responses included “Surprised to find that psychiatric patients are normal people with illnesses” (n=25), “Patients are less violent/aggressive/dangerous than anticipated” (n=24), and “Nursing staff were surprisingly helpful/caring/insightful ‘normal’ to students” (n=20) (Procter & Hafner, 1991, p. 847).

The smallness of the sample size (n=51) was again a drawback. More information on type of clinical setting, length of class and student roles would be beneficial. The authors indicated clinical experience and setting as a factor in positive perceptions of the mentally ill. Clinical location was cited in Proctor & Hafner as a variable contributing to positive results. The authors did describe the setting as a “modern and progressive institution.” (p.849)

Perese (1996)

Perese (1996) supported the importance of modeling professionalism for students and cites this as a factor influencing clinical experience. This outcome study also supports prior work identifying students’ fears prior to starting a psychiatric practicum. The purposes of the study were to identify factors contributing to a positive or negative clinical experience. Perese reports that about 25% of students select a preferred practice prior to starting nursing school and another 40% do so during their clinical experience. Therefore, it is important to identify influencing factors to increase selection of psychiatric nursing as a career option.
Thirty-eight nursing students completed a questionnaire designed by the author after completing a six-week psychiatric practicum. The practicum was divided equally between acute care inpatient units and long-term community care. Year in school or type of program were not given. Eight areas of the experience were explored in sixteen open-ended questions. These included expectation, initial thoughts and reactions, what they liked best and least and what may have helped them, as well as their overall view of the practicum.

Results were summarized and categorized as negative or positive in the eight areas studied. These indicated students' preconceived stigma from the media, lack of confidence and apprehension as negative factors. The most frequently cited negative factor was the nursing staff's actions and attitudes. These were described as uncaring or unprofessional by 44% of the students. Students identified feeling unwelcome. Positive factors were team conferences, one on one instructor communication time and the ability to interact with clients having diverse mental illnesses.

Limitations of the study included the small sample (n=38) of convenience. The author also reports the lack of reliability and validity of the self-designed tool. Results are not generalizable but indicate possible directions for research on factors influencing perception of psychiatric clinical experience.

*McLaughlin (1997)*

McLaughlin (1997) studied whether student nurses’ attitudes towards the mentally ill changed as a result of classroom theory about mental illness and/or contact with the mentally ill. A total of 72 second-year student nurses at a diploma school took part in the study. Methodology consisted of a 20-item Likert scale with ten items related to patient characteristics and ten items about how patients should be treated. The scale was developed in 1960 by Yuker
et. al. The version used in this study was revised by Murray & Chambers (1991), with a reported reliability coefficient of 0.78. In addition, two open-ended questions developed by the researcher (McLaughlin 1997) addressed what students looked forward to or feared when working in a psychiatric setting. The class consisted of two and a half weeks of mental health/psychiatric classroom theory (contact hours not provided) followed by a four-week psychiatric placement. The type of psychiatric facility was not addressed. The questionnaire was given prior to the start of class, again after the theory portion and again at completion of the practicum.

Results indicated two significant changes in attitudes in the post-theory stage and three significant changes in the post-clinical stage. Attitudes towards patient characteristics showed a shift to a more tolerant attitude post-class as well as post-clinical stage. For example, most students answered that mentally ill people “were just as sensible as other people” (p<.05 post theory and <.01 post clinical) and that they were no more likely to feel sorry for themselves (p<.01 post theory but no significant change from pre-class scores). Results also were significant for a positive change in the perception that mentally ill people are just as normal as other people (p<.05 post theory and <.01 post clinical). Students significantly agreed more strongly that mentally ill persons are more easily upset than others (p<.05 post clinical). Respondents also progressively and significantly disagreed that mentally ill people are usually easier to get along with (p<.05 post clinical).

In the post-class stage, attitudes towards treatment of the mentally ill also indicated a significant change. Students strongly disagreed that mentally ill persons should live in institutions, but did agree that residential facilities would be in the best interest of the mentally ill (p<0.01). These results overall indicated a more affirmative attitude post-class in treatment of the mentally ill.
The post-clinical stage also showed three significant changes. The attitude that it would be in the best interest of the mentally ill to live in residential housing remained significant (p<.05). Students agreed more significantly and strongly in the post-clinical stage that mentally ill people are the same as everyone else. They disagreed that you should not expect too much from the mentally ill. The authors conclude that overall students’ attitudes towards the mentally ill were changed positively post-class and remained significant and positive at the post-clinical experience stage. In addition, student nurses demonstrated a reduction in fear and improvement in interpersonal skills (65%). Other positive aspects identified by students were the working relationships with the clinical staff; conversely, the same was true, although this did not appear to affect attitudes towards the mentally ill. These findings supported the previous works of Proctor & Hafner (1991) by providing evidence of decreased fear and improved attitudes towards the mentally ill following clinical exposure. However, this study contrasted with the Proctor & Hafner findings of no attitude change to patients with mental illness in the post-class stage.

A limitation of the study was in the content of the chosen tool. The authors indicated this reflected attitudes towards characteristics of the mentally ill. Some the questions such as “most mentally ill people worry a great deal” or “most mentally ill people feel they are not as good as others” perhaps reflect the mentally ill person’s self perception rather than the students’. The response rate was variable among the three stages from 91 to 94%, making it difficult to ascertain the accuracy of the results. The small study size is a further concern. The small size of the study precludes generalizing but provides information for further research. The type of clinical setting or role of the student nurse was not indicated. Results may vary in an acute care versus long-term setting.
Rushworth & Happel (1998)

The previous research studies have supported the positive influence of a psychiatric clinical experience on attitudes of nursing students towards persons with mental illness and the practice of psychiatric nursing. Aspects of training that students found positive or negative were explored. A gap in the research exists linking this attitudinal change to career choice. Rushworth & Happel (1998) explored the link between psychiatric nursing education and interest in this specialty as a practice focus.

A quasi-experimental pretest-posttest design was used to study 119 undergraduate nursing students at a university. A multigroup time series design was used to study the same participants over two years. A questionnaire with rank-order and open-ended questions was used. Students were asked to rank nine identified areas of nursing practice that included medical, surgical, pediatric, geriatric, surgery, intensive care, midwifery, medical, community health and psychiatry. Open-ended questions explored rationale for the choices.

Phase I was conducted during the first week of the first year of the study. Psychiatric nursing was ranked eighth and least preferred by 32% of the respondents. Only 2% rated it their first choice. Phase II, the posttest phase occurred after the completion of the first semester of the second year. Half of the students have studied a classroom unit on long-term illness/aged care and half had studied a unit on psychiatric nursing. Students were given the same questionnaire. At posttest, psychiatric nursing had become the third most popular choice for those students completing the psychiatric unit. The posttest of the long-term care group did not demonstrate a significant change. Analysis of the open-ended questions revealed initial fear and mistrust of the mentally ill that continued in the long-term care group but diminished following the psychiatric practicum. This supports previous findings (Creech 1977, Perese 1996, Proctor & Hafner 1991.)
Limitations of the study include lack of generalizability. Only one cohort of students was studied. All responses between pretest and posttest could not be cross-matched. The group with an increased interest in psychiatric nursing had just completed this clinical. Long-term follow-up research would need to be done to determine if this group did follow through with a mental health career choice.

Melrose & Shapiro (1999)

Melrose and Shapiro (1999) used a personal construct theory exploration to gain knowledge on students’ perceptions of their psychiatric mental health clinical nursing experience. Participants were six Canadian second year nursing students in a baccalaureate program with an integrated psychiatric curriculum.

The three themes identified were 1) students’ anxiety related more to feeling unable to help than to interactions with mentally ill patients; 2) students’ feelings of lack of inclusion in staff nurse groups; and 3) student emphasis on the importance of non-evaluated student-instructor discussion time. (p. 1451.)

The personal construct theory and repertory grid techniques provided the framework. The students spent two days a week for six weeks in an acute inpatient psychiatric setting. The students, as in previous works, voiced being afraid of patients and anxious about their ability to help. The fear of mental illness was significantly diminished at the end of the rotation but the authors found a continuing lack of confidence. A contributing factor to this lack of confidence was theorized to be the integrated curriculum not adequately addressing the foundations of psychiatric nursing. Also identified, as in previous works, was the busyness of staff and lack of a mentor other than the limited time with the instructor. Short inpatient stays, institutional restructuring and downsizing limited staff’s time with students. The identified issues supported
prior studies and extended understanding of positive and negative factors of a student’s psychiatric practicum.

In summary, a psychiatric clinical experience has been found to be valuable in decreasing fears and negative perceptions of the mentally ill and increasing liberal attitudes towards treatment and housing. Positive changes occurred after classroom education and continued after a psychiatric clinical rotation. Exposure to a mental health clinical practicum may also influence the selection of psychiatric nursing as a possible future career choice. Positive aspects of the psychiatric clinical included being supported by staff and the instructors, the chance to get to know patients with a mental health diagnosis, and improving interpersonal skills. Only one study indicated a persistence of negative stereotypes. A general limitation was study size and cross-sectional or time-limited design. Further information is needed on how clinical location site and specific variables of the experience influenced results. Information was also lacking exploring time in clinical or length of nursing course as a variable. The literature does not compare amount of clinical exposure with significance of results. Clinical exposure time varied from brief exposure (one or two days) to a semester. The content of the courses was not identified. A study comparing student nurses’ attitudes towards mental illness and mental health nursing in an integrated versus separate curriculum would add additional information about the effectiveness of these curriculum approaches. From the review of the literature, it can be concluded that a psychiatric nursing course, both theory and clinical, is of value. This supports the need for further data on how psychiatric nursing is being taught.

The second part of the literature review will discuss factors contributing to the decrease in educational focus of the specialty of psychiatric nursing. The most significant of these was the inclusion of psychosocial components of nursing throughout nursing education. This led to
the eventual merging of the two. Psychosocial nursing, however, is not psychiatric nursing. The second major influence on mental health nursing curriculum was the governmental grants post-World War II to include mental health nursing in nursing programs. This eventually led to the demise of the psychiatric nursing course and led the way to the integrated curriculum. These factors will be examined and their contributions to the current study will be addressed.

*Origins of the mind-body dichotomy*

The separation of mind and body can be traced to the seventeenth century philosopher Descartes. He conceptualized the distinction of mind as completely separate from body (or matter in general.) The mind and spirit were seen as the concern of the religion while the body was in the physician’s domain. This led to the distinction between “mental” and “physical” health that persists today. The accepted language continues this distinction with the terms “mental health” and “physical health”. The Surgeon General’s Report on Mental Illness (2000) discusses the roots of this distinction and proposes that many mental dysfunctions are physical in origin, and physical illnesses can be manifested psychologically or mentally. A nightmare can produce a racing heart and sweaty palms, and a stroke has both physical and mental components. A brain disease can be seen as a mental disorder, depending on the symptoms produced. The Report proposes considering health and illness along a continuum with interrelatedness of mental and physical health. This is in congruence with current and accepted nursing theorists who espouse a holistic view.

*History of Psychiatric Nursing*

Nursing has a long history of advocating for this shift towards wholeness. Prior to 1950, nurses were discouraged, if not forbidden, to talk with patients. Olson (1996) traced this shift to interpersonal nursing through a study of the contributions of three prominent nurses who were pioneers in the field. Peplau, whose Interpersonal Nursing Theory provides the framework for
this work, and Mereness and Fagin. Peplau’s works are often cited as the origins of psychiatric nursing. The text *Interpersonal Relations in Nursing* was controversial when it was first published in 1952. This theory will be covered later in detail. Peplau’s goal was to gain recognition for the therapeutic communication that was part of nursing, rather than just the focus on being task oriented. She wanted “talking with patients legitimized” (Olson p.4). Peplau’s interpersonal focus was in contrast to the popular Freudian or psychoanalytic leanings of the time.

Mereness’s first text in 1949 was based on these psychoanalytic foundations as well as on the neurobiological components of mental illness. The mid 1950s shift towards milieu therapy, the introduction of psychotropic drugs and the shift away from institutionalization were reflected in her subsequent works. The 1958 text of *Psychiatry for Nurses* (5th Ed. as cited in Olson, 1996) reflected incorporation of Peplau’s Interpersonal theory. Mereness continued to advocate for psychiatric nursing and inclusion of psychosocial aspects in professional nursing practice. Her textbooks are the longest running work on psychiatric nursing. Her first text was published in 1940 and the ensuing twelve editions covered 40 years. In 1985, her concern was to advance the profession and develop the psychiatric nursing specialty as one mechanism to accomplish this (Olson 1996).

The contributions of Fagin further enhanced the inclusion of interpersonal nursing and the advancement of psychiatric nursing. Her study “Desirable Functions and Qualifications for Psychiatric Nurses” was published by the National League for Nursing in 1953 and was a landmark for psychiatric nursing and research (Olson, 1996). This led to a recommendation by the NLN that a psychiatric nursing experience and course work be included in all basic curricula (Peplau 1996.) Fagin referred to Peplau as “the inventor of psychiatric nursing” and
incorporated this theory, as well as influences by Mereness and psychoanalysis. In her 1967 article, “Psychotherapeutic Nursing”, she viewed mental illness not as a separate disease entity but as a pattern of difficulty within the person. The nurse as therapeutic agent could help the patient grow and get well (Fagin, 1996).

The three leaders in the field of psychiatric nursing were instrumental in beginning the shift towards holistic nursing and the development of the field of psychiatric nursing. The concern for advancement of the specialty in the 1950s and the 1960s led to some uncertainty as to how to implement these simultaneously without losing the uniqueness of psychiatric nursing. The intent to incorporate therapeutic communication, a previously unheard of phenomenon, led to the integration of these concepts into general nursing curricula as well as separate nursing courses. Political, historical, and financial influences gradually led to the integrated curriculum concept and decreased focus on the specialty of psychiatric nursing. These will be discussed further. Peplau’s Interpersonal Nursing Theory provides the link between mental health nursing of the past and present and will be used as the framework for this study.

*Peplau's Theoretical Framework*

Although Peplau’s theory does not constitute the whole of psychiatric nursing, it provided the historical beginnings of the field and is still applicable today. Peplau first wrote her book *Interpersonal Relations in Nursing* in 1949, but it was not published until 1952 because of the then current social climate and the lack of women’s rights. She developed her theory in response to a need to further develop the understanding of interpersonal relations in nursing and help graduate nurses improve communication skills.

Her theory was the first published nursing theory since Florence Nightingale. It reflected her studies in interpersonal relations and incorporated elements of the developmental model of Harry Stack Sullivan. Peplau was also influenced by the symbolic interactionist George Hubert
Mead (1934) and May’s (1950) work on anxiety as well as learning theories of Miller and Dollard (1941). The underlying assumptions of the original theory are the following:

1. The kind of person each nurse becomes makes a substantial difference in what each patient will learn as he is nursed throughout his experience with illness.

2. Fostering personality development in the direction of maturity is a function of nursing and nursing education; it requires the use of principles and methods that permit and guide the process of grappling with everyday interpersonal problems or difficulties (Peplau, 1952, p. xiii).

These additional assumptions were identified by correspondence (as quoted in Forchuk, p. 6).

3. Nursing can take as its unique focus the reactions of clients to the circumstances of their illnesses or health problems.

4. Since illness provides an opportunity for learning and growth, nursing can assist clients to gain intellectual and interpersonal competencies, beyond those that they have at the point of illness, by creating nursing practices to evolving such competencies through nurse-client interactions.

Peplau’s theory is unique in including the nurses’ self-reflection and response as part of the ongoing process influencing the patient. On page 296 of her 1952 book, Peplau provided a diagram of the interrelationships of physiology, culture, relationships and perceived meanings leading to whole organism response. Her theory was the forerunner to the holistic theories of today. Mental health is an integral component of holistic nursing, so it is essential to study how this is being taught.
Peplau's phases of the nurse-patient relationship

The impact of nursing care on this patient environment is described in the development of the four phases of the nurse-patient relationship. These phases are orientation, identification, exploitation and resolution. Each of these is overlapping as the nurse and patient come together to reach the goals. In later works of the 1970s, Peplau combined identification and exploitation into the working phase.

The orientation phase begins the nurse-patient relationship when an ill person and a nurse come together for a health-related problem. Collaboration is required to clarify and define the problem. The need for orientation is essential for the patient to integrate the event into life experience versus repression and dissociation leading to ineffective coping.

The phase of identification is one in which the relationship continues as a partnership to identify goals. Nursing can provide acceptance to minimize the negative influence of the disease on empowerment and facilitate positive coping. Clarification of perceptions and expectations are an integral part of this phase.

The exploitation phase is perhaps misleading. Peplau acknowledges that there may be patients with exploitive elements in their personality, but in general this is a positive progression in the nurse-patient relationship. The patient is now able to fully utilize what the nurse can offer in terms of interpersonal growth, education, physical care and support. The patient develops skills to become more independent and progression is to closure and resolution.

The goal of the nurse-patient relationship is to prepare patients who have positively coped with their illness and are ready to move on, perhaps with some assistance from home care or the community. The nurse does not "solve" the patients' problems, but provides options and information. Resolution occurs when the need for care has ended.
Roles of the Nurse

The above phases overlap and interact as the process evolves. During the above phases, the nurse takes on many roles. These depend on the needs of the patient and the skills, experience and creativity of the nurse. Peplau (1952) describes these roles as stranger (courteous, accepting approach to begin interaction), resource (provide necessary information), teacher (provide education), surrogate (multiple roles during care and teaching), counselor (goal-focused, problem solving communication), and technical expert (provide nursing care based on technical expertise). Peplau believed in communication as a powerful tool in facilitating positive change. She theorized that talking about issues provided an alternative to acting them out, and that which was acted out would not be verbalized.

The above theoretical framework was chosen for the following reasons:

1. As the foundation of psychiatric nursing practice, this research would perhaps be void without her leadership and definition of the specialty of nursing care.

2. The concepts of the theory are applicable across the spectrum of nursing care.

3. Psychiatric nursing today is still utilizing concepts of the original work. No other theory has as much relevance to the practice.

A further consideration in the choice of this model as a framework for this study is to support the integrity and uniqueness of psychiatric nursing. To utilize a theorist from another discipline or nursing focus would contribute further to the blurring and potential loss of the specialty that provided the impetus for this research.

Psychiatric nursing has responded to the needs of clients influenced by the social, political and economic trends and norms over the years. Leaders in the field of psychiatric
nursing noted the beginnings of loss of the specialty and the detrimental effect this may have on clients and on the profession. Researchers have supported the importance of psychiatric nursing theory and clinical on the ability to care for this population adequately. Clients with a mental health disorder are prevalent in society and may be found in any health care setting. Peplau's Interpersonal Nursing framework is applicable to clients in any setting as part of a comprehensive and holistic practice. Providing care to clients is the focus of nursing practice and research. Since mental health clients are increasing in number and the programs teaching nurses how to care for them may be decreasing, research on this dichotomy and future implications to narrow the gap will be critical to our clients and the profession.
Chapter III

Methodology

I. Design

The review of the literature indicates support for the theory that a psychiatric/mental health nursing clinical can positively or negatively affect nursing students’ perception of the mentally ill and potential career choices. The literature also indicates that while psychosocial aspects of patient care are critical to a holistic approach, these aspects do not constitute the whole of mental health nursing. It is therefore important to examine if a mental health practicum exists and if concepts of mental health nursing are being taught. This chapter will review the research design, instrument, informants, and methodology used to address the research question of “How is mental health nursing being taught?”

The variables of the study are:

Type of curriculum;
1. integrated mental health curriculum
2. nonintegrated (separate) mental health curriculum

Demographics;
3. A.D.N. school of nursing and number of students
4. B.S.N. school of nursing and number of students

Type of clinical practicum;
5. availability of a mental health practicum
6. location of mental health practicum
7. clinical hours of mental health practicum

Exposure to clients with psychiatric diagnoses;
8. opportunity to work with clients with a primary psychiatric disorder

9. opportunity to work with a client with a secondary psychiatric disorder.

A non-experimental design was chosen as the most appropriate for the type of data being sought. The multivariate descriptive method represents the best means for data collection and analysis. A self-report questionnaire was chosen as the survey tool (see Appendices B, C, D). This was self-designed because there is no existing tool to obtain the necessary information.

Face validity was established for the survey tool by two Master’s prepared nurses and one doctoral prepared nurse educator, all with extensive psychiatric nursing or nursing education experience. The tool for the study was also reviewed and piloted by peers and changes were made for content, clarity and ease of use. External validity will be facilitated by homogeneity of survey respondents. Only the Deans / designees of nursing schools accredited by the National League for Nursing (NLN) and/or the Commission on Collegiate Nursing Education (CCNE) will be included. The sample of convenience included all of the accredited nursing programs in the state of Wisconsin.

The structured self-report instrument was designed in two parts. The first section included demographics and open-ended question about the experience of teaching mental health nursing. The second section was color coded to reflect either an integrated or separate mental health curriculum. The dichotomous questions were based on research results identified in the literature review. Related constructs were clustered in the areas of descriptive data on participants, demographics, curriculum design and clinical exposure.

Open-ended questions offer the opportunity to gather expert opinions on the topic of mental health nursing and add richness to the data. The open-ended questions were included to provide a means of gathering supplemental data and to utilize the collective expertise of the respondents.
Questions were designed to maximize information gathered and minimize inconvenience to respondents.

The theoretical framework of Peplau's interpersonal nursing model also supports the use of descriptive analysis. The constructs of psychosocial nursing as presented by Peplau in Chapter II are the foundation of psychiatric/mental health nursing. Studying the current curriculum of this specialty through quantitative analysis will add nursing knowledge about how mental health nursing is currently being taught.

II. Sample

A purposive sampling plan was chosen to gain the information from the informants possessing the knowledge for this study. The informants for this inquiry are the Deans/designees of the Schools of Nursing that meet the inclusion criteria. The two inclusion criteria are an N.L.N. accredited baccalaureate or associate degree nursing program or CCNE accredited baccalaureate program and school location in the state of Wisconsin. Deans and/or their designees were chosen as informants for their potential knowledge of system influences and decision-making, leadership position and expertise with their schools' nursing curriculum.

The sample chosen was obtained from an Internet search of the National League for Nursing and American Association of Colleges of Nursing World Wide Web sites. All of the schools of nursing in Wisconsin listed on the Internet sites are included. The target population was all of the accredited schools of nursing in the United States, but this was not feasible. Therefore a representative sample of one state was chosen. The nonprobability sample was chosen as representative of Midwest schools of nursing, although the lack of randomization makes the data nongeneralizable. The sample size was 30 schools, which consisted of all NLN and CCNE accredited schools of nursing in Wisconsin.
Polit & Hungler (1999) reported the average size of nursing research samples for four decades was 100. The authors also state, “When the researcher has reason to believe that the population is relatively homogenous with respect to the variable of interest, then a small sample may be adequate for research purposes” (p. 290). The sample size varies in being either a private or public college and numbers of students enrolled, but limiting the sample to NLN. or CCNE accreditation provided the homogeneity to justify the sample size. Effect size is not a concern with non-experimental research. Attrition is also not applicable due to the cross-sectional design. Poor response rate was addressed by a two-part approach to data collection. The initial survey was mailed with a stamped, self-addressed envelope. Two weeks following the initial mailing, a postcard was sent as a reminder to complete the survey. Projected return rate exceeding the average 10% was expected following this procedure. The survey design and brevity may also facilitate compliance.

III. Protection of the Rights of Human Subjects

Cardinal Stritch University Institutional Review Board approval was obtained prior to beginning the study. No vulnerable populations will be used for this study. A cover letter was included explaining the purpose and intent of the research. Anonymity was provided with a coding system, which only the researcher had access to. Data will be kept by the researcher for three years in a locked file. The letter of introduction included the statement “participating in this survey implies consent.” See Appendix A for consent form. The risks were minimal, as the research was noninvasive and did not include personal or sensitive information. Survey completion time was approximately 15 minutes.
IV. Data Collection Plan

The data collection plan entailed a mailing to all of the schools meeting the specified inclusion criteria. The level of data needed for return is nonspecific for descriptive research, but the previously described three-part process facilitated a maximum return rate. The main characteristics of the sample were the inclusion criteria. Demographic data addressing school population and qualifications of the respondents provided information on those schools participating in the study. These are included in the descriptive data.

Survey questions were worded to minimize response bias. Anonymity and neutrally worded questions may help to reduce any potential social desirability bias. Extreme response and acquiescence are reduced in dichotomous versus Likert type instruments. If a survey appeared inaccurate or incomplete, the data collection plan included contacting respondents for clarification if permission had been given to do so. This was not necessary.

Descriptive statistics were used to organize and interpret the data. The nominal data and nonrandomized sample precluded use of other data analysis methods.

Each dichotomous question was coded, as was the response. A frequency distribution gave preliminary information on raw data. Tables provided visual representation of the results of each variable. The variables of clinical practicum (inclusion, location, hours) were summarized. Open-ended responses were analyzed for themes and summarized in results. Data entry was double checked for accuracy. Data analysis was done using the Statistical Package for Social Sciences (SPSS) Version 10.0 for Windows. The significance level used will be (p<.05.)

V. Limitations

Weaknesses in studying this problem were the nonrandomized convenience sample and
self-designed tool. Limitations will be addressed in results. The researcher must also assume accuracy of responses.

VI. Assumptions

Further assumptions of the study are that the population was representative, sample size was adequate, the tool reflects the research questions and response rate was sufficient for data analysis. Descriptive statistics were the correct method of data interpretation.

In summary, a two-part survey tool of dichotomous and open-ended items (see Appendices B, C, & D) was sent to the Deans/designees of NLN and CCNE accredited associate and baccalaureate nursing schools in the state of Wisconsin. The tool was designed based on research of mental health nursing and curriculum, utilizing Peplau's Interpersonal Nursing Theory. The cross sectional design for data collection was implemented with a mailing to all schools meeting the inclusion criteria. Sample size was 30. Results were analyzed using descriptive statistics. Survey results, interpretation and implications for nursing will be addressed in the next chapters.
Chapter IV

Data Analysis

Surveys were mailed to all accredited schools of nursing in Wisconsin. The total number of participants was 30. After a two-week period, 18 completed surveys were returned. Deans/designees representing schools that had not replied were sent a reminder postcard resulting in five additional completed surveys. Data collection ended 6 weeks after the initial mailing. The total number of respondents was 23, a 76% response rate. Several of these were incomplete, which will be noted in the results. The data was analyzed using the SPSS Version 10.0 for Windows program.

Demographics

Surveys were addressed to the School of Nursing Dean or designee. The demographic data indicated that the majority of the surveys were completed by psychiatric nursing instructors (52.2%), and Associate Deans (21.7%), two Deans (8.7%), a program coordinator (4.3%) a program director (4.3%) and an interim program director (4.3%). Length of time in this position varied from 10 months to 26 years with fairly equal distribution of nursing experience. The number of students ranged from 28 to 230 in the 14 ADN programs with 53.9% between 150 and 230. Three of the ADN school informants did not respond to this question. Six BSN schools reported 55 to 400 students in the programs, with 83% between 165 and 400. Three BSN schools also left this question blank.

The open-ended questions as well as the dichotomous forced choice items addressed the research question of "How is mental health nursing being taught in accredited schools of nursing in Wisconsin?" The open-ended questions provided rich information. The length and detail of the responses supported the significance and meaningfulness of this study. Question one asked,
"How is mental health nursing being incorporated in the curriculum?" This question addressed the variables of integrated and nonintegrated curriculum, ADN or BSN program, and availability, location and clinical hours of a mental health practicum. The number of mental health theory hours also reflected this inquiry.

Question two, "What factors are currently influencing mental health nursing education?" was addressed in the open ended questions of "Please share any thoughts you may have about teaching mental health nursing today," and "What changes, if any, would you like to see in the future of mental health nursing education?" These open-ended questions will be summarized in a later section.

Question three "Do nursing students have the clinical opportunity to work with clients with a diagnosed psychiatric disorder?" was incorporated into the integrated and separate mental health curriculum surveys with questions related to this variable.

Descriptive statistics are the appropriate method for the nominal data and information being sought. Group statistics yielded invalid data due to the small number of responses and different type information being sought in the two-part survey. For example, the question on the integrated curriculum survey "What year did integration begin?" yielded three responses out of nine possible with a range of 1976, 1992 and 1995. This question was not included in the separate curriculum questionnaire because it was not applicable.

The data will be reported according to the categories of integrated and separate mental health curriculum. Nine respondents reported a program leading to a BSN degree and 14 to an ADN degree. Of the 23 respondents, 6 reported an integrated mental health curriculum and 17 a separate mental health curriculum. These are represented as follows in Table 1:


Descriptive Statistics

Table 1
Type of Program and Degree

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<th>Integrated curriculum-26%</th>
<th>Separate curriculum-74%</th>
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<tbody>
<tr>
<td>Associate degree</td>
<td>17.5%</td>
<td>43.5%</td>
</tr>
<tr>
<td>Baccalaureate degree</td>
<td>8.5%</td>
<td>30.5%</td>
</tr>
</tbody>
</table>

The majority of respondents (74%) reported a separate mental health curriculum format including both ADN and BSN programs. The BSN programs reported increased clinical time (mean 86.36) compared to the ADN programs (mean 72.44). The ADN programs however, reported more mental health theory time (mean 37.167) than the BSN programs (mean 28.43.) The number of mental health theory hours and clinical hours by program are reported in Table 2.

Table 2
Mental Health Clinical and Theory hours by Program

<table>
<thead>
<tr>
<th>Program</th>
<th>N=21</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>(No response from two participants)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BSN – Number of students in program</td>
<td>6</td>
<td>55</td>
<td>400</td>
<td>229.17</td>
<td>124.234</td>
</tr>
<tr>
<td>Mental Health Theory Hours</td>
<td>8</td>
<td>0</td>
<td>52.5</td>
<td>28.438</td>
<td>19.1077</td>
</tr>
<tr>
<td>Mental Health Clinical Hours</td>
<td>7</td>
<td>30</td>
<td>180</td>
<td>86.36</td>
<td>49.510</td>
</tr>
<tr>
<td>ADN – Number of students in program</td>
<td>13</td>
<td>28</td>
<td>230</td>
<td>132.92</td>
<td>65.315</td>
</tr>
<tr>
<td>Mental Health Theory Hours</td>
<td>12</td>
<td>2.0</td>
<td>72.0</td>
<td>37.167</td>
<td>16.980</td>
</tr>
<tr>
<td>Mental Health Clinical Hours</td>
<td>9</td>
<td>18</td>
<td>112</td>
<td>72.44</td>
<td>31.077</td>
</tr>
</tbody>
</table>
It is unknown if the respondents interpreted the question of “How many students are in your program?” to mean number of students in the class, total program enrollment or specifically in the mental health nursing course and this may account for the wide variation in responses. A t-test for Equality of Means comparing the variables of mental health theory hours by separate and integrated curriculum yielded statistically insignificant results (p=.427). Comparing clinical mental health hours by type of curriculum did prove statistically significant (p=.003.) However, because of the discrepancy in the number of responses per type of curriculum, the data was skewed as indicated in Table 3.

### Table 3
Mental Health Hours by Type of Curriculum

<table>
<thead>
<tr>
<th>Hours</th>
<th>Type</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Theory Hours</td>
<td>Separate</td>
<td>17</td>
<td>32.294</td>
<td>18.3840</td>
</tr>
<tr>
<td></td>
<td>Integrated</td>
<td>3</td>
<td>41.500</td>
<td>15.3216</td>
</tr>
<tr>
<td>Mental Health Clinical Hours</td>
<td>Separate</td>
<td>15</td>
<td>71.77</td>
<td>29.536</td>
</tr>
<tr>
<td></td>
<td>Integrated</td>
<td>1</td>
<td>86.36</td>
<td></td>
</tr>
</tbody>
</table>

The significance of the results in the difference between clinical hours in an integrated versus separate curriculum may be the result of the variance in number of respondents versus differences in clinical time. While the data did not provide statistically significant information, this was anticipated with this type of study. The number of separate curriculum respondents was 17 compared to six respondents for the integrated curriculum. This wide range made it invalid to compare the data. Table 4 indicates these results.
The data did provide information on how mental health nursing is being taught with a wide variety of responses. There was little homogeneity of clinical hours, theory hours and clinical location, which provided valuable data on the variability of the subject, and therefore support for studying how these findings may impact nursing practice.

**Student exposure to mental health clients**

**Separate curriculum.**

The literature proposed that since psychiatric inpatient stays are getting shorter, nurses are exposed to clients with mental health disorders in a variety of settings. This study supported these findings. The question “Do students have the opportunity to work with a client with a diagnosed psychiatric disorder whose primary reason for entering the healthcare system was not for psychiatric treatment?” addressed this phenomenon. Eleven of the 17 respondents reporting a separate curriculum answered yes (64%.) Clinical settings in which this occurred covered the spectrum of nursing practice areas including medical-surgical, oncology, acute care, maternity, clinics, nursing homes, community settings and group homes. Thus, it is important for nurses to have psychiatric nursing knowledge and skills to competently care for these clients.
It was assumed that if there were a separate mental health course, students would be exposed in the practicum to clients with a psychiatric disorder as the primary reason for entering the health care system so this question was omitted on the Separate curriculum surveys. All of the 17 separate curriculum respondents indicated that there was a mental health practicum and the clinical locations supported this assumption. Settings for the mental health included inpatient psychiatric units, clubhouses, group homes, community settings, senior day care centers, correctional settings and long-term care facilities.

Student exposure to mental health clients

Integrated curriculum.

All of the 6 integrated curriculum respondents (100%) answered yes to the question “Do students have the opportunity to work with a client with a diagnosed psychiatric disorder whose primary reason for entering the healthcare system was not for psychiatric treatment?”

The integrated curriculum questionnaire also included the question “Do students have the opportunity to work with clients whose primary reason for entering the health care system is related to a mental health diagnosis?” Five of the six respondents (83%) answered yes. The settings were similar to separate curriculum clinical locations. In addition, all six reported that students may also choose a mental health practicum as part of another course. Courses included leadership, community health, internship, advanced complex care clinical, and a mentorship.

Rationale for mental health curriculum

The rationale for adopting either a separate or integrated mental health curriculum provided further insights. There were two primary schools of thought. The primary rationale by those teaching in an integrated format was centered on a holistic focus and the inclusion of mental health as an integral component of the whole being. The respondents in a separate
curriculum espoused the view that mental health as a discreet course provided needed psychosocial and psychiatric skills and eliminated fears and stigma in working with these clients.

*Rationale for separate curriculum*

The question “What is your program’s rationale for providing a separate mental health curriculum” elicited 16 responses (one of the 17 was blank). These were categorized into three major themes. Tradition or the philosophy of the college and faculty was listed in six responses (37.5%). Importance of the content was a concern for nine of the respondents (56%). A respondent shares an example of focus on the importance of core mental health knowledge in the following statement: “Personally, I believe a good RN is always going to have good mental health skills at his or her core.” Another stated, “Mental health/psych pathology concepts would get lost if integrated because ‘fundamentals’ and med-surg instructors are not well-versed in psych nursing theory.” Another respondent had similar thoughts “So content doesn’t get lost.” and another stated this rationale “visibility showing importance.” The complexity of the content and concepts was also a concern within this category.

A third theme centered on the provision of a separate mental health curriculum because nurses will work with mental health clients in a variety of settings. This was reflected within the context the other two major themes. This respondent articulated these concerns and other issues facing mental health nursing:

Our mission as an ADN program is to serve the community's needs. As patients move to the community and nurses move to the community and funding for the services is diminishing, our students/graduates will see this population in a wider variety of settings. They need to understand the population's unique needs, and to see that mentally ill people for the most part have the same needs & desires as everyone else.
A second respondent had similar reflections:

Faculty believe that learning to provide care to clients with serious mental illness in an acute care setting is critical in preparing students to work with a population where mental health issues are escalating. A separate course provides a specific focus on therapeutic communication skills, use of the nursing process and an in-depth focus on mental health/illness issues. Students are thus better prepared to diagnose and treat the clients' human responses to mental health issues in other settings while incorporating concepts of primary prevention.

The remainder of the responses indicated a variety of rationale for maintaining a separate mental health curriculum. One listed psychiatric nursing as necessary to fulfill a State Board of Nursing requirement. Two participants expressed the importance of psychosocial skills as the foundation for coursework to follow and the integration of these concepts in later courses.

Two responses incorporated concern for helping students feel comfortable with mental health clients and decrease fear, which is congruent with the findings of McLaughlin, (1977), and Proctor & Hafner, 1991. Rushworth & Happell (1998) linked this decreased fear and stigma to an increase in choosing psychiatric nursing as a profession. One of the respondents supported this proposal: “Strengthens student nurse knowledge and desire to choose this specialty.”

Another interesting finding linked theory and clinical to improve learning: “To provide clinical experience in closer proximity to theory content enhancing learning and understanding.” Thus, there is a variety of rationale for continuing a separate mental health curriculum, with evidence in the literature to support this practice.

**Rationale for integrated curriculum**

The concerns voiced by proponents of an integrated curriculum were no less valid but
expressed with less depth. Five of the six integrated curriculum respondents answered the question “Why did your program choose to integrate mental health nursing?” in the following manner. One respondent stated “don’t know”. Three referred to the rest of the programs being integrated and one replied “mental health nursing skills are required across health care settings.” Perhaps the participants felt they had already addressed this question on the demographics page.

*Application of mental health concepts*

*Separate curriculum.*

The question “How are students helped to integrate mental health nursing knowledge into their practice?” on the separate curriculum questionnaire received 13 responses. The responses centered on four concepts. These included the importance of laying foundational mental health/psychosocial knowledge, holistic patient care focus, incorporating psychosocial concepts throughout the curriculum and a psychiatric class and/or clinical. The majority of respondents included several concepts. The value of the information is in the content of the responses that lends insight into how mental health nursing is being taught. The following response exemplifies the complexity of teaching mental health nursing:

Students take an 8 week course in mental health nursing with a clinical practicum occurring concurrently with classroom activities - discussion, PowerPoint program including video clips of client behaviors for assessment (use of nursing process, case studies, role playing. Clinically- clinical preparation, client care, pre and post conferences written case study, process recordings, group house tour. All courses in our program emphasize mental health concepts (basic). In testing for each of the nursing process courses, faculty are analyzing student performance in the use of
communication skills. The four main concepts of the respondents are presented in Table 5.

Table 5
Application of Mental Health Concepts in a Separate Curriculum

<table>
<thead>
<tr>
<th>Lay foundational knowledge</th>
<th>Holistic focus</th>
<th>Integrated mental health concepts</th>
<th>Mental health class/clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Starting in the fundamental courses with a review and introduction of communication, uses R/T transference –etc- Pharm- review of the medication”</td>
<td>“Students complete holistic assessment that includes psychosocial areas. Discuss effect of anxiety and depression on hospitalized pts.”</td>
<td>“The therapeutic relationship is emphasized throughout the program. We use the Bondy scale for clinical evaluations. One of the areas within the scale is focused on how the student takes a patient's affective needs into account. This scale is used in every course. Therapeutic comm. is taught in the 1st semester.”</td>
<td>“Clinical practice”</td>
</tr>
<tr>
<td>“This is a very big question. I teach Psych/Mental Health to senior nursing students, but I also co-teach nursing 101 Fundamentals. In Nursing 101 I lay foundational knowledge about mental health that they use throughout their program”</td>
<td>“This is an RN-BSN program. The patient is presented holistically-mental health being one component”</td>
<td>“Psychosocial objectives are integrated in each course in the nursing program for clinical application.”</td>
<td>“Our program has a separate Theory/Practicum for mental health nursing”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Clinical experience &amp; use of a bio-social tool with every (incl. Med surg, OB, etc) clinical rotation.”</td>
<td>“In the classroom and clinical experience”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“All courses in our program emphasize mental health concepts (basic)”</td>
<td>“Through clinical experiences, case studies in class”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Reinforcement in clinical conferences, care plans, journals, etc.”</td>
<td>“(1) Through variety of community and acute clinical experiences such as prison, AA, outpatient, inpatient units (2) write psych care plan (3) mental status exam completed”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>“They are involved in 6 weeks of concentrated theory and clinical for mental health as 1st semester Juniors.”</td>
</tr>
</tbody>
</table>
Application of mental health concepts

Integrated curriculum.

Question five on the demographic page that all participants completed asked, "How are students helped to integrate mental health nursing knowledge into their practice?" The responses were coded into separate and integrated curriculum. Responses to this question from the integrated curriculum centered on the client as a holistic being. Examples included "This is an RN-BSN program. The patient is presented holistically—mental health being one component" and "Psychiatric course content is presented in the classroom. Psychosocial nursing is addressed in all clinical settings." Other responses included the use of classroom, clinical and case studies as well as focused discussions and integrated didactic components as methods to facilitate application of mental health concepts in an integrated curriculum.

Faculty concerns about mental health nursing education

The value of the data is in the insight and information provided. Many respondents listed multiple concerns. Eighteen of the 23 combined respondents (78%) answered the question related to concerns about teaching mental health nursing. Two respondents (11%) expressed stigma against the mentally ill as a concern that was congruent with rationale for a separate curriculum listed earlier. Seven respondents (38%) cited lack of good clinical sites as a concern, again relating to the trend of decreased length of stay that affects inpatient mental health census. The lack of inpatient psychiatric settings perhaps influences the broadening of clinical locations for mental health to correctional facilities, group homes and community settings, which were identified by both separate and integrated curriculums.

The values and perceptions of faculty and the institution (16%) were influencing factors on type of curriculum, as were a lack of experienced faculty, or conversely, the availability of
Mental health nursing mentors in mental health. The importance of mental health to all of nursing was shared by five respondents (27%) with the related factor of a need for more focus on mental health in the curriculum (three respondents or 16%).

Changes in mental health nursing education

The responses to question, “What changes would you like to see in the future of mental health nursing education” reflected prior issues facing mental health nursing education today. Seventeen of the 23 combined respondents completed this question (73.9%). Emphasis on mental illness as a disease process and the need to decrease stigma was reported by three respondents (17.6%). A desire for more clinical/didactic instruction time was also listed by three respondents (17%). More clinical locations in the community (six or 35%) were identified as in prior responses.

Two respondents recommended the need for increased communication and collegiality among mental health faculty as a way to share knowledge and discuss trends and influences on the specialty. One expressed concern for the lack of textbooks. Perhaps increased collegiality would facilitate sharing this information. There were again the opposing viewpoints of two respondents (11%) advocating a separate mental health curriculum and three (17%) proposing increased mental health integration in the curriculum in response to the above question.

Many respondents took the time to write at length, and this provided insight into the passion for the opposing viewpoints of an integrated versus separate mental health curriculum. Investment in maintaining these stances may contribute to divisiveness in the profession. The challenge for the future of mental health nursing may be to combine both of these philosophical viewpoints. Implications for the future of nursing and concerns about current and future trends for psychiatric nursing were expressed by numerous faculty with a depth and passion that led to
insights into the dilemma of mental health nursing education. I will discuss these concepts further in Chapter V.
Chapter V

Summary, Conclusions and Recommendations

Summary and Recommendations

Mental health nursing education questionnaires were sent to 30 accredited nursing schools in the state of Wisconsin. The response rate of 23 was 76%. Descriptive statistics were compiled using SPSS version 10.0 statistical program. The majority of the surveys were completed by nursing instructors (52.5%) and associate Deans (21.7%) with varied experience, ranging from 10 months to 26 years. The participants included both ADN (60%) and BSN (39%) nursing programs. The percentage by degree and curriculum was as follows: Integrated/ADN 17.5%, Separate/ADN 43.5%, Integrated/BSN 8.5% and Separate BSN 30.5%. Student population was between 28 and 230 in the ADN programs with a mean of 133 and 55 to 400 in the BSN with a mean of 229. It is uncertain if this reflected a misinterpretation of the question and total program versus mental health class population was reported.

Mental health clinical and theory hours were compared for each type of program and curriculum type. The mean theory hours for a BSN was 28.43 and clinical hours 86.36. The mean for theory hours in the ADN programs was 37.16 and clinical hours 72.4. A future study could perhaps focus on differentiating the specific content and focus that distinguish the two. It would also be interesting to survey nursing programs nationwide to determine if the trend toward an integrated mental health curriculum is progressing. The results for Wisconsin indicated the majority of mental health nursing programs remained separate (17) and not integrated (6).

Students were also exposed to mental health clients in a variety of settings in either type of curriculum, even though there was not a specific mental health practicum. The majority of both separate (64%) and integrated (100%) curriculum respondents agreed that students work
Mental health nursing 63

with a client with a psychiatric disorder who may have entered the health care system for another reason. Settings incorporated the spectrum of nursing care. This finding supports the need as Peplau (1989) proposed to include adequate training so nurses are competent to care for mental health clients in any clinical setting.

Rationale for adopting either a separate or integrated mental health curriculum elicited varying responses, but the importance of mental health education as an integral component of nursing care was apparent in each. A respondent addressed rationale for the separate curriculum as follows “...a good RN is always going to have mental health skills at his or her core,” which was similar to a response from an integrated curriculum faculty stating “mental health nursing skills are required across all settings.”

The difference between psychiatric and mental health nursing has been the subject of other works, and perhaps these similar answers reflect this. While much of nursing may require the use of psychosocial/mental health skills, much of nursing is not with clients with a psychiatric diagnosis. Another study differentiating these concepts may reflect this distinction in the curriculum.

The application of mental health concepts across both curriculums was addressed by the question “How are students helped to integrate mental health nursing knowledge into their practice?” The integrated curriculum had only 6 responses and reiterated the holistic focus inclusive of mental health needs, using clinical and classroom methods. The separate curriculum had 13 responses and provided specific data centering on four main themes including the holistic focus, providing foundational knowledge, incorporating mental health concepts and mental health class/clinical. Teaching methods for both included classroom lectures and case studies as well as clinical experience. The separate curriculum specified application of didactical
components in a discreet mental health clinical. This question provided a clearer distinction between the two types of mental health curriculum.

This study explored the depth, complexity and variety of nursing positions on mental health curriculum that were identified by Peplau (1989), Dumas (1994) and McGihon (1994) in Chapter One. Peplau (1989) identified the beginning of mental health curriculum integration in the 1950s to 1970s and raised the concern that while it was important to include psychiatric nursing concepts throughout the curriculum, critical components of the discipline of psychiatric nursing and exposure to psychiatric clients may have been lost. Dumas (1994) shared Peplau’s concern that psychiatric nursing was being eliminated in some curriculums and the risk this poses to clients and the profession. McGihon (1994) discussed the factors of decreased length of stay related to insurance managed care and other factors resulting in increased acuity and frequency of clients with psychiatric illnesses being treated in non-psychiatric health care settings.

The changes these authors identified related to decreased funding and insurance coverage, decreased length of stay, increased numbers of clients with mental health needs and the corresponding prevalence of treating these clients in a variety of health care settings were reflected by the survey respondents. The survey questions of “Please share any thoughts you may have about teaching mental health nursing today.” and “What changes, if any, would you like to see in the future of mental health nursing education?” elicited responses echoing the concerns of these psychiatric nursing experts.

Survey results indicated the importance of mental health nursing (27%), yet expressed concern over the lack of clinical locations (38%). Limited clinical facilities related to decreased
inpatient population as a result of current legislation may impede the knowledge that nurses need to care for these clients.

The literature has linked nursing practice to societal needs, influences and trends and this is as applicable today as ever. Mental health parity laws that strive to provide insurance amounts equal to medical coverage for mental health disorders, sit in limbo in the courts or provide only token coverage. The state of Wisconsin has defeated the Parity Bill for the last five years. The national parity legislation provides only nominal mental health coverage requirements, which businesses may seek exemption from for numerous reasons including size of the company. The wording on insurance policies gives lip service to compliance with federal parity legislation in that mental health lifetime coverage is one million dollars, the same as medical, but annual coverage benefits are not specified so that providers may still limit annual inpatient or outpatient coverage to “30 days or $7000, whichever comes first.” This allotted $7000 may provide less than a week of hospitalization (NAMI 2002).

This limit on insurance coverage, along with the deinstitutionalization of the 1970s, affects current psychiatric nursing education. Inpatient psychiatric units have high patient turnover rates that result in a decreased census that doesn’t support nursing students. The focus of mental health nursing is changed to crisis intervention, admission and discharge planning. Clients with acute mental illness are more frequently seen in other settings. Therefore another recommendation would be for nurses to advocate for their clients in the legislative system. Equal mental health benefits would decrease the acutely mentally ill found in numerous settings that may be unprepared to treat them by increasing the available hospital care they may receive prior to discharge into the community.
Increased length of stay related to mental health parity coverage resulting in an increased inpatient mental health population that would support nursing students would benefit the profession as well as the clients. The variety and experience of a mental health practicum would help nurses feel more comfortable with psychiatric clients and enhance their ability to care for them. Increased exposure to mental health clients could decrease negative bias. Nurses may also be client advocates by refusing to participate in increasing stigma towards the mentally ill. Most nurses would not condone ethnic jokes or stereotyping, but mental illness is still fair game. Jokes about crazy people and a media portrayal of the mentally ill as violent perpetuate this stigma.

Changes in mental health nursing education were consistent with the identified current issues and concerns about teaching mental health nursing. Seventeen respondents (73.9%) answered the question addressing mental health education issues as follows: emphasis on mental illness as a disease and decrease stigma; 17.6%, need for more clinical/didactic instruction; 17%, more clinical locations in the community; 35%. A recommendation for increased collegiality among mental health nursing instructors to discuss current issues affecting education was suggested by two respondents. Another proposal of this study would be to initiate a regional mental health instructor’s forum on a regular basis to network, discuss curricula, and share information to enhance mental health education and provide resources and support. The majority of respondents wanted survey results. Perhaps this proposal could be included with the survey results to ascertain interest and explore feasibility of some form of regular meetings.

Theoretical Framework

Peplau’s (1952) theory of interpersonal nursing was chosen as the framework for this study because of its relevance to current mental health nursing. The theory was the first to
incorporate the concept of holistic nursing and include mental health as an integral component of the whole being. This study supported the use of this framework. Principles of Peplau's theory were in evidence in both the separate and integrated curriculum as demonstrated by the incorporation of therapeutic communication techniques and psychosocial nursing concepts. The question "How are students helped to integrate mental health nursing knowledge into their practice" addressed this theoretical foundation. Table 5 summarized these concepts in the separate curriculum. A focus on the holistic being including mental health was a common theme in the integrated curriculum. Psychosocial and interpersonal concepts first introduced by Peplau are reflected in statements by respondents about the importance of communication skills, and that mental health nursing skills lay the foundation for all future practice. Peplau's concepts may not be identified as such, but the framework of these is visible in current mental health curriculum in the forms of nurse-patient relationship and therapeutic communication.

The phases of the nurse-patient relationship of orientation, identification, exploitation (or working phase) and resolution are part of the development of trust and rapport that facilitates healing and change. The brief length of stay or single contact in an outpatient setting may hasten the process of developing a therapeutic rapport, but it remains the foundation of the nurse-patient relationship. The reference to the importance of communication skills by respondents as basic nursing knowledge affirmed the current relevance of this theoretical framework.

The consensus about the importance of mental health nursing in the curriculum by participants reinforced the current application of the interpersonal theory proposed by Peplau. Peplau was the founder of mental health nursing and introduced the concepts as a specialty. Today, evidence of mental health nursing in the curriculum is required for NLN certification.
Psychiatric nursing was present in the curriculum of every respondent, whether in separate or integrated format.

Implications for nursing education

The literature supported the importance of a mental health course to decrease stigma and fear in caring for a population with mental illness. This decrease in fear began with classroom preparation and continued after a practicum. The implication for nursing education is to adequately prepare students in the classroom to facilitate a positive clinical experience. For example, if the students are caring for a client with bipolar disorder but that lecture isn’t scheduled until later in the semester, it is important to provide information on a need to know basis. Perhaps using pre- and post-conference time at the site to review diagnosis, medications, signs and symptoms and appropriate nursing interventions would be a way to address this. Students also need to be prepared with basic mental health nursing skills such as therapeutic communication, self-awareness, appropriate interventions for psychoses, and the biochemical etiology of psychiatric disorders prior to entering the clinical site. The analogy is the preparation in asepsis, physical assessment and medication administration that students receive prior to a med-surg clinical. Normalizing fears by sharing research such as that found in this study may facilitate discussion and alleviate potential misconceptions and stigma.

Other mediating factors to promote a positive mental health clinical experience was students’ feeling accepted by staff, and a positive attitude by staff towards patients. Burnout can occur in psychiatric as well as any other type of nursing and lead to judgmental comments and negativity. When students witness this, it can impact the student’s perception of the clinical site and have a deterrent effect on career choice. Close communication and nongraded 1:1 instructor
time for feedback and support were also perceived as helpful. Enacting research-based practice mandates that it is essential, not optional, for this contact to occur on a regular basis.

Psychiatric nurses face the same nursing shortage and increased inpatient acuity as other settings. The busy inpatient nurse may not have time to mentor students and role model psychiatric nursing skills. The high patient turnover lends itself to crisis intervention, admissions and discharge planning. It may be difficult for students to fully appreciate the complexity of the psychiatric nursing role. Therefore, it is also up to the instructor to role model therapeutic communication and other psychotherapeutic interventions.

Conclusion

Mental health nursing education may reflect the divisiveness of the profession on other issues such as entry level for practice. The role of the ADN and BSN nurse has been a longstanding debate. Similarly, each state board of Nursing has differing competencies and specifies the realm of nursing practice. Nurses may perform an incision under physician supervision in one state but not another. The abstract yet complex domains of nursing lead to confusion and lack of consensus among the profession.

Despite the diversity of opinion around how mental health nursing should be taught and in what format, the consensus of this study indicates that mental health nursing is deemed important and of value. No participant recommended less time on the subject but rather concern over how to best teach a complex and abstract topic. The challenge for nursing is to develop competencies for practice that can be incorporated across the spectrum of nursing education, including ADN, BSN, integrated or separate mental health curriculum. While all Wisconsin professional nurses must pass the same State Board exam, this may reflect theoretical psychiatric knowledge and test taking skills rather than skill and comfort level. Knowing the signs and
symptoms of schizophrenia is of little use to the actively hallucinating post-surgical client in pain whose nurse is afraid to approach a psychotic client. Standardization of didactic and clinical components of mental health nursing education may help insure that all nurses have an adequate knowledge base and experience to care for a mental health client. Research on outcomes in a separate versus integrated mental health curriculum, such as NCLEX scores in the areas of psychiatric and psychosocial nursing, could lend further insights.

While this study cannot be generalized outside of the state of Wisconsin, it provided valuable information about mental health nursing education that can be the basis for further research. Exploring the variables of method and content that were shared in the open-ended questions could be used to develop a tool further exploring any difference between an integrated or separate curriculum. Studying the trend towards an integrated curriculum nationwide could provide a basis for comparison to Wisconsin. Perhaps the majority of schools, as in Wisconsin, are continuing with a separate curriculum for numerous reasons. If so, is the trend reversing or never got fully underway? Identifying influencing factors on mental health nursing education could also be the basis for future research. Clarification about the concepts of mental health as a component of holistic nursing and the study of psychiatric disorders and the interrelatedness of the two would lend insight to the existing dilemma. Tradition was cited as a contributing factor to curriculum design. It would also be interesting to explore this further. This study reaffirmed that while confusion over how to teach and define this specialty continues, consensus coexists about the significance of mental health nursing to the profession.
References


*Archives of Psychiatric Nursing, X, (1), 3-10.*


*Journal of Psychosocial Nursing, 27, (2), 18-28.*


Appendix A

Dear School of Nursing Dean or Designee, April 25, 2002

My name is Judy Elliott. I am a graduate student in Nursing Education at Cardinal Stritch University in Milwaukee, Wisconsin. I am researching mental health nursing curriculum for my Master’s Thesis. The purpose of my study is to explore current mental health nursing education. You were selected as a participant because I am contacting all of the NLN and CCNE accredited nursing schools in Wisconsin. The total number of participants is small, so your cooperation will be greatly appreciated. Please complete and return the survey that best applies to your mental health curriculum within two weeks of receiving it. A stamped, addressed envelope is provided. A follow up postcard will be mailed if there is no response in a two-week period.

Consent to participate is implied by completion and return of the enclosed survey. You may withdraw at any time from this study without penalty. All information will be confidential and only the researcher will have access to it. Both you and your organization will remain anonymous and all data will be reported in the aggregate. The data will be kept locked for a three-year period at the researcher’s home. Cardinal Stritch University Institutional Review Board has approved this study. My Thesis Committee and Research Advisory Chair Dr. Ruth Waite also granted approval for this study. Dr. Waite may be reached at 414-410-4388.

The survey will take about 15 minutes to complete. Thank you for your cooperation. I can be contacted at 414-355-9674 or via e-mail at judyannelliott@msn.com. If you have any questions or concerns please feel free to contact me. I will be happy to mail you the results of the survey if you wish. Please circle the response on the bottom of the survey that indicates this and I will send you survey results upon completion of this study.

Sincerely,

Judy Elliott
3710 W. Pelican Lane
Brown Deer, Wisconsin 53209
Appendix B

All participants complete this questionnaire.

Circle the appropriate YES/NO response and fill in the blanks.

1. Please answer the following questions about yourself.

   What is your position?
   
   How long have you been in this position?

2. Does this program lead to a B.S.N. degree?
   YES NO

   How many students are enrolled?

3. Does this program lead to an A.D.N. degree?
   YES NO

   How many students are enrolled?

4. Does this program lead to a Diploma degree?
   YES NO

   How many students are enrolled?

5. How are students helped to integrate mental health nursing knowledge into their practice?

6. Please share any other thoughts or concerns you may have about teaching mental health nursing today.

7. What changes, if any, would you like to see in the future of mental health nursing education?
I would like a copy of survey results. YES NO

Name _____________________________________________

Address ___________________________________________

May I contact you by phone for further information or clarification? YES NO

Phone number _______________________________________

Thank you for your time. Please return surveys in the enclosed, stamped envelope.
Appendix C

Separate Mental Health Curriculum Questionnaire

Please circle the appropriate YES/NO response and fill in the blanks

1. How many mental health theory hours are included in your program? ____________

2. Is there a mental health practicum? YES NO

3. If yes, what kind of clinical locations sites are available for your mental health practicum? Circle all that apply.
   - Community
   - Acute inpatient psychiatric unit
   - Long-term care facility
   - Group Home
   - Other ________________________________

4. Do students have the opportunity to work with a client with a diagnosed psychiatric disorder whose primary reason for entering the healthcare system was not for psychiatric treatment? YES NO
   (i.e. a medical or surgical patient with schizophrenia or major depression.)
   At what type of clinical sites?
   ______________________________________________________________
   For how many hours? ___________________________________________

5. How many mental health clinical hours are included in your program? ______________

6. What is your program’s rationale for providing a separate mental health curriculum?
Appendix D

Integrated Curriculum Questionnaire

Please circle the appropriate YES/NO response and fill in the blanks.

1. What year did your program begin integrating mental health nursing? ________________

2. Why did your program choose to integrate mental health nursing?

________________________________________

3. How many mental health theory hours are included in your program? ________________

4. Do students' have the opportunity to work with clients whose primary reason for entering the healthcare system is related to a mental health diagnosis?

   YES  NO

   If yes, at what type of clinical sites?

   ______________________________________

   For how many hours? ________________________

5. Do students have the opportunity to work with a client with a diagnosed psychiatric disorder whose primary reason for entering the healthcare system was not for psychiatric treatment (i.e. a medical or surgical patient with schizophrenia or major depression?)

   YES  NO

   If yes, at what type of clinical sites?

   ______________________________________

   For how many hours? ________________________
6. May students choose a mental health practicum as part of another course such as Leadership or Community Health? 

YES  NO

Which course(s)? ________________________________
Appendix E

Survey Instructions

Thank you for taking the time to help me with my research. Please note that there are two surveys to be completed. All participants complete the survey with demographic data as directed (white).

If your nursing program has an integrated mental health curriculum, also complete and enclose the cream colored survey.

If your program has a separate mental health curriculum, also complete and return the blue survey.

For the purposes of this study, operational definitions are as follows:

Integrated curriculum refers to aspects of mental health nursing being incorporated throughout nursing school, including clinical practicum, without a separate mental health or psychiatric nursing course in the program.

Separate mental health curriculum refers to a course, including a practicum, focusing on psychiatric diagnoses, treatment and mental health nursing.

Enclose both surveys in the stamped, addressed envelope.