

UNDERGRADUATE NURSING STUDENTS' ATTITUDES
TOWARD MENTAL ILLNESS AND
MENTAL HEALTH NURSING

by

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ABSTRACT

Historically, nurses have lacked recognition for the work they do, especially in the area of mental health. There is a shortage of qualified mental health nurses to meet the demand for services. Many rural areas in the United States have few or no mental health services to offer communities. Encouraging positive attitudes toward mental health nursing is an important step in the recruitment of new nurses into the specialty. This study used Colaizzi's method of phenomenology to explore the beliefs held by undergraduate BSN students towards mental health nursing and how undergraduate nursing education affected those attitudes. The purpose of the research was to understand undergraduate nursing students' attitudes toward mental health, to understand the impact that content and clinical experiences and experiences with non-mental health faculty have on attitudes toward mental health nursing, and to understand how undergraduate nursing education can contribute to the de-stigmatization of mental health nursing. Guided by Goffman's (1963) stigma theory, 20 participants were interviewed. Data analysis revealed three major themes: a) student nurses had varied attitudes toward mental health nursing, b) students had varied understanding of mental illness and mental health nursing at the end of the course rotation and c) clinical experiences and teaching strategies produced attitudinal changes in undergraduate nursing students. The two subthemes extracted from the first theme were students attitudes ranged from favorable to unfavorable and attitudes were based on experience and exposure to mental illness and mental health nursing. Subthemes from the second theme included students did not comprehend content as presented and they compartmentalized illnesses as

medical or mental. Subthemes from the third theme included students had concerns over loss of technical skills and they did not comprehend the role of the mental health nurse even after clinical experiences.

DEDICATION

This dissertation is dedicated to all those who have helped me and given me the encouragement and wisdom to do this research and write and rewrite until the work is completed. My family and friends have been an unending source of love and support throughout the years that it has taken me to get to this place. To Anne Springfield, who before God called her into his loving arms tirelessly prayed for me and encouraged me in this work, I am forever grateful. I would also like to say thank you to my God, who has called me to this work and has done a work in me enabling me to complete it.

This dissertation is especially dedicated to the forgotten people who suffer alone from mental illness.

“The purpose of life is to contribute in some way to making things better.”

Robert F. Kennedy

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ATTESTATION

I have been both a medical surgical nurse and a mental health nurse for most of my clinical career. As I moved into the role of nurse educator, I continue to teach both mental health and medical surgical nursing. During my initial nursing education at a diploma program, I developed an interest in mental health nursing after my clinical experiences and was not at that time discouraged by anyone from specializing in mental health, except for the typical response of “Do a year of med-surg first.” I entered into my first nursing position as a medical surgical nurse, fearing that if I went directly into mental health, all of my nursing skills would be lost. While I was working in that medical surgical position, the facility where I was employed opened up a brand-new mental health unit. I had “done my year,” so I applied and was hired to work in this new area. All the while, I worked on other floors of the hospital as a per diem nurse.

As I began my new and exciting position, it became increasingly clear to me that mental health nursing was not highly valued as a specialty. No one was happy that the unit had opened. The physicians who were supposed to complete the admission history and physical exams were less than willing to come to the unit when called. I often had to get a supervisor to insist that the physicians come down to the mental health unit. One of the physicians actually asked me if I wanted to be a “real nurse,” and if I did, why I was working in a mental health unit.

After working as a mental health nurse for several years, I decided that I would like to try maternal child nursing, and when a position opened up in the labor and delivery unit, I applied and was offered the position. I accepted and worked there for a very short time before I was told that

they hired me because they were told to, but they really did not need a psych nurse in the unit. My “preceptor” left me to figure things out on my own, and when I asked questions, she said that if I hadn’t been in mental health I would know the answers. My questions related directly to the labor and delivery process, so I am not sure why she felt I would have known more had I not been in mental health. Additionally, I had been working on other floors of the hospital at times but had never been an obstetrical nurse. One of the patients came in with a very serious situation. Her baby had died in utero, and she was going to have a delivery by induction of labor. I spent time with the patient and cried with her as she mourned the loss of her precious child. I was told by the nurse manager to go back to psych because crying with a patient was inappropriate and I was a typical “sensitive” psych nurse.

At another facility where I worked, I took care of a mental health patient who was pregnant and had been hospitalized for several days with schizophrenia. This patient was in denial of her pregnancy, but this baby was not going to be denied. She went into labor while I was working the evening shift. Although her amniotic membrane had not ruptured, she clearly was having contractions at regular intervals. When I called the obstetrical resident, he refused to see her, saying that she probably was not in labor and how would I know the signs, being a psych nurse. Her membrane did finally rupture and I called again. The resident asked me if I was sure she hadn’t just urinated on herself. After all, she was crazy. (This was a patient who had never been incontinent and who was well-known to our unit.) During my shift, she began to scream that she needed to have a bowel movement, and I didn’t bother to call. I put her in a wheelchair and ran to the labor and delivery unit. She was crowning by the time I got her there, but she had her baby in the labor and delivery unit, not the mental health unit. My judgment as a nurse had not been respected because I was a mental health nurse. My patient was not treated with dignity because

she was mentally ill.

Not treating the mentally ill with dignity is not uncommon in the medical professions. One of my colleagues recently related a story about the first time as a nursing supervisor that she had to cover and round on the mental health unit of a large community hospital. She was told, “When you go down there (to the mental health unit) to do your rounds, keep walking straight and don’t look any of them in the eye. That way they won’t attack you. It’s also better to do your rounds at feeding time so they won’t notice that you are there.” I could not help but wonder if she was describing a patient unit or the gorilla cage in a zoo.

Recently I was sent as a nurse educator to “straighten out” the nurses on a senior behavioral health unit, where there had been several incidences of falls and medical issues that were poorly handled. This, of course, was blamed on the nurses’ lack of medical surgical experience and knowledge, as well as the fact that they did not know how to communicate with physicians. I went with a colleague to do a learning needs assessment, only to find that a root cause analysis was never done for any of the incidents and the nurses were just blamed for the problems. We were told that they were psych nurses and lack the skills to work with the patient population. Indeed, the population is extremely fragile, but in order to correctly care for medically fragile patients, nurses need equipment, and to be respected in a collegial manner by the rest of the healthcare team. In actuality, the following list is descriptive of our findings: the nurses, we felt that they were more than willing to be educated in areas they recognized as problems. As we followed the nurses, we found them willing to learn and able to identify areas of need for further help. We did sense, however, that there were several areas of frustration with the way the unit runs. Some of the problems we observed were as follows:

- Nurses did actually communicate with the doctors, but the doctors often would say no to a

request for labs to check the nutritional status of a patient or to other patient needs assessed by nursing.

- Nurses were often pulled away to answer call bells when they were in the medication room and when they were working on documentation.
- Nurses are responsible for walking the patients, but on other units, physical therapy carries the responsibility. Physical therapy avoids this unit.
- Nurses work without a place to put water and medications down when giving medications to a patient. This is related to the design of the floor. Medications are given out in a common eating area.
- Nurses were not provided with adequate equipment and the equipment provided was not readily available for the nurses and not in plain sight, again related to the design of the floor. In one case, there was an emergency where a patient had a seizure, bit his tongue, and aspirated the blood, but the suction equipment brought up to the unit by the code team was outdated and did not function properly.
- The patients began their day in the day room, so a private and thorough physical assessment was not possible, although management demands that this be done.
- My colleague and I questioned the orientation process and found that there were no designated preceptors, checklists, or meetings with management.
- Several nurses admitted to not taking breaks during their shifts because of staffing issues and patient behaviors. They stated that they clocked out anyway so that they did not get in trouble. On day 1, one nurse who rounded with one of the nurse educators was questioned on why she was still on the unit after her shift was done. It was stated prior to this incident that we would follow the nurses on rounds and that we were to offer insight. There would

not a problem if a nurse stayed late to address issues with us.

Finally, as a nurse educator, I have heard my own colleagues discourage students from entering the mental health specialty with statements such as “You can’t talk to crazy” and “Get them out of my ER.” One of the students was told, “You are too good of a nurse to be a psych nurse.” When I heard this, it triggered a memory of a very well-meaning friend and colleague saying the same thing to me. I could continue, but I think my point is made. I pray that my study and this dissertation, when published, will help students and educators rethink the preconceived ideas of mental health, and that more nurses will be drawn to mental health, where the need is so great but nurses are so few. In addition, I hope that all nurses will remember to be holistic in their treatment approach since the mind and body should never be separated in the treatment of disease—either physical or emotional.

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CHAPTER 1 – INTRODUCTION

Introduction

Pretend that you are a patient in an emergency room, with an open wound that is bleeding profusely and the nurse caring for you says, “You can stop bleeding if only you would try!” This scenario truly borders on the ridiculous, but mental health patients are often treated in like fashion, as if they are able to control their illness by willing themselves to be well. Now further imagine that you are a nursing student who wants to care for the mentally ill, and your nursing professor says, “I thought you wanted to be a nurse!” It may sound far-fetched, but in fact this is exactly what happens to some students who express a desire to specialize in mental health nursing.

Historically, nurses have lacked recognition for the work they do, and this lack of recognition has been noted widely in the field of mental health (Holmes, 2006). While there continues to be a shortage of qualified nurses in all areas of nursing, the aging workforce in the area of mental health is a significant concern. The average age of the psychiatric mental health nurse is over 50 (Brown, Cashin, Graham, & Shaw, 2013). There also exists a greater shortage in certain geographic areas. Florida, Alabama, Texas, Georgia, and Nevada have the lowest ratio of mental health nurses per capita (Hanrahan, 2008). Many mental health providers practice in more affluent areas of the country, where there may be better mental health insurance coverage than in less affluent areas (Bird, Dempsey, & Hartley, 2011).

There are some rural areas in the United States where there are no mental health services available (Hanrahan, 2008). Not only is there a shortage of mental health nurses, there appears to

be an increased demand for mental health services (Author, 2008). The inseparability of mental and physical health is undeniable, and the loss of mental health providers could lead to a costly increase in physically ill patients financially burdening the healthcare system. The World Health Organization Fact sheet updated in April 2016 expresses the following salient points:

1. *Mental health is more than the absence of mental disorders.*
2. *Mental health is an integral part of health; indeed, there is no health without mental health.*
3. *Mental health is determined by a range of socioeconomic, biological and environmental factors* (World Health Organization, 2016).

Problem Statement

Often, since mental health patients are stigmatized, there is an associative stigma for those who are willing to work closely with them (Gouthro, 2009). Encouraging positive attitudes and destigmatizing the mental health specialization form an important step in the recruitment of young nurses into mental health nursing. Additionally, it is of extreme importance to understand the reasons for these negative attitudes and take action to change them. It is of utmost importance as well that nurses and educators become more reflective in their own practices. Given that mental health nursing is not held in great esteem by many healthcare professionals (Holmes, 2006), job status may not greatly encourage the choice of mental health nursing by newly graduating nurses. There is a potential for non-mental health nurse educators and mental health nurse educators to encourage mental health nursing as a specialty choice by modeling more positive attitudes toward mental health nursing to their students (Gerrity, 2012). There is also a need for mental health nurses to enter the specialty since the need for qualified nurses in mental health is not being met by the supply of nurses entering mental health as a specialty (Brown et al., 2013). In light of this urgent need, nurse educators need to be reflexive regarding their own values and must consider reviewing

content, theory, and clinical experiences in nursing education.

Attitudes

In psychological literature, attitude is defined as “a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor” (Eagly & Shelly, 2007, p. 598). This definition includes an evaluation of something and the response being either positive or negative based on past experience with that entity. The evaluations made by the individual may be conscious, but they may also be unconscious, based on exposure to the entity. An individual may also make an evaluation affectively (based on feelings and emotions). If undergraduate nurses are exposed to positive attitudes in their clinical experience and encouraged to understand that mental health nurses make a difference and in fact do practice “real” nursing, they may learn that mental health nurses make a very positive impact on the lives of the patients they treat (Gerrity, 2012). In addition, and most importantly, they may decide to pursue job placement in the area of mental health nursing, where the shortage increases (Happell, 2008a).

The concept that experience and exposure to good role modeling formulates good attitudes seems somewhat intuitive, but there is often a disconnect between what is taught in the classroom and exposure to mental health nursing in clinical placements, as well as the attitudes of non-mental health nursing faculty (Halter, 2008). In placements and in the classroom, students observe and interact with both positive and negative role models (Rungapiadachy, Madill, & Gough, 2004). Nursing students may see nurses who are truly patient advocates, as well as nurses who remain behind closed doors in a charting area, not engaging with patients in the unit. Seeing those poor role models may contribute to the belief that mental health nursing is for those who do not want to be “real” nurses but prefer to sit behind the desk and do paperwork and nothing else (Rungapiadachy, Madill, & Gough, 2004). Clinical educators may be better role models than the

nurses on the unit by engaging with patients and students during the clinical day.

Nurse educators are expected to teach their students about non-judgmental care. The core competencies of nurse educators also include the integration of respect, professionalism, and caring that helps students develop into competent and caring professionals (National League of Nurses, (NLN), 2005). The Essentials of Baccalaureate Education for Professional Nursing Practice (2008) also address the issue of non-judgmentalism and social justice in essential 8. The key concepts listed in essential 8 are as follows: altruism, autonomy, human dignity, and social justice. Social justice is “acting in accordance with fair treatment regardless of economic status, race, ethnicity, age, citizenship, disability, or sexual orientation” (EBEPNP, 2008, p. 28).

In addition, while nurse educators should be helping students achieve affective outcomes in nursing, there appears to be incongruence between what nurse educators should do and what they are actually doing (Happell, 2008a). Students are not encouraged to (even if they express a desire) become mental health nurses (Thongpriwan et al., 2015). If the curriculum is changing, one of the first areas of content to be decreased is mental health (Ross & Goldner, 2009). In a phenomenological study of non-mental health nurse educators’ attitudes toward mental health, Gerrity (2012) indicated that non-mental health nurse educators tend to refrain from assigning clients with mental health issues to their students in the clinical area because they feel a lack of confidence in their ability to treat the mental health patient holistically.

Along with a lack of confidence, Harms (2010) found that non-mental health nurse educators had perceptions of working with the mentally ill that could be categorized into four themes. Those themes identified were related to images associated with mental illness, perceptions of mental illness, influential factors, and impact of perceptions on students, patients, and other nurse educators. Some of the images that emerged from the study were behavioral in nature,

including suicidality, self-injurious behaviors like cutting, psychosis, other challenging behaviors, and agitation. The perceptions of non-mental health nurse educators were often emotional in nature, ranging from comfortable (compassionate and empathetic) to uncomfortable (fear, frustration, anger, sadness, and anxiety). Some of the nurse educators indicated that a lack of experience in working with the mentally ill caused them to fear what might happen to a student if left alone in the room with a patient who had a comorbid mental health diagnosis.

The purpose of this research was to a) explore undergraduate nursing students' attitudes toward mental health, b) understand the impact that content and clinical experiences and experiences with non-mental health faculty have on attitudes toward mental health nursing, and c) understand how undergraduate nursing education can contribute to the de-stigmatization of mental health nursing.

This research was guided by the following questions under the framework of stigma theory as outlined by Erwin Goffman (1963), who posited that understanding stigma is not possible without understanding social interactions. Understanding social interactions incorporates a broader understanding of the effects of stigma on the lives of persons with mental.

1. What attitudes do undergraduate students have toward mental health nursing?
2. Has content taught in the mental health course impacted student attitudes toward mental health nursing in a negative or positive way?
3. Do clinical experiences and teaching strategies negatively or positively impact attitudes toward mental health nursing?

Theoretical Framework and Research Related to Stigma

Stigma as a concept implies that a person is set apart or marked, based on some visible or invisible negative attribute (Goffman, 1963). Stigma has also been defined as an attribute that

discredits the stigmatized person. Those who are stigmatized by society are generally limited in their prospects, and their ability to reach their potential becomes greatly reduced (Bates & Stickly, 2013). Goffman (1963), in his seminal work on stigma, posited that people depend on stereotypes to guide their interactions and place individuals in certain categories. According to Goffman, stigmatization comes about when certain groups or individuals are viewed as having a specific negative attribute that is exaggerated, resulting in global marginalization and devaluation. Stereotypes are socially constructed and are closely related to our own experience and interactions within social settings. Social construction of reality refers to the theory that the way we present ourselves to other people is shaped partly by our interactions with others, as well as by our life experiences. How we were raised and what we were raised to believe affect how we present ourselves, how we perceive others, and how others perceive us. In short, our perceptions of reality are influenced by our beliefs and backgrounds. Our reality is also a complicated negotiation. What is real depends on what is socially acceptable (Goffman, 1963). If we are engaging with a stranger in a social interaction and evidence arises that that person has an attribute that deviates from the socially acceptable attributes of cultural norms, that attribute is the basis of stigma. Stigmas, therefore, are based on past experiences related to our perceptions of reality (Kasima, 2014).

The behavioral outcome of stigma is prejudice, and prejudice leads to negative stereotyping. Stereotyping is making categorical statements about groups of people. Stigma can cause suffering that is needless, excluding people who are stigmatized from participating in daily activities or seeking medical treatment for other issues. The delay in treatment is not limited to treatment for mental illness (Sickel, Secat & Nabors, 2014). Those who are mentally ill often delay treatment for chronic health conditions like diabetes and heart disease, leading to a greater burden of cost on taxpayers to care for them. In addition to the taxpayer burden, individuals with a mental

illness have disproportionately higher mortality rates than those who do not suffer from a mental illness (Sickel et al., 2014). For example, people who have been diagnosed with schizophrenia or another debilitating mental illness die on the average of 25 years earlier than those who do not have a mental illness. Comorbidity with chronic illness, such as asthma, heart disease, cancer, or diabetes, is the cause of death in three out of five mentally ill persons (Sickel et al., 2014). These conditions are exacerbated by limited access to healthcare, whether the barriers are attitudinal or structural.

There are multiple barriers to seeking treatment, and access to treatment has not kept up with the demand or increasing incidence of mental illness. The demand for mental health substance abuse treatment has risen approximately 20% in the past 4 years; however, many states continue to cut funding in the area of mental health (Sickel et al., 2014). Ethnic minorities are also less likely to seek treatment than their European-American counterparts (Sickel et al., 2014). Research has also indicated that there are significant barriers related to the severity of mental illness, such as logistics, language, racism, and attitude of the providers (Sickel et al., 2014). Another powerful factor that creates barriers to treatment is the high prevalence of mental health stigma (Sickel et al., 2014).

The Substance Abuse and Mental Health Services Administration (SAMHSA) and the CDC have examined public attitudes toward mental illness in two surveys. In the 2006 Health Styles survey, only one-quarter of young adults between the ages of 18 and 24 believed that a person with mental illness can eventually recover. In 2009, adults in 37 states and territories were surveyed about their attitudes toward mental illness, using the 2007 Behavioral Risk Factor Surveillance System Mental Illness and Stigma Assessment. This study found that:

- 78% of adults with mental health symptoms and 89% of adults without such symptoms

agreed that treatment can help persons with mental illness lead normal lives.

- 57% of adults without mental health symptoms believed that people are caring and sympathetic to persons with mental illness.
- Only 25% of adults with mental health symptoms believed that people are caring and sympathetic to persons with mental illness.

These findings highlight both the need to educate the public about how to support persons with mental illness and the need to reduce barriers for those seeking or receiving treatment for mental illness. The Essentials of Baccalaureate Nursing Education (2008) indicate that it is the responsibility of the baccalaureate-prepared nurse to “promote achievement of safe and quality outcomes of care for diverse populations” (p. 14). It can therefore be reasoned that it is the responsibility of the baccalaureate-prepared nurse to educate the public regarding mental illness. Negative attitudes about mental illness often underlie stigma, which can cause affected persons to deny symptoms; delay treatment; be excluded from employment, housing, or relationships; and interfere with recovery. The findings also indicate that there is a need to recruit caring and competent nurses into the mental health specialty, since nurses are often the ones who educate the public, along with offering treatment.

To further understand the stigma that has been attached to mental illness, some researchers distinguish between three types of stigma: public stigma, self-stigma, and courtesy or associative stigma (Larson & Lane, 2009). Public stigma refers to stigma that occurs because the culture accepts or endorses stereotypes and therefore discriminates against a particular group. Self-stigma references the loss of self-esteem that may occur as a result of being part of a stigmatized group. Finally, associative or courtesy stigma is attached to those who are in some way involved with a stigmatized group (Larson & Lane, 2009). Courtesy or associative stigma leads to blame, shame,

and contamination. Culture may hold to the belief that family members of mentally ill people are not competent, and in nursing culture, there is a widespread undercurrent of thinking that mental health nurses are not really competent nurses at all (Happell, 2008).

Stigma is not a new concept. In his seminal work in 1963, Goffman delineated three types of social stigma:

1. Overt, clearly visible deformities, such as scars, or the physical manifestations of leprosy, anorexia nervosa, or other visible disabilities.
2. Aberrations in personal traits such as mental illness, drug addiction, alcoholism, or criminal background are often labeled character flaws.
3. Tribal stigmas, which are traits that may be real or imagined, that do not follow the norm of society or of the prevailing culture.

Bates and Stickley (2013) used Goffman's theoretical framework to explore how mental health nurses can reduce the stigmatization of those who seek mental health services. They indicate that, although many professionals state that it is a priority to address the stigma, many unfortunately often unknowingly reinforce it. Related to this reinforcement is the fact that mental health providers and mental health laws are operative against the backdrop of public safety and public concerns. In a public survey done in 2010 by the Office of National Statistics (UK), a) 39% of those who responded felt that those with mental illnesses are dangerous, b) 67% believed that "asylums" are appropriate facilities for the treatment of the mentally ill, and c) 19% believed that those with mental illnesses are different from those with other types of illness and that mentally ill people had weak personalities that contributed to their illness. These attitudes contribute to the fact that those with mental illness are at best isolated by society and at worst actively feared by many in the culture. Unfortunately, healthcare personnel may be major contributors to these stigmatizing

attitudes (Ross & Goldner, 2009).

Studies have shown that people with severe mental illness (SMI) are indeed stigmatized. They have difficulty finding gainful employment or finding suitable places to live (Whitely & Campbell, 2014). There are monetary costs associated with the stigma as well. Individual families with children having some type of mental illness lose approximately \$300,000 of their lifetime income, which is already significantly lower than those with non-mental health diagnoses (Sickel et al., 2014). There is also an enormous societal economic burden. Comparative cost of illness studies show that the cost of mental illness is high in relation to those diagnosed with a physical illness, yet only 6.2% of U.S. healthcare spending is devoted to the treatment of mental disorders. Poor treatment of mental illness may lead to exacerbation of chronic physical illnesses that are also left untreated (Sickel et al., 2014). It is more likely that a person with a physical disorder only will seek treatment than one who has a mental illness only, even with a comparable level of impairment (Whitely & Campbell, 2014). Nash (2014) performed a descriptive qualitative study describing mental health service users' experiences of diabetes care. Semi-structured telephone interviews were used in the collection of data from the seven people who participated in the study. Stigma was a common participant experience. One of the study participants stated, "Part of my thinking at that time was well you've kind of overlooked this because you know I have mental health problems, you've just sort of thought well he's kind of making this up and because I wasn't clear about what I was feeling" (Nash, 2014, p. 719). Along with stigma, Nash (2014) indicated that six of the seven participants mentioned having complications, which may be related to poor treatment-seeking behaviors exacerbated by stigma.

Those who carry stigmas may also be the victims of undue scrutiny by the public, as well as state and government authorities (Foucault, 1995). This scrutiny may lead to the bearer of the

stigma internalizing feelings of shame and a lack of self-efficacy. Due to these feelings, many with a mental health diagnosis (such as schizophrenia) attempt to hide their SMI from friends and colleagues (Link, Phelan, & Bresnahan, 1999). The stereotype exists that those who are mentally ill are responsible for mass shootings and other heinous crimes; thus, the scrutiny exists. Despite this scrutiny, in crimes committed by persons with mental disorders, only 7.5% were directly related to the symptoms of their illness. According to research reported by the American Psychological Association, the vast majority of those who are mentally ill are not violent, not criminal, and not dangerous (Peterson, Skeam, Kenealy, Bray, and Zvonkovic, 2014). While the media tends to sensationalize crimes committed by those with a mental health diagnoses, Peterson et al. (2014) indicated that in interviews with 114 patients diagnosed with bipolar affective disorder, 29 had a criminal history. The major factors relating to criminal behavior that differentiated the 29 with a criminal history were impulsivity and impaired inhibition. Both impulsivity and impaired inhibition have been found to be related to criminal behavior in those without a mental illness (Peterson et al., 2014).

In addition to the stigmatization of the patient, there has been some research that psychiatric nurses suffer from associative stigma within the profession of nursing (Happell, 2008). Some of this stigma may be attributed to the prizing of technical skills over relational practice (Corrigan & Wassel, 2008; Halter, 2008). The lower status and devaluation of mental health nurses may be due to the segregation of patients from other patients in hospital settings (Corrigan & Wassell, 2008). According to Ross and Goldner (2009), those who are associated with the mentally ill are often judged by the same stigmatizing stereotypes as their patients.

There is some existing literature concerning mental health nursing identities and how stigma impacts nursing care of the mentally ill (Gouthro, 2009). Negative stereotypical perceptions

of mental health are seen commonly not only within the general public, but among different healthcare personnel, including nursing and physicians (Natan, Drori & Hochman, 2015). Gaebel, Zasko, Cleveland, Samjeske, Stuart, and Sartorius' (2014) findings indicate medical students are not inclined to select a career in psychiatry. Medical students describe the field of mental health as "lacking scientific foundations, depressing and ineffective, and requiring the capacity to work with dangerous and crazy people" (Natan, Drori, & Hochman, 2015, p. 388). Similarly, nursing students rank mental health nursing as the "least worthy" profession (Natan, Drori, & Hochman, 2015, p. 389). Other studies also indicate mental health nursing is considered inferior nursing or not even real nursing (Halter, 2008; Happell, 2008; Ross & Goldner, 2009). Stereotypes of mental health nursing may also deter nursing students from working in this field (Gough & Happell, 2009).

Negative characteristics are frequently attributed to those nurses who choose to specialize in mental health. In comparison to nurses who work in other specialties, mental health nurses are the least likely to be described as "skilled, logical, dynamic and respected" (Halter, 2008, p. 24). Additionally, Halter (2008) posited that it is essential to recognize the existence of negative perceptions, and perhaps stigmatization, of mental health nursing by nurse educators, nursing students, other healthcare professionals, and the public. Stigmatizing attitudes toward mental illness and mental health nursing may deter students from entering the field of mental health because of the associative stigma that is evident, and may also result in poor care and further stigmatization of those who are mentally ill (Ross & Goldner, 2009). Nurse educators may hold stigmatizing beliefs regarding mental health nursing, and may in fact view the decision to enter mental health nursing as a character flaw in the student (Halter, 2008). As a professor of nursing at Halter's study site indicated, whether wittingly or unwittingly, many nurse educators make

statements that are biased toward patients with mental illness. These biases, as well as negative statements and behaviors toward patients with mental illness, are a problem because they can often affect the behaviors and attitudes of nursing students (Harms, 2010).

In his *Notes on the Management of Spoiled Identity*, Goffman (1963) explores the world of persons whom society does not consider “normal.” According to Goffman, stigmatized people are those that do not have full social acceptance and are constantly striving to adjust their social identities: physically deformed people, mental patients, drug addicts, prostitutes, and others who are stigmatized by those who would decide cultural norms. Goffman relies extensively on autobiographies and case studies to analyze stigmatized persons’ feelings about themselves and their relationships to “normal” people. He studies the variety of strategies that stigmatized individuals use to deal with the rejection of others and the complex images of themselves that they project to others.

The stigma that has been attached to mental health clients is well-documented in the literature (Gouthro, 2009). Mental health patients may be stereotyped and experience prejudice and discrimination. Gouthro (2009) posited that the negative perceptions of mental health professionals may also increase the marginalization of mental health patients. In addition, mental healthcare has been assigned a low status among nursing professionals. Peplau (1982) also noted the belief that those who take care of the mentally ill possess some kind of character flaw or mental illness themselves. Nursing students have been shown to hold similar misconceptions (Kosikinen, Mikkonen, & Jokinen, 2011). Media portrayals of mental health nursing have contributed to the stigma, with characters such as Nurse Ratched being depicted as sadistic and controlling in the movie *One Flew Over the Cuckoo’s Nest*. Her character is representative of everything that is frightening about mental health patients and mental health nursing (DeCarlo, 2007). According to

DeCarlo's (2007) ethnographic analysis of films from 1942 through 2005, mental health nursing is considered abnormal and secretive yet dangerous work. She looked at 19 films, including *Snake Pit* and *One Flew Over the Cuckoo's Nest*. These films both create and reinforce stereotypes. The recurrent theme in all of the movies that she examined is that the nurse practicing in the mental health setting is often the violent and sadistic antitheses to the true work of a nurse. Many of these films were not meant to portray mental health nursing realistically, but the unfortunate consequence has been that many view them as accurate, and in fact, Nurse Ratched has become a symbol of the typical mental health nurse (DeCarlo, 2007).

In addition, research documents that the media has often identified violent attacks on public figures with mentally ill persons as perpetrators and has significantly increased prejudice (Pesconsolido et al., 2008). Mass shootings on college campuses and in malls, and even going as far back as Columbine, have been identified by the news media as being perpetrated by a mental health patient or patients who have "slipped through the cracks" in the mental health system. The following is a simple diagram visualizing the snowballing effect of stigma on the mental health patient and the need to address mental health issues within society and culture:

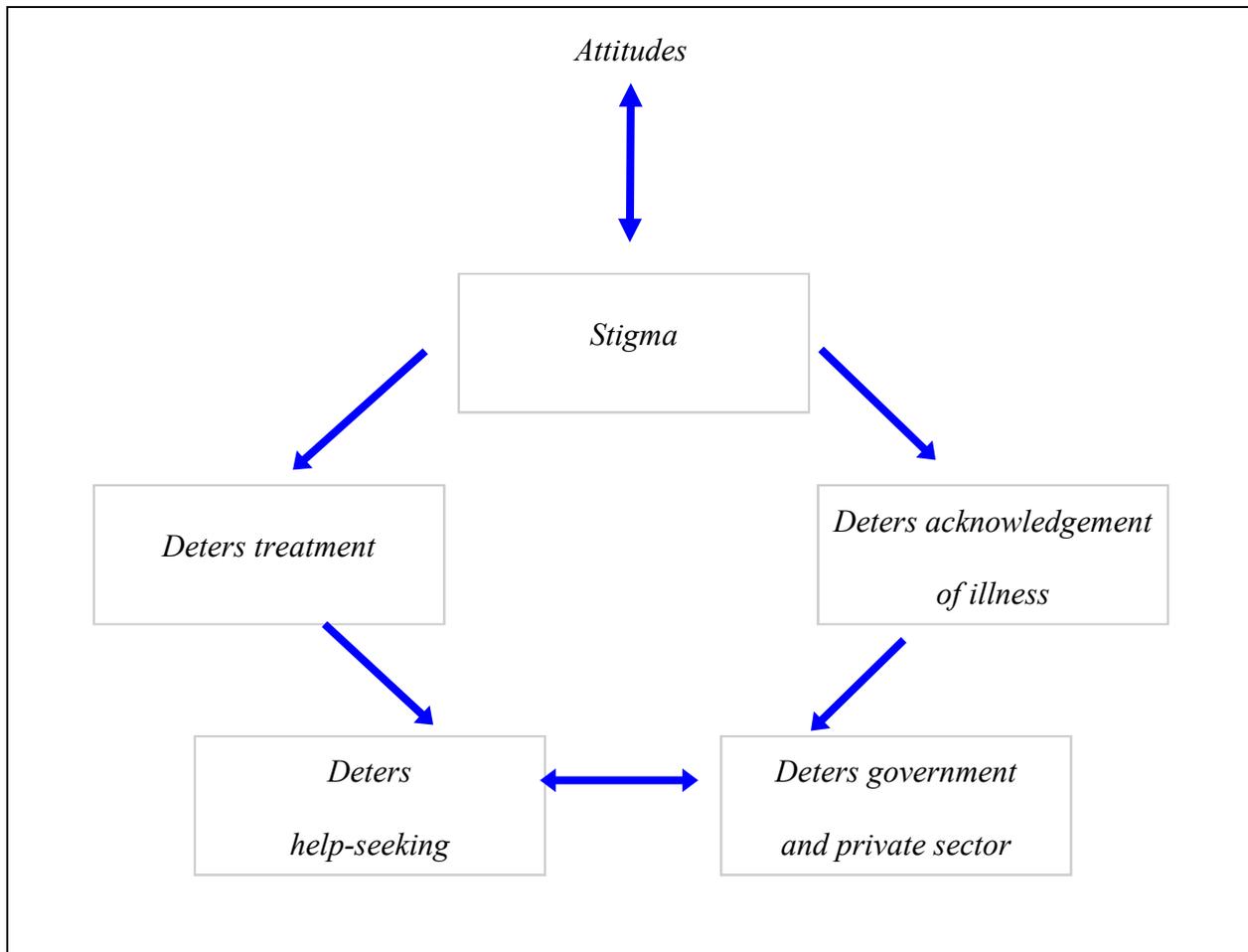


Figure 1: The snowballing effect of stigma on the lives of mental health patients. This figure illustrates how stigma deters acknowledgment and treatment.

The overarching issue becomes important to the recruitment of new nurses because the associative stigma also prevents entry into the mental health specialty, as students do not enter into mental health nursing and in fact are stigmatized for expressing a desire to do so.

Operational Definitions

For the purposes of this study, the following terms are defined:

- *Nurse educator*—any faculty member responsible for providing theory and/or clinical

teaching to nursing students at the school of nursing participating in the study.

- *Attitude*—an individual's predisposition to evaluate a symbol, object, or aspect of the world favorably or unfavorably.
- *Mental illness*—any psychological condition diagnosed by a psychologist or psychiatrist.
- *Stigma*—the perception that an individual or group possesses a discrediting, exaggerated, and misunderstood flaw.

CHAPTER 2 – REVIEW OF THE LITERATURE

An exhaustive review of the literature was conducted regarding the study's topic via searching for articles and texts. A variety of electronic databases was used, including but not limited to CINAHL, OVID, ProQuest Health and Medical complete, Ebsco Host, ERIC, and Google Scholar. Having access to the interlibrary loan system through work, I was also able to obtain relevant articles from medical and academic libraries across the United States. A variety of combinations of the following key words were used: *attitudes, perceptions, faculty, teachers, educators, nursing education, nursing students, baccalaureate, mental illness, psychiatric nursing, psychiatric illness, and stigma*. Articles that were selected for review included those that were relevant to the study's conceptual framework of stigma, the study's questions, and research that focused on students' attitudes toward mental health nursing as a chosen specialty. In addition, literature was reviewed relating to non-psychiatric nurse educators' attitudes toward mental health. This chapter reviewed the relevant literature for the research presented in this dissertation.

Review Related to Attitudes of Students and Nurse Educators

While the literature was very sparse on the current attitudes of students and educators in mental health nursing in the United States, several studies completed in Australia and the United Kingdom indicated that mental health nursing is less than highly respected as a specialty in nursing and that many times undergraduate nursing students are actually discouraged by nurse educators from entering the specialty. This chapter was written to review the relevant literature for the research presented in this dissertation. The following section provides a review of the attitude

literature and also discusses previous research on teaching strategies, content, and clinical experiences in undergraduate nursing that may contribute to the stigmatization of mental health nursing.

The first study to be discussed was a classic study completed in 1976 by Wilhite and Johnson. In this study, the independent variable was identified as nurse educators' (n=10) attitudes toward old people and the interaction of faculty with their clinical groups. The dependent variable was a post-test assessment of student nurses' (n=80) attitudes toward the elderly. Wilhite and Johnson (1976) reported a statistically significant difference (improvement) ($p=0.79$; $P<0.10$) in the attitude scores after the eight-week clinical rotation. There was a positive correlation between attitudes of nurse educators and the mean student group attitude change. The researchers did acknowledge that there was not necessarily a cause and effect relationship, but they nevertheless concluded that "change in student attitudes was functionally related to attitudes of the faculty" (Wilhite & Johnson, 1976, p. 432). While it is true that Wilhite and Johnson focused their research on older adults and my study focused on mental health, nurse educators have historically recognized the stigmatization of older adults (Gerrity, 2012) and have made curriculum changes that reflect an effort to de-marginalize this population group. These curricular changes have not occurred in the area of mental health.

In 2010, Harms conducted a study exploring the perceptions of non-psychiatric nursing faculty toward mental health patients. In this study, Harms (2010) used a qualitative design to explore the perceptions of 18 non-psychiatric nurse educators toward patients with mental illness via one interview with each participant. Harms reported three findings relevant to this dissertation research.

First, 72% of the participants recalled memories that triggered discomfort about their own

student experiences with the mentally ill, and only 22% related comfortable memories from their professional experiences. Second, the nurse educators often reported a lack of both self-confidence and a sense of efficacy in their abilities to provide effective and therapeutic care to patients with a mental illness. The most frequent reason for their lack of confidence was anxiety and not knowing how to be therapeutic. Third, avoidance was a common theme. Only 28% of the nurse educators “indicated they would assign students to patients with mental illness during clinical rotations” (Harms, 2010, p. 69).

The research conducted thus far on nursing attitudes of nursing students indicated that undergraduate nursing students did not value mental health as a viable option for specialization. DeKeyser and Kahana (2006) conducted a study of attitudes of 178 undergraduate students using a self-designed tool that indicated mental health nursing was ranked lowest of 10 specialties in the area of social need. Psychiatric/mental health nursing was ranked 7th in prestige and 9th to 10th in their preference of nursing employment after graduation. DeKeyser and Kahana used a survey tool and questionnaires that were distributed to undergraduate nursing students at three different points during their undergraduate educational experience. The survey was distributed to this convenience sample during the first, third, and fourth years of schooling. The research questions were as follows:

- a) What were the perceptions of baccalaureate nursing students of clinical specialties?
- b) What factors affected these perceptions? Checklists were provided to the students related to attitudes, factors influencing attitudes, and career choices.

Data were analyzed by frequency of response using Spearman rank order correlations through SPSS. The study was completed in Israel, and the researcher reached the following conclusions.

Critical care was consistently ranked as the highest preference in all perception checklists, followed by emergency, maternity and pediatric nursing. Psychiatric, community, and gerontological nursing were consistently found at the bottom of the list. High levels of association were found among students from different class cohorts and calendar years. Life experiences were ranked as the factor that most influenced career choice. Nursing perceptions are strongly influenced by personal experiences and other personal contacts, and sometimes by nursing instructors. Therefore, there is a need for international nurse educators and recruiters to develop new, creative strategies to encourage nursing students to pursue careers in areas presently considered less popular.

Muldoon and Reilly (2003) completed a study using a self-designed tool in which mental health nursing was ranked as the least preferred nursing career option. The intent of the study was to determine the role of gender in influencing career choice; however, the results speak to preconceived notions regarding entrance into various nursing specialties. A survey was used to collect data. The gender appropriateness of several nursing specialty areas using a seven-point Likert scale was explored. The specialties that were rated as highly female or female included nurse teacher, nurse midwife, palliative care, and elder care. Those that were considered gender-neutral included mental health nursing, indicating (according to Muldoon and Reilly) that males are more suitable for mental health than are females. This contributes to the misconception that brute strength may be needed to control violent mental health clients. The popularity of specialty areas was also calculated based on the number of participants who indicated that they would consider a career in this area. Of the 384 students who participated in this study, mental health nursing, the specialty that was rated as most appropriate for men, was also the most unpopular. Given that nursing continues to be viewed as a generally female profession, this indicates that

fewer nursing students are interested in mental health as a specialty than other specialty areas.

In another study, Surgenor (2005) investigated student attitudes toward mental health nursing by utilizing an attitudinal questionnaire and cross-sectional design to determine attitudes toward mental health clients and mental health nursing. The study employed a six-point Likert scale in which students rated their agreement or disagreement with statements related to psychiatric nursing and psychiatric patients. The higher the scores, the more favorable the attitudes toward psychiatric nursing. Additionally, certain demographic data were collected regarding age, gender, ethnicity, year of nursing, intended specialty of nursing practice, and whether participants had previous contact with mental disorders. The results were analyzed using the relationship between attitudinal scores and student groupings. A total of 140 undergraduate nursing students participated in the study. The results were more positive for students who held a prior desire to work in the field of mental health. A disconcerting fact was the negative attitudes that continued to be held by those who wish to pursue careers in other specialties. Given that nurses will encounter mental health issues in all specialty areas, it was of utmost importance to develop more positive attitudes in those who will pursue other specialty areas.

Additional studies elicited similar results. Happell (2008) employed the Psychiatric/Mental Health Clinical Placement Survey for First/Last Day of Placement (PMNCP-FLDP) in her research, using a quasi-experimental design. The aim of the study was to determine if increased hours of theory and clinical practice had an influence on students' attitudes towards mental health nursing. Out of the 162 surveys that were distributed, 148 students completed and returned them—a return rate of 91%. Some of the students were in the first year of placement, while others were in the second year. Second-year post clinical placement students were students who had elected to take mental health nursing, while in the first year, the placement in mental health was compulsory.

While students at post-clinical placement responded more positively to certain items on the tool (psychiatric nurses make a positive contribution to people with mental illness: $d=0.32$, $p<0.0005$), students who were in their first year of placement and did not indicate a desire to pursue psychiatric nursing as a specialty did not respond positively to items on the tool. These results indicate that little is being done to recognize or change the existing attitudes toward mental health as a nursing specialty. The two different levels of responses were analyzed for significance using t-tests. Additionally, a separate analysis of course evaluation relative to preparation for mental health nursing was conducted using Pearson's correlation coefficient to determine the strength and direction of the relationship between the two variables. Significance tests were two-tailed, and the alpha was set at 0.05. The results of Happell's research suggest that the amount of theory and practice to which undergraduate nurses are exposed does influence their attitudes toward people with mental illness and to the mental health specialty. It was necessary to state, however, that assuming that clinical experience primarily determined a change in attitude negated the impact of time devoted to theory. Time spent in theory could also impact changes in attitudes.

Happell (2008) used a quasi-experimental design to study the impact of the theoretical component of an undergraduate mental health nursing course at a university in Victoria, Australia. The amount of theory in the course was increased from 20 hours to 30 hours. A total of 233 undergraduate students took part in the study, which surveyed attitudes of students who had received the differing hours of theory. In the case of the students who had more theoretical hours, they responded more positively to feeling prepared and having an understanding of mental illness. In addition, they indicated fewer negative stereotypes, and some even indicated a desire to enter mental health as a nursing specialty.

Additionally, although much of the research regarding attitudes of students toward mental

health nursing has taken place outside the United States, Halter (2008) completed research at the University of Akron. Her study addressed the concept of stigma by association, or courtesy stigma. She posited that there is stigma by association attributed to mental health nurses. Participants who were already RN's or LPNs were asked to rank their own preference in nursing specialty from 1 to 10, and then asked to rank their preferences according to their assumptions of society's preferences. Out of 122 participants, 69% ranked mental health as number 10 in personal choice, and 75% ranked it as 10 in society's choice. A repeated measures analysis of variance (ANOVA) was conducted on the 10 personal preference items based on the hospital where the nurses were employed. In terms of characteristics associated with nurses who work in various specialty areas, psychiatric nurses were viewed extremely poorly by other nurses. Nurses practicing in this area scored lowest in terms of being skilled, logical, dynamic, and respected. In ranking relative to the other specialties, they were also likely to be identified as introverted, dependent, disinterested, and judgmental.

Based on Halter's study, it was apparent that, although nurses possess a great deal of influence both at work and off the job, it was clear that mental health nurses were not regarded with positive attitudes by their peers in other specialties. If, in fact, this negativity was perpetuated as stigma by association, the role of nurses and nurse educators in continuing the stigmatization is profound. If contact and education were key to diminishing negative stereotypes, nursing education should emphasize content and intentional clinical and classroom experiences that address the problem of stigma. Education should also play a role in addressing the issues of incompetence and weakness, from the perspective of psychiatric nurses and people with mental illness. Students should be educated and socialized in an atmosphere in which mental illness is viewed as a brain disorder, not a personal flaw, and in which psychiatric treatments are seen to be

scientific and requiring skill, not merely as custodial care. Mental health nursing should be respected as a specialty with a more clearly defined role than currently exists. Even nurse educators show a lack of respect for mental health nursing (Natan, Drori, & Hochman, 2015).

A recent study conducted by Thongpriwan et al. (2015) indicated that the more exposure students have to mental health patients, the more prepared they feel to care for those with mental health diagnoses. A total of 225 students of varying demographics were interviewed via Survey Monkey. Students in the study who reported no experiences or brief experiences in a mental health setting did hold to more negative stereotypes than those who had more exposure to mental illness. In addition, students who had little experience in mental health settings expressed significantly higher anxiety levels regarding mental health nursing than those who were afforded more opportunity to work with mental health patients (Thongpriwan, Leuck, Powell, Young, Schuler, and Hughes, 2015). Students from different nursing programs did not report significantly different perceptions of mentally ill clients and negative stereotypes. Negative stereotypes were significantly different between students who had some exposure to mental health clients and those who did not ($p=0.0147$). There was also a significant difference between students who had prior mental health experience and those who did not in interest in a future career in mental health nursing ($p=0.0005$).

Review of the Literature Related to Content and Clinical Experiences

The review of literature related to the second research question was completed, and a study by Gough and Happell (2009) is now discussed. A survey of 703 undergraduate nursing students (post-clinical placement) was conducted, noting that specific characteristics were more prominent in students who indicated a desire to work in mental health. These characteristics included males, those who spent greater than 30 minutes with a preceptor, and those who remained on the unit for

8 or more hours a day in their placements. This study certainly indicated those teaching strategies (extended-hour placements and extended time spent in preceptorship) may have an impact on student attitudes. The study could also indicate that males may be preferred in mental health for simple brute strength due to the perceived high probability of mental health patients being assaultive (Gough & Happell, 2009).

Another study was conducted by Gough and Happell in 2007 in an attempt to further discover factors that influenced attitudes of undergraduate nursing students toward mental health nursing. The study was completed pre-placement using the Psychiatric/Mental Health Clinical Placement Survey for the First Day of Placement questionnaire. To complete this study, the PMHCP questionnaire was distributed, consisting of a total of 24 statements and 7 demographic questions. Statements reflected the students' preparedness for the mental health field, attitudes toward mental illness, and attitudes toward mental health nursing. The statements were written and responded to in the form of a seven-point Likert scale ranging from *strongly agree* to *strongly disagree*. The responses were coded and statistically analyzed in SPSS version 12. Frequencies were calculated based on codes such as *negative stereotypes*, *KMI* (knowledge of mental illness), *anxiety surrounding mental illness*, and *valuable contributions of mental health nurses*. Examining the demographic questions, a multivariate analysis was used to determine whether differences did exist between gender and year of study. The results of this study clearly indicated that those students who felt most prepared for the role of mental health nurse indicated a greater desire to enter the field (Happell & Gough, 2007). It was interesting to note that these researchers indicated that attitudes toward people who are mentally ill were less of a determining factor in students deciding to pursue a career in mental health than perceived preparedness and attitudes of nurse educators.

Other studies, however, indicated that students' attitudes toward mentally ill clients did in fact influence their decisions to pursue career choices in other areas of nursing (Stevens & Delahunty, 1997). Additionally, a 2008 study by Happell included the clinical component of the psychiatric rotation using a self-designed survey tool, completed in three parts. The pre-education results listed psychiatric nursing as ranking eighth among nine specialties that students considered. After a clinical experience including preceptorship, psychiatric nursing was ranked fourth among the specialties. The respondents indicated that they believed that psychiatric nurses made a positive contribution to patients who are mentally ill and that the psychiatric nursing experience provided important skills that will transfer to practice in other areas of nursing (Happell, 2008). One part of the study also indicated that students with more hours of theoretical preparation, as well as more clinical hours, were more likely to desire a career in mental health nursing than those who had fewer hours of clinical and theory time (Happell, 2008).

Another interesting study regarding educational experience was performed by Adams (1993). In this quasi-experimental study, students were either placed in a clinical setting with a graduate student as a preceptor (condition 1) or in a substance abuse unit as well as several other specialty units with a graduate student preceptor (condition 2). Both groups spent the same length of time in the mental health rotation. Not surprisingly, those students placed in the group that was given the more varied experience were more likely to choose mental health nursing as a potential career choice (Adams, 1993). The educational experience appeared to be of greater importance than other factors in influencing attitudes toward mental health nursing. The general pattern of results seemed to indicate that longer placements and a greater number of theory hours yielded more positive attitudes toward psychiatric nursing.

Given that more theory hours and clinical experiences had positive influences on mitigating

stigma, Happell (2015) posited that there is indeed an underrepresentation of mental health content in nursing curricula. In a qualitative exploratory study, she noted that deans of nursing schools in Australia agreed that BSN programs were not “preparing graduates for beginning practice in mental health settings” (Happell, 2015 p. 333). One of the reasons identified for this lack of preparation was an overcrowded curriculum. According to Happell, (2015) educators have been unwittingly adding to the problem by assuming that when new topics were added to the curriculum, other less-essential topics were removed. Given that the content in mental health (as in other areas of nursing) continued to grow as the body of nursing knowledge grew, the dilemma of what to place into the curriculum would remain an ever-present reality.

A second barrier to quality mental health education was the scarcity of clinical placements (Happell, 2015). One participant in Happell’s (2015) study suggested that students should complete their mental health rotations in medical-surgical units, given the high prevalence of comorbid mental health and medical diagnoses that can be seen on medical floors. The drawback to this “solution” was that mental health placements in medical-surgical units do not influence the development of more positive attitudes toward people who are mentally ill (Happell & Platania-Phung, 2012). Placement in medical-surgical units to focus on mental health also undermined the philosophy of holism that colleges of nursing embrace. Undergraduate programs seek to prepare the practitioner to provide care based on the theory and ethics of holism and have outcome criteria requiring the nurse to treat the client holistically (Happell & McAllister, 2014). The placement of students in a medical-surgical unit for the mental health concentration of the curriculum was by nature reductionist, while we espoused holism as a directing standard for that same curriculum. Additionally, mental health nurses were functioning in other areas aside from acute care hospitals, but many programs have not made use of areas like community-based centers, assertive

community treatment (ACT) teams, and visiting nursing mental health teams (Happell & McAllister, 2015). Happell and McAllister (2015) related in their study, “No participant discussed the need for locating and providing clinical learning experiences outside the acute care setting” (p. 334). Rather, they took clinical placements where they could find them. If we as educators want to provide students with the opportunity to appreciate mental health nursing as it exists presently, it would behoove us to provide experiences in the full range of mental health practice. Clinical placements that cover the full spectrum of mental healthcare, including primary care, treatment, recovery, and rehabilitation, may make a difference in attitudes and draw more nurses into the mental health specialty.

Hiring and retaining qualified faculty to teach mental health nursing was also a problem related to the student educational experience. Happell and McAllister (2015) have indicated that there has been a longstanding shortage of qualified educators in the mental health area. According to the study, some universities had difficulty in recruiting qualified mental health instructors and were therefore using non-mental health nurses to deliver content in the area, along with coaching clinical experiences. The Mental Health Nurse Education Task Force in 2008 emphasized the importance of mental health instructors having expertise in the field, but evidence has shown that support for this recommendation by colleges of nursing has been ignored by directors of nursing programs (Happell & McAllister, 2015). As long as mental health nursing as a specialty remains marginalized, it will continue to reflect the discrimination toward mental illness observed in the community (Halter, 2008).

Since there was a stigma attached to mental illness, the benefits of involving mental health service users in the education of nursing students has been largely ignored. Benefits to student learning have been identified in several areas, including attitudinal change. Ganzer and Zauderer

(2013) have demonstrated that consumer involvement assisted in the development of a more holistic model of teaching mental health. They did a qualitative study using an in-depth interview process and Colaizzi's steps to analyze data and identify significant themes. The study included 12 undergraduate students completing a course in mental health recovery as part of their nursing education in a university in Queensland, Australia. One of the major themes that emerged through the study was influencing nursing practice. "The course has helped me to work with patients rather than working over them, to be more understanding of what the patient is going through" (p. 268). Another participant stated, "The recovery course has certainly changed my ideas of nursing and how I will interact with people in the future in my nursing practice" (p. 268). In some students, the study also elicited a change from focusing on just the physical or just the emotional to focusing on the whole person. "I certainly look at people differently. I now know when I am working with people with chronic diseases, I tend to view them as a whole person. And in terms of residents in aged care, I have a lot more insight into how they must be feeling now and I think that's affected how I approach them" (p. 269). Another participant spoke of persons who are mentally ill being able to change. "Because I have been taught by [a person] with lived experience of mental illness, the two things I will take forward with me is that there is light at the end of the tunnel and the importance of hope" (p. 270).

In addition to placements and theory hours, attitudes were influenced by nursing faculty who held negative attitudes toward mental health nursing. In some cases, nursing faculty have overtly discouraged entrance into mental health nursing by students (Happel, 2009). Although nursing faculty should be held to a higher standard regarding intolerance toward the marginalization of mental health nursing, this was frequently not the case. Rather, stigmatizing attitudes were reinforced by nursing faculty, who assumed that students should acquire more

medical-surgical skills in their first year after graduation and then pursue a specialty (Shattell, 2009).

Review of the Literature Related to Teaching Strategies

While there was some literature that addressed the attitudes and factors that affect attitudes of students toward mental health nursing, very little was found about teaching strategies that addressed the stigmatizing beliefs that existed toward mental health clients. One descriptive qualitative study was found in which instructors incorporated creative teaching strategies using reflection and an individual project that depicted their understanding of what it is like to live with mental illness. According to Varcarolis, Carson, and Shoemaker (2006), empathy was an essential component of the therapeutic nurse–client relationship. Using empathy and therapeutic rapport as a framework, Webster (2009) conducted a qualitative study of nursing students and their attitudes toward mental health. She described her students’ responses to the patients in her study. One of her students wrote that she never realized that she had placed a stigma on mentally ill clients until she realized how nervous she was about having to talk to a patient and that her anxiety was completely unfounded (Webster, 2009). Some of the students in the study recognized their anxiety and used reflective journaling. The reflective journaling was an impetus to try to create a therapeutic relationship with patients.

In addition, several studies were conducted to examine the usefulness of virtual patient simulation and standardized patients. One such study applied the use of virtual patients, and the application of the study may be particularly useful in online environments (Guise, Chambers, & Valimaki, 2012). Virtual patients were used online, and case studies were tested for content validity and piloted with 99 mental health nurses already in practice. These nurses, considered content experts, were recruited via convenience sampling. The experts were asked to evaluate

content according to presentations, usability, and the desired learning outcomes of the course. Nurses enjoyed using the case study technology and indicated that virtual patients link theory and content in meaningful ways (Guise, Chambers, & Valimaki, 2012).

Using standardized patients in mental health rotations has also improved critical thinking skills and self-confidence. Guise, Chambers, and Valimaki (2012) collected data from 112 undergraduate nursing students over three semesters regarding the use of standardized patients. A nine-item satisfaction survey was used. Students indicated that the learning experience improved their self-confidence in talking to mental health clients, as well as sharpening their critical thinking skills. In addition, working with standardized patients also decreased their anxiety levels (Robinson-Smith, Bradley, & Meakim, 2009).

Another teaching strategy that decreased anxiety levels was reflective learning. Ganzer and Zauderer (2013) engaged students in a self-reflective exercise with the goal of preparing themselves mentally for their first rotations. They responded to one question about their perceptions regarding the clinical rotation in mental health. The same question was asked after the rotation, giving students an opportunity to actually reflect on their learning experience. In this qualitative study, the themes that emerged were fear of the unknown, fear for personal safety, and anxiety regarding how to talk to mental health clients. Students reported less fear after the rotation and believed that having the opportunity to reflect on their perceptions was helpful in allowing them to feel more “realistic about going to the mental health rotation” (Ganzer & Zauderer, 2013, p. 245). In yet another qualitative study, 20 nursing students wrote narratives of critical incidents they observed or participated in on the units. Students’ narrative skills were stimulated and they were “possibly sensitized...for listening to the stories of their future patients” (Kosikinen, Mikkonen, & Jokinen, 2011, p. 627).

While reflective journaling and other creative teaching projects were important in the de-stigmatization of mental health clients and in decreasing student anxiety, there appeared to be continued prejudice toward mental health patients and mental health nursing. A lack of understanding of the impact of trauma also contributes to the stigma attached to mental health. According to Courtois and Gold (2009, p. 3), “Despite the establishment of a solid base of scientific literature on trauma and the growing attunement of society and the media to the adverse psychological impact of traumatic events, this area has yet to be decisively incorporated into the core curriculum of training in psychology and other professions.” There was a great deal of literature that deals with the high incidence of trauma among those who were in the mental health and legal system (there seems to be a crossover), but there was very little about pedagogy that addressed these issues in professional curricula, including nursing (DePrince & Newman, 2012). According to a landmark study at the University of South Carolina, 90% of mental health clients have been exposed to (and most have actually experienced) trauma. In addition, 75% of clients in substance abuse treatment reported histories of trauma, and 97% of homeless women had been the victims of either physical or sexual trauma (Muskett, 2014). As students witnessed traditional kinds of treatment (seclusion and restraints), such clinical experiences may have perpetuated the stigma of mental health.

Despite a lack of measures available for assessing the effects of teaching strategies on student nurses’ career choices and attitudes toward mental health nursing and clients with mental illness, Hayman-White and Happell (2005) investigated 802 nursing students’ attitudes toward mental health nursing, mental illness, clients with mental illness, and their preparedness for the mental health field, using a self-report scale. They concluded that educational strategies have the potential to positively affect nursing students’ attitudes and level of preparedness.

If the goal of mental health professionals was to promote recovery and encourage choice and self-determination, it behooves us to try to understand how the stigmatization of mental health patients and mental health nursing affects patient care, and to find a means of educating students that does not continue the marginalization of the specialty. Students should be taught about care that eliminates practices that re-traumatize and exacerbate symptoms in clients who have already experienced devastating events that have led to mental illness. Many studies of women in psychiatric hospitals and prisons have indicated that patients/clients have a high level of trauma in their histories (Muskett, 2014). Despite the literature available on the concept of trauma-informed care, schools and colleges of nursing do not appear to have been addressing this issue in their curricula; their apparent indifference to such research passively instilled fear into students because they continued to teach the same content, thereby increasing anxiety.

Few studies addressed how to decrease student anxiety; however, a qualitative study conducted by Hung, Huang, and Lin (2008) identified themes to incorporate within the curriculum to break the stigma of mental health, including developing a trusting relationship with the patient and gaining professional knowledge and skills, and the process of student growth through reflection. The question of incorporating trauma-informed care into the undergraduate nursing curriculum has not been addressed in the existing literature, nor have creative teaching strategies addressed incorporating trauma informed care into the clinical experience (Freedberg, 2008). Students were often burdened with techniques for self-defense prior to clinical placement rather than content that assisted them in identifying precursors to aggression and de-escalation techniques. Literature could not be found to indicate that trauma-informed care was taught in undergraduate nursing programs; therefore, it was probable that the high level of trauma experienced by mental health clients was not addressed in undergraduate nursing programs

(Muskett, 2014). This researcher has anecdotally spoken with colleagues who taught in undergraduate nursing programs in the mid-Atlantic region of the United States. These professors indicated that mental health pathologies were taught, but there was nothing in the curriculum to address the high levels of trauma in mental health clients.

The reviewed literature did indicate that there was some use of reflective teaching strategies, journaling, and simulation by individual mental health instructors. In simulation, there were very few scenarios for the mental health rotation (Halter, 2008). While simulation was becoming more widely used as a teaching strategy for undergraduate nursing, the use of simulation in mental health nursing has specific issues related to cost and qualified faculty to direct simulations (Brown, 2015). Despite these issues, Galloway (2009) found that the use of simulation in mental health nursing is beneficial and worth the investment. Using simulation experiences, including virtual reality, may be helpful in addressing “mindfulness, therapeutic communication, assessment, and critical thinking” in mental health (Brown, 2015 p. 448).

Additionally, understanding the reasons for the negative attitudes and taking action to change them had implications for the use of specific teaching strategies in mental health nursing in undergraduate nursing education. Given that mental health nursing was not held in great esteem by many healthcare professionals (Holmes, 2006), job status may not greatly encourage the choice of mental health nursing by newly graduating nurses. One of the professors at the site of the research study indicated that “There is a need for more increased awareness about what we say about mental illness. We somehow do not feel a need for political correctness as we use words like ‘crazy’ ‘wacked out’ and other diminutive terms” (personal communication, June 16, 2016). There was a potential for nurse educators to encourage mental health nursing as a specialty choice by engendering more positive attitudes toward mental health nursing in their students, not only by

role modeling but by choosing teaching strategies and content that lead to a better understanding of mental illness. In order to understand and choose those strategies, nurse educators need to understand the impact that content and attitudes may have on nursing students.

CHAPTER 3 – METHOD

The research for this dissertation was conducted for the purpose of exploring undergraduate nursing students' attitudes toward mental health and mental health nursing, as well as students' attitudes toward content and clinical experiences. Additionally it was hoped the researcher might glean an understanding of how content, teaching strategies, and clinical experiences affect those attitudes.

Based on the study's questions, the research method chosen for this study was a phenomenological descriptive qualitative research. At one point, this researcher considered a quantitative design, but it was rejected for the following reason: Quantitative, by definition, means calling for a measurement or an amount of some specific entity. Much of the literature reviewed for this study focused on nurse educators and students' attitudes while quantifying and listing preferences using quantitative designs. A quantitative design would have been helpful if the purpose had been to quantify attitudes/experiences and measure some change in attitudes. However, because the focus of this study was to understand the students' lived experience with the phenomenon under investigation and the meanings they brought to the experience, a qualitative design was selected. Pinto-Fultz and Logsdon (2009) stated that "qualitative research captures unique perspectives and information about phenomena that were previously unknown to nurses" (p. 34). Qualitative research is best when the researcher is exploring a "holistic account of a phenomenon" (Webb, 2016 p. 104).

Additionally, the qualitative research method was also selected based on the following

description of Streubert-Speziale and Carpenter (2007): (a) the belief that there are multiple realities; (b) the need to discover, describe, and understand phenomenon; (c) the desire to interpret the individual's meanings and experiences rather than measure them quantitatively; (d) the search for rich narrative descriptions of the experiences; and (e) the willingness to acknowledge the researcher's role and participation in the inquiry process. Because the above descriptions of qualitative research are conducive to the purpose of this study, the descriptive phenomenological method was considered most appropriate. The purpose of phenomenology, then, was to understand phenomena, not to "master, control, or dominate it" (Colaizzi, 1978, p. 56).

Besides its alignment with the purpose of the study, phenomenology was chosen because the literature indicated that it was used by scholars exploring similar topics. Phenomenology has been used in (a) nursing education (Young, 2008), (b) mental health or psychiatric nursing (Graham, 2001), and (c) experiences with stigmatized populations (de Guzman, 2009). In addition, the research topic was the lived experiences of nursing students leading to their beliefs regarding mental health nursing. The aim was not to begin with a theory and predict outcomes, but rather to "inductively develop a pattern of meaning" (Creswell, 2007, p. 21). Qualitative designs lend themselves to holism, focusing on the understanding of a whole phenomenon—such as the lived experiences of undergraduate nursing students during their mental health rotations.

The method for data collection in the study was open-ended semi-structured face-to-face interviews that were audiotaped to maintain accurate accounts of information given. These data were then reviewed and analyzed. Permission to conduct research was obtained by the assistant dean of the nursing program of Gwynedd Mercy University, a private university in the mid-Atlantic region of the United States. IRB approval was obtained from both Gwynedd Mercy University and the University of Alabama. The method of analysis chosen was Colaizzi's (1978)

seven-step method of analysis of phenomenological data. Colaizzi developed this method in order to ensure a rigorous analysis of data. The method included the following steps:

1. Reading and rereading the participants' descriptions of the phenomenon to acquire a feeling for their experience and make sense of their account.
2. Extracting significant statements that pertain directly to the phenomenon.
3. Formulating meanings for these significant statements. The formulations must discover and illuminate meanings hidden in the various contexts of the investigated phenomenon.
4. Categorizing the formulated meanings into clusters of themes that are common to all participants; referring these clusters to the original transcriptions for validation and confirming consistency between the investigator's emerging conclusions and the participants' original stories; not giving into the temptation to ignore data which do not fit or prematurely generating a theory which conceptually eliminates the discordance in findings thus far.
5. Integrating the findings into exhaustive description[s] of the phenomenon being studied. Employing a self-imposed discipline and structure to bridge the gaps between data collection, intuition and description of concepts. Describing included coding segments of text for topics, comparing topics for consistent themes, and bridging themes for their conceptual meanings. Based on this description a prototype of a theoretical model about the phenomenon under investigation was formulated.
6. Validating the findings by returning to some participants to ask how it compared with their experiences.
7. Incorporating any changes offered by the participants into the final description of the

essence of the phenomenon (Colaizzi, 1978, pp. 48–71).

See Table 1 for a synopsis of the seven steps.

Table 1: *Steps in Colaizzi's Method of Data Analysis*

Step in analysis	Purpose
Reading and re-reading descriptions	To acquire a general feeling for the experience
Extracting significant statements	To generate information pertaining to the specific phenomenon being studied
Formulating meanings	To illuminate meanings hidden in various contexts of the phenomenon
Categorizing into clusters of themes and validating with original text	To identify experiences common to all participants
Describing	To elicit understanding of the phenomenon
Returning to participants	To validate the findings and ensure data triangulation
Incorporating changes based on feedback from participants	To further ensure data are valid

Participant Selection and Ethical Considerations

The participants recruited for this study were baccalaureate undergraduate nursing students who had a variety of backgrounds and experiences, including some who had previous experience working in the area of mental health. In addition, the participants were in an accelerated second degree program. Colaizzi (1978) identified two criteria for participant selection. The first criterion is that participants are experiencing the phenomenon being studied, such as the development of attitudes toward mental health nursing as related to their educational experiences. In addition, participants were chosen who were willing to participate in the interview process, were interested in the phenomenon, and were able to grant permission for the interviews to be audiotaped. In

addition, participants were selected who were willing to participate in the clarification process. The second criterion was the participants were able to articulate their experiences. After procuring the meeting time and place of the undergraduate summer mental health lecture class, students were invited to participate in the study. I addressed the class to describe my research study and distributed letters of invitation to each class member. The letter of invitation also included a brief description of the study. Not all students in this class of 80 students were selected to be interviewed due to the qualitative nature of the study, and several of the students declined to participate.

After the selection of participants, interviews were conducted. At the time of interview, demographic information was de-identified, and each interview was placed in a separate numbered folder on the recording device. The list of students interviewed was numbered, corresponding to the number of the file on the recording device for the purpose of follow-up after completion of all of the interviews. Semi-structured interviews were conducted with BSN nursing students during the summer behavioral health experience at Gwynedd Mercy University. These students were 19 years of age or above. Interviews were conducted by this researcher, a University of Alabama doctoral student carrying out dissertation research. The sample size was 20 students and included participants who were strictly voluntary. Informed consent was obtained. Each participant was given a copy of the informed consent and was assured that they were able to discontinue the interview process at any time if they reached levels of discomfort they felt would make it impossible to continue with the interview. Prior to beginning this research, IRB approval was obtained from both the University of Alabama (protocol ID 7385) and Gwynedd Mercy University (protocol ID 0516IRB). The study was not conducted until full IRB approval was obtained from both universities. The following table illustrates the demographics of the participants in the research.

Demographics

The demographic characteristics of the selected participants are listed in table 2 below:

Table 2: *Demographics of Participants*

Characteristic	Number	Percent
Gender		
M	2	10
F	18	90
Age Group		
19-29	16	80
30-39	3	15
40-49	1	5
Ethnicity/Race		
African American	6	30
Asian/Hispanic	1	5
Caucasian/White	12	60
Native American Heritage	1	5
Prior Education		
Bachelor of Science	13	65
Bachelor of Arts	7	35
Other		

Protection of participant confidentiality was achieved through interviews in a private area of the research facility. Audiotapes and transcripts were kept in a locked office and will be destroyed five years after completion of the research. The recorded files were password-protected, and all data was de-identified. No names or identifying data were used in the reporting of findings. All participants were made aware of the voluntary nature of the study and that they could withdraw from the study at any time. Each participant was also informed of the risks and benefits of being in the study. Written informed consent was obtained at the beginning of the first interview.

In planning for this study, this researcher met with the Assistant Dean of the School of Nursing at Gwynedd Mercy University. She agreed that stigmatization of mental illness and mental health nursing existed and was worthy of study at the study location. During this meeting, we discussed the nature of the study (i.e., voluntary, adult participants could choose not to participate, participants' confidentiality would be upheld, participants could withdraw from the study at any time, and the study would have no compensation, nor would it affect in any way the participant's grade or relationship to the university). The assistant dean reported that the dean of the nursing school at the university was in agreement with allowing the research, and she provided the contact information for the faculty teaching the summer mental health rotation to arrange for a meeting.

Procedure

Qualitative interviews involved special kinds of conversations that could be used by researchers who study the perspectives and experiences of the participants (Polit & Beck, 2006). Given that my interest in this study was the lived experiences and attitudes of nursing students toward mental illness and mental health nursing, this researcher deemed the semi-structured interview to be the most effective method for gleaning the information that was sought. Hatch (2002) asserted that interviews were the most effective method to discover the constructs that the participants used to organize experiences and make sense of their worlds. Interviewing was the preferred method of data collection in the area of phenomenology because it allowed the researcher to explore and understand the way the participants make meaning of experiences with the phenomena under investigation (Colaizzi, 1978). Two other data collection methods were discussed in Colaizzi's work on phenomenological studies including written sources and participant observation. Written protocols, such as surveys regarding the phenomena, had the benefit of saving time and eliminating the need for lengthy interviews, especially given that these

interviews needed to be transcribed immediately after they occurred. However, Colaizzi (1978) posited that data gleaned from interviews were frequently richer than written data and had the added benefit of the researcher observing nonverbal behaviors during the interview process.

Observation of lived-events methodology could carry the risk of what Colaizzi described as the researcher committing “experience error” (Colaizzi, 1978, p. 67). Experience errors occurred when the researcher attributed perceptions to participants that emanated from personal experiences. In order to avoid experience error, it was necessary for the researcher to note and describe only what he or she heard, smelled, saw, and so on. These descriptions were not useful in understanding the perceptions of the phenomena under study, and limited the ability of the research to answer the research questions. The observation method, while useful in some studies, was generally reserved for inquiries that investigate phenomena about which the participants are unaware (such as ethnography) or are unable to articulate (Colaizzi, 1978). Observation was therefore rejected as a data collection method for this study. Considering all three methods of data collection, the semi-structured interview was decided upon as most reflective of the aims of the study. Colaizzi (1978) recommended the use of informal, interactive interviews with open-ended questions to gain an understanding of the participants’ experiences with the phenomena. Per the recommendation of Colaizzi, a series of questions was developed prior to the start of the interview to guide the interview process (see Appendix A). Although the prepared questions were used as a guide to the discussion, some the questions were changed or not used at all, based on the direction of the discussion (Colaizzi, 1978). Additionally, a three-column note-taking tool was developed for use throughout the interviews, giving this researcher the opportunity to write down potential follow-up questions and make note of significant non-verbal communication, such as facial expression and tone of voice, as well as verbal statements made by the participants during the

interviews. In addition, this researcher was able to use the third column to write personal thoughts that arose during or immediately after the interview.

The data collected were the responses of the participants (including follow-up questions) to allow participants to provide open and in-depth descriptions of their experiences surrounding the phenomenon under investigation. The first part of the interview focused on experiences and what led them to enter the profession of nursing. Each participant was given the opportunity to express any belief or attitude they held related to mental health and mental health nursing, including any previous experience with mental health clients or mental health nursing. The second part of the interview focused on whether beliefs changed after the rotation, and any barriers they encountered during the rotation or previous rotations in medical-surgical nursing. Finally, the participants were asked to describe why they did or did not want to enter the mental health specialty.

Semi-structured interviews ranged from 20 to 30 minutes. The semi-structured interviews were tape-recorded with the participant's consent, as previously stated. They took place in a neutral, private office at the research site. Note taking by this researcher was kept to a minimum to allow for active listening, but on a few occasions notes were made. This researcher noted significant nonverbal communication or jotted down a note when a reminder was needed to ask a follow-up question based on a participant's response to an interview question. The participants were asked to describe specific experiences and events to provide rich detail about their experiences whenever possible (Colaizzi, 1978). Interviews were conducted in English. The interviews were transcribed verbatim. Demographic data were collected from each participant, and transcripts were coded for themes by this researcher. Data were analyzed using Colaizzi's seven-step method for interpreting phenomenological data. The study was completed over the summer

semester during the 2015–2016 academic year. This researcher maintained awareness that some of the questions were of a sensitive nature and advised the students they could stop the interview process at any time if they felt too uncomfortable to continue. None of the participants became distressed in any way, and all interviews were completed as planned. In addition to safety, participants were assured of the confidentiality of the information given, since some did discuss personal experiences with family members who were mentally ill. This researcher did not want her position as a nurse educator and a mental health nurse to influence responses of the participants, so to accomplish this purpose, non-leading open-ended questions were asked and a nonjudgmental approach was taken. This researcher refrained from using any verbal or nonverbal response that would indicate surprise, offense, or disbelief to their responses. In addition, all questions were phrased to communicate a genuine desire to understand their experiences and not to judge them in any way.

Data were collected from Gwynedd Mercy University students in the latter part of the mental health rotation during the summer semester. Gwynedd Mercy University is a small religiously sponsored university in Southeastern Pennsylvania. Interviews took approximately 20 to 30 minutes, and saturation was reached after 20 interviews. Data were transcribed from the tapes immediately after interviews for the purpose of ensuring clarity and detail. The transcripts were reviewed for the purpose of discovering additional questions, if necessary. Tapes were listened to three times prior to transcription. This provided additional opportunity to develop a preliminary analysis prior to actual transcription of the tapes (Colaizzi, 1978). The purpose of using Colaizzi's method of data analysis was to bring together individual descriptions to create a universal description of a phenomenon. First, the transcripts were read two times. These readings allowed this researcher to gain a preliminary understanding of the responses. The data were

again reviewed line by line, and significant statements, terms, and phrases were extracted. Significant statements were those that were relevant to the study's topic and framework. The third step in the analysis was to formulate meanings for each significant statement. The fourth step in data analysis was to organize the group of meanings into overarching themes. After developing themes, the fifth step was to return to the transcripts and validate the findings thus far. In both the analysis and written data, this researcher looked for significant differences and outlying experiences that contained major differences from other participants in the study. Step six was to integrate the findings into an exhaustive description of the phenomenon. The final step was to return to the participant to validate that the exhaustive description of the phenomenon accurately reflected their experiences.

One round of one-on-one interviews was utilized. All one-on-one interviews were conducted in a private, neutral location at the research site. With permission from the participants, the interviews were recorded on two devices. A second device provided a backup in case the main recorder malfunctioned. Taking as few notes during the interview as possible allowed for active listening and authentic presence during each interview. Notes were written for four purposes: a) when a participant used a word that the researcher might not recall or understand while transcribing the data, b) when a participant exhibited a nonverbal behavior that would not be captured in the audiotape, c) when the researcher had a thought or expression that she wanted to recall during transcription and data analysis, and d) when the researcher wanted to ask a follow-up question but did not want to interrupt the flow of the interview by asking the question at that time. To manage the data, the researcher created a folder on her password protected home computer and downloaded the interviews to it, identifying each interview by number only. The number of the interview corresponded to the number of the participant on a list

that was kept separately in a locked file cabinet in the researcher's office. After transcribing, the transcripts were kept in a separate folder on her computer, again identified only by numbers that were assigned at the time of the interview. The researcher returned to each participant after the interviews with findings to validate data. Because data analysis was congruent with data gathering in qualitative research, data were transcribed verbatim as soon as possible after each interview. The number of the interview corresponded to the number of the participant on a list that was kept separately in a locked file cabinet in the researcher's office. After transcribing, the transcripts were kept in a separate folder on her computer, again identified only by numbers that were assigned at the time of the interview.

Steps Used to Review and Analyze Data

In the process of data analysis, the researcher followed the following twelve steps:

1. The researcher listened to the tapes from interviews three times.
2. After listening three times, the researcher transcribed taped interviews.
3. After transcription of taped interviews, the researcher read transcripts from the interviews to get a sense of the whole.
4. The next step involved review and highlighting significant statements that pertained to the research questions.
5. All significant statements were then placed in a new Word document numbering each significant statement with the number of the participant interview from which it was extracted.
6. The researcher then read through the significant statements to create general meanings.
7. Analyzing the general meanings, three broad categories were created from which this researcher later extracted themes. The categories included a) experiences, b) beliefs and perceptions, and c) desire to enter mental health nursing. The themes that were created included

- a) experiences prior to the mental health rotation, b) experiences during the rotation, c) perceptions of mental illness, d) perceptions of mental health nurses, and e) desire to enter mental health as a specialty.
8. The meanings were then organized into subthemes as follows: a) personal experiences with mental illness prior to entering nursing school, b) anxiety around the mental health rotation, c) understanding of mental health diagnoses, d) fear for personal safety, e) fear of saying the wrong thing, f) fear of loss of technical skills, g) belief that mental illness does not improve, and h) belief that mental health nurses are unable to care for medical issues.
 9. The researcher then returned to the original transcripts to validate the finding of themes and subthemes to look for discrepancies. There were frequently differences between participants' perceptions and their actual experiences.
 10. The data were then reorganized into major themes and subthemes.
 11. The next step in data analysis entailed integrating the results gleaned into a description of the phenomenon.
 12. Finally, the researcher returned to the participants via phone conversation with the findings to validate whether the description of the phenomenon truly reflected their experiences and that no omissions were made or that there was no need for further description. In the next section, I have discussed methods that were used to ensure that the data collected were both valid and trustworthy.

Methods to Address Trustworthiness

Streubert-Speziale and Carpenter indicated that the issue of “rigor in qualitative research is important to the practice of ‘good science’” (2007, p. 97). Nursing education research may change current paradigms in the practice of nursing and ultimately affect patient outcomes. It was

therefore urgent that studies were designed to avoid researcher bias. This researcher used several means to ensure that the data collected were trustworthy. The primary means used in this study were the kinds of data collected and the detailed attention to collection procedures, including validation with the participants both during and after the interview process. Tape-recording and immediate transcription (rather than note-taking and observation only) ensured the elimination of making judgements, data interpretation and missing data were eliminated. Participant validation increased the accuracy of the study's findings. In order for phenomenology to be trustworthy, the researcher should examine his or her own values, beliefs, biases, and feelings about the phenomenon under investigation. This researcher used the process of reflectivity and bracketing to set aside her preconceptions and biases, as well as reactions to the research. A bracketing journal was maintained prior to and throughout the research process. Additionally, there was dialogue with other researchers about personal biases. These were written down in the journal. Through constant self-reflection, the researcher was able to identify potential assumptions that would have limited her ability to remain objective during the analysis and interpretation of the data. The researcher did not want her position as a nurse educator and a mental health nurse to affect the validity of the data, so to accomplish this purpose, non-leading open-ended questions were asked and a nonjudgmental approach was taken. The researcher refrained from using any verbal or nonverbal response that would indicate surprise, offense, or disbelief to the responses of the participants. In addition, all questions were phrased to communicate a genuine desire to understand their experiences and not to judge them in any way.

Finally, the researcher was not affiliated with the school of nursing where the study was conducted. According to Polit and Beck (2006), conducting qualitative research in an area in which the researcher works or is already known raises several issues and ethical considerations. While it

was possible that the clinician/researcher would get better results because of knowing the situation and having the trust of participants, it was equally possible that the researcher may get less information. Students of the researcher may feel coerced to participate and may limit the information they give or expect compensation of some sort for their participation. Conducting research in one's work area created problems related to the validity, reliability, and meaningfulness of the data. For this reason, this researcher chose to collect data outside of her work environment.

CHAPTER 4 – FINDINGS

Introduction

The purpose of this research was to a) explore undergraduate nursing students' attitudes toward mental health, b) understand the impact that content and clinical experiences and c) understand how undergraduate nursing education can contribute to the de-stigmatization of mental health nursing. To answer the overarching questions, the following research questions were developed.

- a.) What attitudes do undergraduate students have toward mental health nursing?
- b.) Has content taught in the mental health course impacted student attitudes toward mental health nursing in a negative or positive way?
- c.) Do clinical experiences and teaching strategies negatively or positively impact attitudes toward mental health nursing?

Themes

In the following section, the researcher will discuss the major themes and subthemes that were elicited from the interviews. Data analysis revealed the following major themes: a) student nurses had favorable and unfavorable attitudes toward mental health nursing, b) students had varied understanding of mental health nursing including compartmentalizing mental illness and anxiety/fear and c) clinical experiences and teaching strategies produced attitudinal changes that ranged from ambivalence about mental health nursing due to a loss of technical skills to a

confirmation that they did not want to specialize in mental health. None of the students interviewed decided to enter the mental health specialty as a result of the mental health rotation.

Before the major themes were described, it was important to point out that there was a great deal of variation in the students' personal experiences with mental illness. Personal experiences included any experiences they had prior to beginning their nursing education. This included a family member who had a mental illness, or media portrayal, to self, or any combination thereof. During the interviews, this researcher did not define the term *mental illness* for the participants. Keeping with phenomenological research methodology, the term *mental illness* was used broadly in all questions. Using the term *mental illness* in a non-specific context allowed the students to describe and express their own feelings, beliefs, experiences, and attitudes toward those with a mental health diagnosis. The students used a number of terms when describing their experiences with mental illness, including but not limited to, *depressed*, *bipolar*, *substance user*, *talking crazy*, *out of it*, and *autistic*.

Major theme 1: Student nurses had varied perceptions and attitudes toward mental health nursing. Two subthemes were extracted from major theme 1. Detailed explanations of these subthemes follow.

Subtheme 1. The first subtheme that related to research question 1 was students' attitudes toward mental health nursing ranged from favorable to unfavorable. Table 3 shows the different attitudes that emerged during the interview process. It was important to note the word *attitudes* was broad and encompassed perceptions and beliefs about mental health nurses and mental health nursing. It was important to note as well, some of the students held these perceptions prior to the rotation, while others gained these beliefs during the course of the rotations. Rotations were held at a variety of locations. All were similar because students were placed in locked units of acute

care hospitals or mental health facilities. None of the students did their rotations in mental health community centers or transitional living arrangements nor did any of the students follow an Assertive Community Treatment (ACT) team as they visited patients. The following table indicates a continuum of attitudes held by the interview participants. The participant numbers are indicated in parentheses by the attitudes.

Table 3: *Attitudes toward Mental Health Nursing Prior to and During Student Nurse Roles*

Favorable	Unfavorable
It's a hard job (1, 3, 7)	Have no technical skills (1, 2, 5, 6, 7, 9, 10, 13, 15, 20)
Psych nurses are not afraid to talk to the patients and are relational rather than technical – (1, 4, 10, 12)	Not sure what psych nurses do (1, 6, 7, 9, 11, 12, 13, 14, 16, 17, 18, 19, 20)
Affirming to the patients, able to keep them calm (4, 7, 15, 16)	Different/strange; not real nurses (7, 8, 9, 10, 12, 14, 16)
	Afraid of the patients—don't want to be involved in talking to patients (2, 3, 5, 6, 8, 9, 10, 11, 12, 14, 16, 20)
	Don't want to get involved with medical issues (2, 3, 5, 6, 8, 9, 10, 11, 12, 14, 16, 18, 19, 20)
	Mentally ill patients don't get better (1, 2, 4, 5, 6, 8, 10, 12, 15, 16, 17, 18, 19, 20)

As was evident in Table 3, the attitudes expressed by the student nurses reflected varied perceptions. Additionally, as reflected these responses were mentioned by more than one student. This variety of attitudes was based both on personal experience and experience in the nursing rotation. For example, participant #20 said, “I don't think I ever really understood what psych nurses do. I mean, I had no conception of how different mental health nursing is until I went to the floor.” Participant #16 said that she always felt that “mental health nurses are strange and I don't want my career to be limited by being like they...they don't seem to want to do real nursing.”

Participant #2 reflected on her personal experience in working with behavioral issues in a residential unit: “These kids had behaviors and the nurses just left it all up to us to take care of them. It seemed like as the tech, I was in the line of fire and the nurses just gave the needles and the pills and left us to deal with the issues. Also, if I asked for help with someone who had a medical problem, they didn’t know what to do. We had a guy, well, he was really sick and I don’t know what was wrong but he had a fever and, uh, the nurses wouldn’t do anything until he started throwing up. Then...and I don’t get this and I am not a nurse...they tried to give him Tums and Tylenol. He was just gonna throw that stuff up, you know? So I thought to myself I am never gonna work as a psych nurse! I want to be a real nurse.” Participant #16 corroborates the perception of participant #2 with the following statement: “Like my instructor said, she said that in mental health it’s different. We don’t touch anything medical. We are psych nurses.”

Participant #5 has a family member who was diagnosed with a mental illness. She stated that she felt uncomfortable being on a mental health unit because being with psych patients all the time made her feel stigmatized. Based on her comments, having a close family member diagnosed with a mental illness can lead to one feeling not only embarrassed, but also stigmatized by association. Being a close relative of someone with mental illness can lead to perceptions that others avoid not only the loved one with mental illness, but the relatives of that person as well. “I didn’t see the nurses help so I want to avoid mental health nursing...to avoid those feelings of stigma again.”

Subtheme 2. The second subtheme related to research question 1 was students’ attitudes were frequently related to previous exposure to mental illness and mental health nursing. It was again important to note exposure included personal, professional, and media exposure. Students who had prior exposure to friends and family who were mentally ill were less likely to stigmatize

mental health nurses. Two of the favorable impressions in Table 1 came from participants who stated they had family members who had been helped by mental health nurses. Participant #12 stated that she had a family member who had a bipolar disorder and comorbid substance abuse. “I guess we were fortunate because all the nurses in (the facility) were very supportive. They had educational groups and spent time one on one with (my relative). They gave her a second chance after she tried to kill herself. They referred her to a good therapist and now she functions just like you and me, as long as she stays on her medication. And the nurses told her, there is no difference between this and any other illness. You have to take your medication even if you don’t think you need it because if you stop it you will be back in (the facility). I was surprised at her level of functioning...you know what I mean?”

Participant #10 also had a family member who was depressed and hospitalized for an eating disorder. The student stated, “My cousin lost a lot of weight and we suspected something was going on with her because she was never hungry and would sit at the table and just sort of play with her food and not eat it. Once in a while she would take a small bite but then it would take her a really long time to chew and swallow. She was down to a skeleton...like really skinny, and she would be up during the night doing sit-ups because she thought she was fat. She finally passed out and agreed to go to the hospital or was told by my aunt and uncle that she had to go—I am not sure which it was. Anyway, at first she was very angry but eventually she started working on stuff—you know, like issues. She gained weight while she was there and the nurses spent time with her, like when she would get upset ’cause she gained weight. She said the counselors would have groups right after meals but when she woke up in the middle of the night with a nightmare, the nurse would always spend time with her. She used to freak out when she gained weight but the nurse would calm her down. She had a nurse therapist who did family therapy. Man, that must’ve

been a really hard job for the nurses and I really respect what they do.” Conversely, participant #20 stated that it was hard to think about becoming a psychiatric nurse because “the patients are so chronic and it is very depressing.”

Some students based their beliefs about mental illness and mental health nursing on media, such as movies, television, and media coverage of high-profile crimes, such as shootings in public areas and in schools. Media coverage of mass shootings impressed upon students that mentally ill patients were aggressive and unstable. Participant #3 noted that she couldn’t understand why anyone would want to work “with people who always wanted to hurt you. I mean, psych nurses must have problems themselves. One of my other instructors said that to me and I believe that is the truth. Look at all these people who go around shooting other people in malls and stuff. I don’t think I could do it. No offense, but I just don’t get why anyone would go into mental health. Look at all those shootings in malls and schools. That’s just sick.”

Participant #4 mentioned some beliefs that emanated from watching movies. “I saw this old movie about a guy who goes into a mental unit. He caused a lot of trouble but the nurse didn’t seem to know what to do except she was real mean and never smiled. She didn’t! Somebody dies at the end and she threatens the guys with shock treatments and stuff. So when I thought about psych nursing, that is what I thought. And then I saw this show called *Black Box* and the person was like bipolar or something. She was a doctor but she got really crazy when she didn’t take her meds. Maybe that is more real than the movie but I still don’t see how I could help somebody like that. They are not willing to help themselves.”

Major theme 2: Students had minimal understanding of mental illness and mental health nursing even at the end of the course. The second major theme related to research question two. All interviews were completed during the last week of the course after all content had been

delivered and just before the final. Based on the responses of several students, students gained minimal understanding of mental illness and mental health nursing even at the end of the course. Because of the nature of the summer rotation, a great deal of content was delivered in a very short time.

The responses of the students involving mental health content led to two subthemes. The first subtheme related to question 2 was; although a great deal of content was presented in the lecture portion of the course, several of the students who spoke with this researcher continued to compartmentalize mental illness rather than think holistically. Subtheme 2 was students clearly were made anxious and fearful by lecture content prior to arriving at their clinical sites. The lecture content contained methods to address violence and maintain safety on the units, including what the students described as a self-defense course.

Subtheme 1: Students continued to compartmentalize mental illness rather than think holistically about the patients. While nurse educators were expected to teach holistically, it seemed that compartmentalization of mental illness continued to occur. Participant #2 did not seem to understand the biological basis of substance use disorders. “While we were on the unit, they had an Alcoholics Anonymous (A.A.) meeting. What surprised me was there was such a wide range of people there. These people that have addictive personalities just seem to play the game. And they are not physically ill. One guy kept saying that he needed to come to meetings because it kept him together. I can’t see why he needed it. It’s a mental illness, right? So why can’t he just stop drinking and hurting himself and his family. If he detoxes, that is physical. But for this meeting, it’s not like he is physically ill. He just needs to stop, that’s all. And I am surprised at how they come in on their lunch hour from work in their business suits to the meeting for the mental health patients. I guess I just don’t understand how people can hurt themselves and their families this

way. It's not like a physical disease where they can't help it." It is interesting to note that at one point participant #2 asked if alcoholism was a mental illness and later came to the conclusion that since it was not a physical disease the patient should have been able to help himself without a support group.

Participant #9 said that her experiences in clinical rotation did not really have to do with mental illness, but she had worked with behavioral issues. "It was more like a behavioral problem, but I don't know if the two are the same. Some of the issues that I came across were ...um...children who overdosed. Um, on pills. I also saw a lot of people with, like, paranoia. They were just...very paranoid. Always looking around them, very paranoid, very anxious, you know. And I saw a number of children, too, who had, like, multiple cuts that just, like, you know, ran along their arms and forearms. They blamed it on depression and how they didn't...well...like themselves, but I think it was more behavior." With further probing, she stated, "Prior to the rotation, I never fully understood what mental illness was, but depression is a mental illness. I had an idea of mental illness as people who just could not function because they had hard times or weren't trying or something." Based on her responses, participant #9 did not, with the lecture content given, develop an understanding of mental illness that allowed her to articulate her experiences in terms of the relationships of behaviors she witnessed to mental illness. Additionally, her responses seemed to indicate a compartmental separation of behavior from illness. Rather than glean from content an understanding that behaviors that she observed were related to depression or psychosis, she mentally separated the behaviors from the illness: "They blamed it on depression, but I think it was more behavior."

Subtheme 2: Students were clearly made anxious and fearful by the lecture content prior to arrival at their clinical sites. A recurring statement from the participants in responses to the

interview question regarding their reaction to content was they were clearly made anxious and fearful by the lecture content prior to arrival at their clinical sites. Not all of the students were anxious related to content, but overall in the interviews, certain content did frighten them. Content was delivered based on the *Diagnostic and Statistical Manual V*. It was presented mostly by PowerPoint due to the large amount of content that needed to be delivered in a short time (Scott, 2014). Along with diagnoses and disease processes content, students were given instruction including “self-defense,” as participant #1 labeled it. “Um, based on the lecture content, some patients can become very physical. And you need to know how to navigate, you know, an outbreak or anything like that, and that raised a few concerns. You know, because you know, you’re not supposed to...yeah, I mean, a person’s first instinct is to protect themselves. And you’re not supposed to do that, you’re just supposed to kinda block and ward off slowly. That was more than a little concerning to me.” When further asked about actual content, participant #1 could not remember if they were taught any verbal methods of de-escalation.

Participant #3 reacted similarly: “Um, well, the physical training we had to do really scared me. It scared me more than a little bit. I don’t think I can defend myself very well. It sounded like we were going to have to be on guard every moment—like tense, you know, because we were not safe on the units. We had to be able to react, we couldn’t have our backs to the patients...I was really afraid that I would get hurt.” Only participant #4 had a slightly different reaction to lecture content. “It’s kind of a stigma...it’s just like you...kind of stay away from them because...oh they are crazy. But my outview [participant’s wording] changed because with the lecture I don’t look at them as crazy people any more. So now I just look and think that person is schizophrenic. And I think there is a stigma of patients being violent. Our professor tried to say that only a small percentage are violent. But most people were still scared.”

Despite being told by the instructor that a small percentage of mentally ill patients are violent, participant #6 also admitted to having safety concerns during the mental health rotation. “We had to learn to do holds and everything like that and the whole time I have been a tech on a medical floor we never learned how to do anything like that, so it’s like...okay...what kind of aggression are we going to experience, I guess.” The participant, when probed, went on to say, “I had mental health patients on a medical floor but we handled it by dividing them up based on their condition. We never needed to do self-defense training for that. We were not really trained to deal with them on a medical floor at all.”

Participant #14 described her experience with content in the following manner: “Um...I guess I expected to walk into a room where there were a lot of people screaming and acting out. I expect mental patients to always act out. We talked a lot about kids with conduct disorders and I just expected that they would be trying to fight with me and hurt me as soon as I walked into the room. But when I got there, I didn’t even know they had issues until I...uh...read their charts.” Participant #14 went on to say that the lecture at times made her view patients as crazy, always acting out: “Like, you know, they act out, but I guess that is not every mental patient.” Based on the responses of participants #1, 3, 6, and 14, the lecture content that pertained to safety issues was disturbing for many of the students and caused some angst prior to the actual time spent on the various units used in the rotation.

To answer the third research question, a third major theme was extracted from the interview data. For the students interviewed, clinical experiences did produce a change in attitudes and teaching strategies including paperwork were deemed as difficult to complete and not useful as learning tools for the students. The third major theme follows:

Major theme 3: Clinical experiences and teaching strategies produced a change in attitudes toward mental health nursing.

The major theme that was extracted in relation to the third question was that clinical experiences and teaching strategies produced a change in attitudes toward mental health nursing that ranged from ambivalence about mental health nursing to a confirmation that they did not want to specialize in mental health. Table 4 below indicates participants' attitudinal changes as a result of the clinical experience. The clinical experience includes assignments that must be completed as a result of having therapeutic interactions with a chosen client. Student responses are listed and the numbers of the participants who made the response are included in parentheses.

Table 4: *Changes in Attitudes*

Ambivalent	Definitely do not want to enter mental health nursing
Can't indict all psych nurses, but it seems they are not interested in patient contact (1, 7)	I am not interested in the field (13, 15, 16, 17)
It's a huge struggle to decide (2, 3, 7)	I don't want to get hurt (5, 6, 10, 11, 12, 15, 16, 18, 20)
I didn't see enough to know if I want to do it (2, 3, 7,)	I don't want to lose my skills (1, 3, 7, 8, 10, 11)
I can't decide yet because I don't have enough information (1, 3, 9)	I want to be "hands-on" (6, 8 , 14, 15, 16, 17, 19, 20)
I am not sure (3, 9)	I don't want to work with people who don't get better (5, 7, 15)
Maybe some nurses do more than I saw (14)	I want to treat illness (5, 15, 16, 19, 20)
Maybe I would like it in a community setting (2,3,7)	I don't want to sit behind a desk (4, 5, 13,15, 16, 17, 18, 19, 20)

Two subthemes that emerged from this major theme were related to a belief that entering mental health would cause a loss of technical skills and not having an understanding of the role of mental health nurses. None of the students who participated in the interview process actually expressed a desire to enter the specialty. Those who were ambivalent prior to clinical experiences

felt as though being in the mental health setting for clinical learning rotations confirmed that mental health nursing was not a desired work setting after graduation. Some who had no opinion prior to the rotation responded ambivalently to the final interview question.

Subtheme 1: Students were concerned that entering mental health would cause them to lose their technical skills in nursing. One of the major issues discussed in the interview process was the loss of technical skills while working in the mental health setting. Participant #6 stated, “I don’t think I want to specialize in mental health because I don’t know if it is my thing. I think that it’s more the medical care aspect that gets me. I feel like all of the training we get is for, you know, actual like nursing, acute care. I feel like all the stuff we do in school doesn’t really apply to mental health. You know, like IVs and stuff. You don’t get to use that in the psych facilities. So mental health is much less technological, and we don’t get enough training for mental health. So for now, I have to say that I don’t really want to work in psych.”

Participant #19 described the reason for not wanting to be a mental health nurse: “I don’t think that psych nurses use their other nursing skills and that they limit themselves by saying that they are not medical nurses. And there are no technical skills involved in diagnosing mental illness. If someone has a thyroid problem, you can get labs to confirm. If they have a heart attack, their troponin levels will be elevated. But there is no lab value that tells you a person has schizophrenia. So how do you know what is wrong? Medical nurses have to have great skills and be very smart to catch things as they change with patients. But mental health nurses can only guess at what is wrong. And instructors have told me that if I take a job in mental health, I will lose all of my nursing skills.” Participant #20 related a similar feeling: “I just went through nursing school and I have a lot of new skills. If I take a job as a mental health nurse, I will lose all my skills and I won’t feel like a real nurse.” It is interesting to note here that neither participant #19 or #20 related

concerns about loss of mental health skills if they decided to enter another nursing specialty. Participant #18 also voiced some concerns about loss of skills when entering mental health nursing: “My professor said that if a patient has any medical issues at all, we don’t touch it. We send them right out because we are not medical nurses. We are psych nurses. So I guess that’s why I don’t want to be a psych nurse. It’s really not like real nursing, I guess.” Participant #8 seemed to concur: “It seems like the technical side of nursing is missing. I think that the technical side of nursing is exciting. I think I would be bored as a psych nurse.”

Given the responses of participants #19 and #20, it would appear that the belief that psych nursing causes a loss of technical skills is being perpetuated by clinical rotations where nurses are not willing to address medical issues and where technical skills are not used by nurses. In addition to concerns about loss of technical skills, the second subtheme answering the third research question was students did not really obtain an understanding of what mental health nurses did in the clinical area.

Subtheme #2: Students did not understand the role of the mental health nurse even after the clinical rotation. When asked about their experiences at the various clinical sites, students were often frustrated by the fact that they never really came to an understanding of the role of the mental health nurse. Some of them felt that the assignments given were meant as busy work rather than actual learning experiences. Participant #4 related, “I liked going to the AA meeting and writing about it, but I didn’t learn how to be a psych nurse. It was just a meeting.” Participant #15 described the change from being ambivalent about mental health to definitely not wanting to enter the specialty. “From my experience, I would say that I would have considered mental health potentially, but I think now that I have seen that mental health nurses don’t really do a lot, I can’t work like that. I need to be busy, to know that I am really helping someone get better. When we

learned about groups and educating the patients in lecture, I thought I would enjoy doing that. But I don't really see that happening.”

Participant #15 related that he came into the rotation with an open mind, but his mind was changed very quickly by what he observed on the unit. “For the most part, honestly, like, I saw them at the desk, mostly doing paperwork, I guess. I am not sure what some of their titles were, but there were people there, who were not dressed in scrubs...maybe activities...they seemed to be doing more with the patients...like on the floor doing activities and such. When I was introduced to who the nurses were, they were mostly at the desk. That made me decide that I do not want to be a psych nurse because I honestly love being...I want to be tactful...I love being hands-on and I like the balance between the patients and the paperwork. But seeing them just strictly at the desk, whether that was their duty or not, for the full shift...that just turned me off. Because I like to work with patients. I want to be able to understand them more...and their background, so really, when I saw them just sitting there I was just like...I definitely do not want to do this.”

Participant #8 made some similar observations in his rotation: “I see nurses giving medication and I see nurses who talk to the patients some of the time. But it is mostly the psych techs, who really connect with patients. I don't want to indict all psych nurses, because this was just one floor, but I think maybe that they should do more to try to connect with the patients instead of writing on charts and giving medications.” Participant #7 says that he did not see enough on the units to decide about his career choice after graduation: “We did not give medications, nor did we do any kind of groups. We were told it was an observational experience, and we spent time watching what was going on but not participating. I kept wondering when my patient was actually going to be allowed to sit down and talk with me. It was hard to get my process recording done

because the patients were always doing other things. I wanted to practice therapeutic communication but I just couldn't. This was supposed to help with our understanding but there was no time, so it became an assignment that we just had to get done. We also had to journal about the experience, but not really getting a chance to talk to patients, it was really hard to journal. The assignments seemed like busy work.” The inference this researcher made from the data was although various teaching strategies were used in the clinical areas, including the process recording and reflective journaling, students felt that time limitations made the assignments feel like busy work rather than learning activities.

The previous section provided a discussion of the analysis of data gleaned from the research. From the data, the researcher was able to answer the three research questions as follows:

1. Undergraduate nursing students' attitudes ranged from favorable to unfavorable but were mostly unfavorable.
2. Content in some cases has impacted student attitudes negatively, creating some degree of anxiety and fear regarding content related to safety on the unit and the compartmentalization of mental health rather than holistic thinking
3. Clinical experiences and the teaching strategies that are associated with clinical experiences often had a negative impact on students' attitudes toward mental health nursing due to concern about losing technical skills and not understanding the role of mental health nursing.

Summary of Data Analysis

In response to the first research question, the researcher learned that undergraduate students' attitudes were often related to and based on exposure to mental health nursing and

exposure through other sources, such as media and the opinions of others. In the interviews, students talked about avoidance of mental health patients due to the stigma they carried. This stigma also transferred to mental health nursing. The first major theme that was derived from the interviews was that students had varied attitudes and perceptions toward mental health nursing. The first subtheme was that perceptions ranged from favorable to unfavorable. The second subtheme was students' attitudes and perceptions were frequently related to prior experience. In particular, some non-psychiatric nurse educators did have negativistic views of mental health nursing that they passed on to students by advising them not to enter the specialty. Students had either positive or negative feelings based on what they observed within the rotation or outside of school. Students who worked with mental health patients or who had family members or friends who were treated by mental health nurses showed more positive attitudes than those who did not. Students whose experience was through media prior to the rotation often had the most negative attitudes.

In reviewing the data analysis for the second question, this researcher concluded that content taught in the mental health course led to fear and anxiety of working with mental health clients. The fear and anxiety ranged from fear for personal safety to fear of saying the wrong thing and upsetting a patient or fear for personal safety, thus perpetuating negativity regarding the specialty. During the mental health rotation, students were taught that they needed to be on their guard, the way of escape should never be blocked, and they needed to be careful what they say in order not to incite a patient to violence. This was very anxiety-producing in most of the students this researcher interviewed.

The third question relating to clinical experiences led to the conclusion that, for this group of students, clinical experiences and teaching strategies did not lead to positive attitudes toward

mental health nursing. In fact, these strategies and clinical experiences could have contributed to students who had a possible interest in mental health nursing becoming ambivalent regarding the specialty. It remained unclear whether the brevity of the experiences or the lack of variety in experiences were the major contributors to this negativity regarding mental health nursing. Clinical paperwork the students completed was a chore rather than a learning experience, since students were often not given access to the clients on the unit for one on one therapeutic interactions. Additionally, teaching strategies were not varied due to the brevity of the rotation, thereby making deep learning difficult if not impossible.

CHAPTER 5 – CONCLUSION

Data analysis reveals three major themes that are related to the research questions. In addressing key concepts for question one, the major theme was student nurses had varied attitudes toward mental health nursing. Two subthemes related to question one indicated students attitudes ranged from favorable to unfavorable and often these attitudes were based on previous experience to mental illness and mental health nursing. Some students had favorable attitudes related to prior experience with treatment of family and friends and some held unfavorable beliefs, often related to stereotypes and media portrayal of mental illness. Careful analysis of the data revealed the second major theme as it related to the second research question. The major theme was students had varied understanding of mental illness and mental health nursing. The first subtheme indicated even at the end of the rotation, students continued to display a lack of understanding of mental illness. A second subtheme emerged as a result of the lack of understanding of mental health content as the students continued to compartmentalize mental illness and physical illness rather than viewing the mentally ill holistically. The third major theme was clinical experiences and teaching strategies produced attitudinal changes in undergraduate nursing students. The first subtheme from the third major theme included students were concerned over loss of technical skills. Students did not want to enter the mental health specialty, often because they felt it would cause the loss of technical skills and limit their possibilities in other areas of nursing. The second subtheme was participants did not comprehend the role of the mental health nurse even after clinical experiences. The lack of understanding of

the role of the mental health nurse led to an attitudinal change in some students from prior ambivalence to decisively stating they did not want to enter mental health nursing.

The purpose of the following section is to review, analyze and discuss the study findings as they related to the current body of literature and conceptual framework of stigma. In this chapter, the researcher describes the implications and recommendations based upon the current findings as they relate to mental health nursing education. In addition, the chapter includes changes in the researcher's thinking and recommendations for future research as well as the limitations of the research.

My initial interest in this area came from concerns about the stigma associated with mental illness in society in general. Nurse educators must provide and model holistic and non-judgmental care for all clients; however nursing education has not modeled holism in content, clinical experiences or teaching strategies (Happell & McAllister, 2015). Despite concern about the stigma attached to mental illness and mental health nursing as a specialty, there was no other qualitative research regarding how nursing education affects attitudes that may lead to stigma and courtesy stigma. Until now, only one other researcher has investigated the effects of attitudes of non-psychiatric nurse educators on undergraduate nursing students.

Summary of Findings Related to Existing Literature and to the Conceptual Framework

This study was the only study in the literature which phenomenologically explored the attitudes of nursing students toward mental health nursing and how nursing education affected these attitudes. As indicated in the literature review, most studies have been done quantitatively. Harms (2010) qualitatively focused on exploring how non-psychiatric nurse educators' experiences with mentally ill patients influenced their perceptions of and ability to work with the mentally ill, but did not explore their views about how their perceptions and nursing education

affected their students' perceptions. However, in the significance of findings section in her dissertation, Harms did—based on her overall findings—report, “Faculty must be aware of their own attitudes and the impact these have on students’ learning and perceptions about the population” (pp. 80–81). Some of the participants in my study indicated that faculty had made disparaging comments when they spoke of mental health nursing. Gerrity, (2012) also qualitatively studied how the attitudes and perceptions of nurse educators impacted their students’ attitudes. She discovered that nurse educators did believe that there was a direct relationship between their attitudes, and their level of comfort with mental health patients translated to their students. She did not, however, explore the relationship of content, teaching strategies, and clinical experiences on students’ attitudes. This researcher could not find other studies related to attitudes based on the three concepts that drove the research questions for this study.

In completing this study, this researcher discovered that students had many preconceived ideas prior to entering the mental health rotation in their program, and that their nursing education did influence their feelings about mental health patients, mental health nurses, and entering mental health nursing as a specialty. Based on Goffman’s stigma model, students gained their understanding of mental health through many avenues, including the experience they had in the mental health rotation through content, clinical experiences, or assignments (teaching strategies). Mental health stigma and stigmatized attitudes toward those who work with the mentally ill were socially constructed. In the educational environment, students were highly influenced by what was observed and taught. In the clinical areas, students observed nurses who were unwilling or unable to meet with patients. This directly contradicted the concept that mental health nursing was (or should have been) relational in nature. In the students’ experience, mental health nurses remained behind windows or locked doors, not relating to patients except when there was a crisis or when it

was time to dispense medications. What was real to the student depended on what was observed and what was socially acceptable (Goffman, 1963). To the student, it was not socially acceptable to remain in an area of the unit that distances nurses from patients; however, this was the reality they experienced in their clinical rotation. Unfortunately, the participants in this study had a very brief and narrow look at the nature of mental health nursing and often observed the socially unacceptable behavior of nurses distancing themselves from the patients in their care thus adding to the belief that mental health nurses did not want to be “real” nurses.

Additionally, Goffman indicated in his work that an individual who may have been acceptable in some cultures was stigmatized based on possession of an undesirable differentness that others in the culture did not understand. Therefore, that person (the mental health nurse) is looked upon with negativity by other nurses and perhaps nurse educators because of a desire to work with socially unacceptable persons. As participant #3 indicated, “there is something wrong with someone who wants to work with people who want to hurt them.” Again, the educational experience did very little to de-marginalize the mentally ill or mental health nursing.

The mental health rotation at the study site was not unlike the rotations described in the literature review completed prior to the study. Securing clinical placements for mental health (as in other specialty areas) may be challenging; however, Happell and McAllister (2015) indicated that, in their mixed-methods study, “no participant discussed the need for locating and providing clinical learning opportunities across the range of spaces in which mental health nurses are, or could be, working” (p. 334). The reality created by clinical experiences in undergraduate nursing programs stigmatized both mental health nurses and mental health clients because students did not get the opportunity to observe nurses who were leading groups, doing individual therapy, teaching, and interacting meaningfully with mental health patients, nor did they get to observe mental health

patients who are functioning in society and living productive lives. Nursing education should be relevant to practice and should provide opportunities for students to appreciate and understand mental health nursing as it is practiced in the 21st century. Although nursing education has moved to community-based practice at the BSN level for many other areas, there seems to be a disconnect from the community-based model when it comes to mental health (Happell & McAllister, 2015). Here it is important to mention the APNA Essentials of Psychiatric Mental Health Nursing (2007) in the baccalaureate curriculum include Patient Care Roles (#6) and Health Care Settings (#7). While understanding evolving care settings is listed as a component of #7, it seems to be glazed over in the curricula of BSN programs as the medical model and disease process continues to be taught. Clinical placement remains all too frequently in acute locked settings (Happell & McAllister, 2015).

Additionally, although nursing education has made a concerted effort to destigmatize the elderly population through varied community experiences, this has not been the case in the area of mental health (Gerrity, 2012). In many undergraduate programs, clinical experiences in nursing care of the elderly included community center experiences with elderly clients who were active and continued to contribute to society through activities like feeding the homeless, making blankets for maternity centers, and offering services to homeless veterans. The purpose of these experiences was to destigmatize the elderly and give a more realistic picture of how many elderly persons have been able to remain active citizens. In my own nursing program, clinical experiences included community senior centers. Additionally, during lecture, role plays and skits were incorporated as a teaching strategy for the purpose of conveying to students the perceptions of senility and fragility often ascribed to the elderly were inaccurate. As lead mental health instructor at my program, I have incorporated teaching strategies that debunk some of the myths surrounding

the mentally ill and mental health nursing; however, our clinical sites remain in acute hospitals on locked units.

As important as teaching mental health through a community-based lens is, educators continue to teach content based on the idea that mental health patients are dangerous, which leads to further stigmatization of the mental health patient and deters new nurses from entering the mental health specialty. Participant #18 stated, “When they told us about how we need to be on our guard, I got this picture of people trying to just attack me for no reason. I thought about how that stigmatized nurses, too. I thought they must have problems of their own to want to work in that environment.” Natan, Drori, and Hochman (2015) addressed courtesy or associative stigma among educators and professional nurses. Mental health nurses were believed to be “neurotic, inefficient, and unskilled,” as well as having mental problems of their own (p. 388). Nursing education did very little to dispel this myth in the content that was taught.

Implications for Change in Nursing Education

The results of this study suggest two opportunities for change in nursing education. The first opportunity is in the clinical experiences that are assigned to students. Because mental health preparation needs to be relevant to practice, (as preparation for all areas of nursing does), clinical opportunities should be provided that cover the full spectrum of mental health care, from primary care to targeted interventions to treatment (crisis, acute care, and outpatient) to recovery and rehabilitation. Most mental health patients are no longer in state hospitals or in acute care units. Just as nursing education has shifted paradigms from hospital care to community-based care in other areas, the same shift needs to occur in the area of mental health nursing. Psychiatric nurses practice in a variety of health settings, caring for individuals from conception through late life who are highly vulnerable and at risk for mental health disorders. Even with a growing body of literature

about the importance of mental health, risk factors for mental illness, and mental health-related disparities, the focus on mental health promotion and disease prevention continues to be minimalized in nursing education (Pearson et al., 2015). Additionally, the safety content should be taught as it relates to all clinical experiences since aggressive and angry behaviors are not limited to those who are mentally ill.

Secondly, to develop a clearer understanding of content, nursing instructors should develop engaging ways to teach mental health nursing. In the traditional classroom, students are passive learners who take copious notes or endeavor to memorize PowerPoints in order to pass a content exam. Students can become more active learners by being involved in problem-based learning, case studies, and gamification (Day-Black, Merrill, Konzelman, Williams, & Hart, 2015). With these methods, students may spend more time learning outside the classroom, but will have a richer learning experience within the classroom setting. “Active learning methods help students move away from being ‘spoon-fed’ facts and figures to developing concepts, understanding principles and applying knowledge in practice” (Day-Black et al., 2015, p. 90). Nursing education must continue to transition to keep pace with changes in practice. Just as nurses in the clinical setting must challenge routine interventions, nurse educators must meet the challenge to change pedagogy to inspire deep learning in students. Mental health nursing as a practice continues to evolve into a much more evidence-based science (Harmon and Hills, 2015). Content taught in mental health courses should include newly revised mental health standards of practice that include research, communication, and collaboration skills recommended in the Quality and Safety Education for Nurses (QSEN) pre-licensure competencies, and the AACN (2008) Baccalaureate Essentials (Harmon & Hills, 2015). As mental health nursing evolves, nursing education must evolve with it. Teaching based on QSEN competencies may help change attitudes toward and stigmatization of

those with mental health disorders and those who care for them, additionally encouraging mental health nursing as a positive choice for specialization. The QSEN standards include the following: Patient centered care, teamwork and collaboration, evidence based practice, quality improvement, safety, and informatics. While evidence based teaching indicates that lecture delivered through power point slides is not likely to produce deep learning, nursing educators continue to use lecture and power points as a major teaching strategy (Harmon & Hills, 2015). In the classroom setting, learning can be enhanced by using case studies, gaming, and other evidence based teaching strategies (Day-Black et al., 2015). Since evidence also indicates more and varied clinical experiences contribute to engendering more positive perceptions towards mental health nursing, nursing education should include more clinical time in areas other than acute care for the mental health rotation.

It is hoped that this study will encourage nurse educators to engage in self-reflection to assess whether their own pedagogy has or has not continued the marginalization and stigmatization of mental health nursing and mental health patients. It is hoped as well that nursing education will move toward a community based model in mental health education. In addition, this research is intended to encourage faculty to re-assess the curriculum components in both theory and clinical rotations to determine if stigmatization of mental health patients and nurses is addressed. It should also be mentioned that both theory and clinical rotation should be examined to determine if sufficient time is allotted to provide a quality educational experience for students. Nurse educators, students, and other mental health professionals can actively address stigmatization of mental health and mental health nurses to help diminish the deleterious effects of contributing to their own stigmatization.

Additionally, the results of this study yields implications for social change. Positive social change includes actions to promote the dignity and worth of all individuals. To address the potential for positive social change, the results of this study indicates nurse educators should examine their pedagogy and utilize evidence based teaching practices to ensure deep learning leading to the demarginalization of mental illness and mental health nursing. By reflecting on their own pedagogy and the impact it has on the perceptions of undergraduate nursing students on mental illness and mental health nursing, nurse educators may develop an increased awareness of their own attitudes toward mental illness. Additionally, it may encourage undergraduate nursing students to develop a truly nonjudgmental attitude of caring for all clients with the same respect, regardless of their diagnoses. Most importantly, with the suggested changes to pedagogy, nursing students may be more likely to enter the mental health specialty based on a more realistic experience in their nursing education.

Reflections on the Research Experience

On a personal level, I noted a shift in my self-confidence as a researcher because of the research process. When I began my journey with the University of Alabama, I was full of self-doubt about my ability to successfully complete the requirements of a rigorous doctoral program, as well as a research study. Although my level of self-doubt gradually decreased with successful completion of each course, my lack of self-confidence continued until I completed my interviews and data analysis. As part of the study's design, I returned to the participants to determine if my findings accurately reflected their experiences. When all participants agreed that my description of findings was an accurate reflection of their experiences, my self-doubt was lifted.

I also doubted that I would be able to set aside my personal biases as a researcher because of the passionate beliefs that I have about the need to care for the mentally ill with both competence

and compassion. I was able to minimize personal biases in essentially three ways. First, I communicated to the students who participated in the research my own interests as a researcher. Second, I used my journal to bracket (or set aside) my own personal feelings that arose during the course of the study. Through the use of the research journal, I was able to reflect on my personal feelings and biases while not allowing them to interfere with the analysis and interpretation of the data. Third, in the process of interviewing students, I used open-ended questions and a nonjudgmental approach to guide the exploration of the participants' lived experiences of the mental health rotation. Open-ended questions began with phrases like *describe*, *tell me about*, and *what are your experiences...?* Through these three strategies, I was able to minimize personal biases, and the participants were able to openly share experiences during the psychiatric mental health rotation and with mental illness, a topic that many may conclude to be sensitive in nature. When using probing questions, I was careful to avoid choosing words or comments that would bias the responses of the participants.

Changes in My Thinking Because of the Study

In the course of the study, I have had some significant changes in my thinking about the phenomenon explored. I began this journey with a passion about addressing the stigma of mental illness and mental health nursing in order to recruit new and competent nurses to care for this stigmatized group. During the study, I maintained a journal to bracket my thoughts and feelings so that I could focus with wide-open eyes and ears on exploring the lived experiences of the participant BSN nursing students with the phenomenon. I learned both attitudes and experiences were diverse, and that the experiences of a very brief mental health rotation in nursing school did not contribute positively to their attitudes. I also learned even though their clinical experiences did not contribute positively to their perceptions of mental health nursing, students wanted to be

compassionate toward the mentally ill. As participant #19 stated, “After all, these are people, too, and we need to take care of them when they have a medical issue.” Finally, I came to understand mental health nurses significantly contribute to their own oppression by making broad statements indicating a lack of willingness to treat medical issues. Prior to this study, I did not consider how the statement contributes to the negative view of mental health nurses. Mental health nurses need to remember that first of all they are nurses who must treat their patients as whole people, not people who are compartmentalized into mental and physical. The nursing education courses during my studies at the University of Alabama have certainly reinforced the concept of holism.

Study Limitations

This study was conducted at a small religiously sponsored university in southeastern Pennsylvania. It represented only a small number of students in mental health nursing, and the perceptions that were uncovered may not necessarily be ascribed to other nursing students. While qualitative phenomenology is not intended to be generalized to a broad group or population, it is hoped that the responses of the participants will be powerful and add to the body of work regarding the stigmatization of mental health patients and the associative stigma of mental health nursing.

Recommendations for Further Research

Further research should be completed in the area of specific content and teaching strategies that may be utilized, leading to the de-stigmatization of mental health patients and mental health nursing. In addition, research on changes in attitudes of students after a rotation in the community should be completed to assess how varied clinical experiences may de-marginalize mental health nursing as a specialty. While there has been research on clinical experiences related to length of time spent with a preceptor (Happell et al., 2008), there has been little qualitative research addressing how experiencing mental health patients in the community changed attitudes and

beliefs about mental illness. There has also been little research investigating the effects of various teaching strategies on comprehension of mental health content. Further research should be completed on effective ways to educate both students and non-psychiatric nurse educators to meet the needs of the mentally ill patient. In addition, replication of this study with participants from other nursing schools would be helpful.

Conclusion

In this study, the researcher explored BSN nursing students' lived experiences with and attitudes toward mental illness and their perceptions regarding how content, clinical experiences, and teaching strategies affected those attitudes. The researcher used a phenomenological design and one-on-one interviews with 20 students in their summer rotation in mental health.

The findings of this study are important because no other scholars had directly explored nursing students' perceptions of content, clinical experiences, and teaching strategies or how nursing education affects students' desire to enter the mental health nursing specialty. According to Pearson et al. (2014), "even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services" (p. 14). Gaining an understanding of how pedagogy affects students' attitudes in this area may ultimately have an effect on the patients for whom those students will care in both medical units and mental health units. Thus, these attitudes may also affect patient care and increase access to care for the mentally ill far into the future.

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APPENDIX A: INTERVIEW QUESTIONS

1. Describe your experiences with mental health clients.
2. Can you tell me about at least one experience working with a mental health client this semester?
3. How did you feel about mental health clients before the rotation? Did your feelings change after the rotation, and if so, in what way?
4. After hearing the lecture content, did you have any concerns about working with mental health clients? If so, what were those concerns?
5. Have you encountered any barriers while working with mental health clients during clinical experiences? If so, describe what those barriers were.
6. Tell me why you do or do not wish to enter the mental health specialty.

APPENDIX B: INTERVIEW NOTE-TAKING TOOL

Date: _____

Time Interview Began: _____

Time Interview Concluded: _____

Participant File number: _____

(Participants were assigned a number during the interview process to ensure anonymity.)

Questions <i>(see Appendix A)</i>	Potential follow-up questions or significant participant statements	Personal thoughts, impressions, or comments

Validation of transcripts (Participants)		
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APPENDIX C: RESUME OF LOIS KONZELMAN

36 School Rd., Horsham, PA 19044

215-479-2779

Lois.Konzelman@gmail.com

Summary

Nurse Educator

Values and supports the use of evidence-based practice in nursing; passionate about educating the future generation of nurses

Compassionate, caring, and knowledgeable in current practice

Enthusiastic about nursing education both in the classroom and in clinical work to advance the profession of nursing

Believes nursing should be defined not by other health professions but rather by nurses themselves as nursing moves to community-based and primary care models

Education

Doctor of Education in Instructional Leadership, expected graduation	2017
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University of Alabama, Tuscaloosa, Alabama

GPA: 3.9

Completing classes toward obtaining an education degree in nursing. Completed practicum at Gwynedd Mercy University, doing clinical and didactic teaching, student assessments, evaluations, and outcomes assessments.

Master of Science in Nursing	2011
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Temple University, Philadelphia, Pennsylvania

GPA: 3.6

Completed practicum at Widener University, including lecturing, developing learning activities for undergraduate students using group activities and student learning assessments; used technology as means of teaching hands-on nursing skills; assisted in the clinical simulation lab. Developed clinical simulations and role plays in the area of mental health nursing.

Bachelor of Science in Nursing 2007

Temple University, Philadelphia, Pennsylvania

GPA: 3.5; graduated cum laude

Completion of RN Diploma Program 1984

St. Francis Medical Center, Trenton, New Jersey

GPA: 3.5

Career history and accomplishments

Nurse Educator, Roxborough Memorial Hospital School of Nursing 2014 - present

Classroom and clinical instructor in Freshman term of 21-month RN diploma program.

Mentor and role model for students in the beginning phase of their nursing career.

Counsel and assist students in need of extra help.

Nurse Educator, Prism Career Institute

2012-2014

Classroom instructor in Growth and Development, Body Structure, and Function and Pharmacology I. Also assisting where needed in mental health nursing and clinical labs. Current position is working with disadvantaged students to give them an opportunity to change their lives.

Visiting Nurse, Abington Home Health

2011-2012

Visiting clients in their homes, doing psychiatric evaluations, and making treatment recommendations to clients and physicians. Using clinical judgment in the field to ensure the safety of all clients.

Utilization Review Coordinator, Montgomery County Emergency Services

2009-2012

Responsible for reviewing clinical data with third-party payers and ensuring appropriate levels of care for clients. Collaborated with reviewers to assist with difficult dispositions in finding appropriate placement in the community when possible. Composed and followed up appeals letters.

Clinical Instructor, Gwynedd Mercy College

2009

Mentored and guided students in the psychiatric nursing clinical rotation. Encouraged critical thinking skills in utilization of the nursing process as students transferred classroom theory to the clinical setting. Read and commented on self-reflection journals, submitted evaluations of student learning to the program coordinator.

Clinical Instructor, Montgomery County Community College

2008

Mentored and guided students in the psychiatric nursing clinical rotation. Encouraged critical thinking skills in utilization of the nursing process as students transferred classroom theory to the clinical setting. Read and commented on self-reflection journals, submitted evaluations of student learning to the program coordinator.

Charge Nurse, CATCH INC.

2002-2009

Worked with mentally ill clients in a long-term setting. Supervised psychiatric technicians, administered medications, and developed recovery-friendly treatment plans. Evaluated learning needs of staff and developed in-services to meet those needs. Developed in-service education for staff and delivered in-services as needed.

AFFILIATIONS and PUBLICATIONS

American Nurses Association

Pennsylvania Nurses Association

Sigma Theta Tau Honor Society of Nursing

APNA

NLN

AJBNF – Gamification: An Innovative Strategy in Nursing Education Fall 2015
