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## **The experiences of undergraduate nursing students working in mental health care settings in the Western Cape, South Africa**

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### **Abstract**

The mental health care environment is perceived to be a stressful clinical learning environment for nursing students to work in due to a myriad of factors. These factors include amongst other, the physical environment, the patient population, perceived student unpreparedness and the emotional demands placed on the students which are inherent in the nature of the work. The use of the self as a therapeutic tool in caring for mentally ill patients may also present a challenge for students. The aim of this study was to explore and describe the experiences of student nurses working in this challenging environment. A qualitative approach using an exploratory, descriptive design was used. Purposive sampling was employed to select sample of 36 student participants who met the eligibility criteria. Data collection was by means of focus group interviews. Data were *analysed* by means of Tesch's method of content analysis. Lazarus's cognitive transactional model of stress-appraisal-coping was used to structure the themes. The main themes were organisational, sociological, physiological and psychological emotional responses. Each main theme had sub-themes namely: effect of the organisational climate and organisational culture; socio-cultural background and youthful age a detriment; bodily responses and lastly, the compromised self and the self in growth. In conclusion, students' mental health experience was perceived as mostly negative and coping was problem-focused. A quantitative study to measure student stress, anxiety and depression among student nurses working in mental health care settings and also from other diverse student populations should be conducted.

**Keywords:** Experiences, Higher education institution, mental health care settings, student nurses.

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### **Introduction**

The mental health care environment is stressful for health care workers and especially student nurses (Tully, 2004; Pryjmachuk & Richards, 2007; Morrissette & Doty-Sweetnam, 2010). The stress experienced by the students may be due to internal and external factors. Internal stress refers to the sources of stress emanating from within the individual who includes thoughts and beliefs the students may have about the mental health care environment. This includes, among other, the stigma associated with mental illness and the negative stereotypes against people who have mental illness (Happell & Gough, 2007). Students may experience intense fear, worry and anxiety about caring for the

mentally ill patients who are oftentimes portrayed as unpredictable and violent. They may also experience a myriad of emotions related to the stigma they experience about associating with mentally ill patients in other words 'stigma by association' (Halter, 2008).

In anecdotal reports, students working in mental health care settings in the Western Cape stated that they were afraid of the patients. The fear of the unexpected, the locked wards and the stories they had heard about mentally ill patients' from the clinical staff appeared to exacerbate their own insecurities. Notwithstanding the two week orientation at the beginning of the year provided to prepare students for the clinical placement, they remained fearful.

External stress originates from outside the individual and refers to situations or events that the nurse has no control over. This may be an unsatisfactory working environment which is fraught with challenges such as staff shortages, lack of safety and conflictual interpersonal relationships among others. The placement of students in clinical settings may also be perceived by mental health care staff as an additional load in an overburdened environment. Staff may not have time to address the students' learning needs. Students may then feel that they are being used as cheap labour to do menial tasks instead of having their learning needs met (Nolan & Ryan, 2008). In addition, Bunce (2002) asserts that students might not know what nurses actually do, and thus have unrealistic expectations of clinical placement. This situation may result in miscommunication between the staff and the students, which leads to student's experiencing emotional distress as qualified staff place pressure on them.

Emotional distress in students may also be precipitated by the students' educational unpreparedness, thus contributing to the perception that the mental health environment is stressful. Students who deem themselves unprepared to work in the mental health care setting may lack clinical confidence, which implies that they do not think that they can work in mental health care settings. This is usually based on lack of mental health care experience (Bell, Horsfall & Goodin, 1998). However, this may be perceived as inadequate preparation for the nature of the work and perceived lack of support and thus unpreparedness for the complexities of mental health nursing (Magnussen & Amundson, 2003; Ewashen & Lane, 2007).

The emotional demands of mental health nursing may also be related to the interpersonal relationship, which is the central focus of mental health nursing care (Frisch & Frisch, 2011). This relationship between the student and the patient is a therapeutic process where interventions are planned and implemented. Within this process, students have to use themselves in such a way that they become a therapeutic instrument in the intervention process. This

provides the opportunity for person-to-person connection (Frisch & Frisch, 2011). Barker (1992: 62) alludes to the therapeutic process as a 'potential emotional minefield' - as the student has to have a greater sense of self-awareness and self-understanding. It is through knowing themselves that the students are able to care for mentally ill patients. The use of the self may present challenges for students who have an underdeveloped self-concept. They may feel insecure and question their ability to help people with mental illness (Stuart, 2009).

The assumption is that one of the ways to address the challenges student nurses experience in the mental health care setting, is by providing the needed support. There are existing student support services at the university, for example academic support and therapeutic services are offered to the general university student population. The challenge however, is that these interventions focus on students' learning needs and general mental wellbeing. They do not necessarily address specific aspects relating to self-awareness, emotional resilience and self-efficacy - neither does it offer emotional support for students working in mental health care settings.

This article therefore reports on a study conducted by a lecturer at a higher education institution which aimed to explore and describe the emotional experiences of nursing students' working in mental health care settings,

## **Methodology**

A qualitative research approach with an exploratory descriptive design was used to achieve the aim of this study. A total of 36 fourth-year nursing students were purposively sampled and volunteered to participate in the study. The students were from the University of the Western Cape and in the final year of study in the Bachelor of Nursing degree.

Focus group discussions were held with students during October–November 2011 before the students completed the nursing programme at the end of 2011. Five focus groups were conducted, with between five to nine participants in each.

Development of the data collection tools was influenced by Lazarus's Transactional model for stress-appraisal-coping and the study objectives. The interview guide focused on experiences of participants while working in mental health care settings.

The data were analysed using Tesch's approach to content analysis by identifying themes in the data which allowed for structured organisation of data

to take place (Creswell, 2003). The Nvivo 8 software package was used to facilitate the process of storing, sorting and analysing the data.

Trustworthiness was ensured by credibility, transferability, dependability and confirmability. Credibility was ensured by spending time in the field to establish rapport with the participants. All interviews were audio-taped. Transferability was ensured by the presentation of a dense description of the participants, research context and setting together with appropriate quotations from the data collected. An audit trail and coding of data by an independent coder enhanced the dependability of the study. Reflexivity occurred through the use of a self-reflective journal.

Ethical clearance for the study was obtained from the Ethics Committee of the University of the Western Cape. Permission for access was obtained from the relevant authorities. Informed consent was obtained from each participant before they could participate in the study. The participants were assured of anonymity and confidentiality.

## **Results**

Students' experience of working in the mental health care setting focused on the organisational, sociological, physiological and psychological emotional responses that were elicited whilst working in the Higher Education Institution (HEI) and mental health clinical setting are reflected in Table 1.

**Table1:** Emotional responses of students' working in the mental health care setting

<b>Main themes</b>	<b>Sub-themes</b>
1. Organisational emotional response	1.1 Effect of the organisational climate 1.2 Organisational culture
2. Sociological emotional response	1.3 Socio-cultural background 1.4 Youthful age a detriment
3. Physiological responses	1.5 Bodily reactions
4. Psychological emotional response	4.1 The compromised self 4.2 The self in growth

## **Discussion**

A literature control is presented during the discussion with the purpose of supporting the findings of this study through existing literature.

### **Theme 1:** Organisational emotional response

The organisational emotional responses refer to the climate and the culture of the mental health care environment and the influence thereof on the participants.

*Sub-theme 1.1 Effect of the organisational climate*

Some participants' appraisal of the organisational climate purports a sense of mutual trust, warmth, support and recognition, as being unsupportive. The organisational climate is a description of the mental health setting by the individuals (includes students) who work in it. Features such as communication, leadership, conflict and rewards depict an organisational climate (Castro & Martins, 2010). Students reported being unprepared to work with patients despite being exposed to theoretical content: *"I don't think anything can really prepare you until you actually come to the setting...you can sit in a class but if you don't see the actual patients in the hospital, you can't really be prepared"*. Students appeared to lack confidence in their skills and could not articulate them with conviction, which resulted in distress. This finding is supported by Wells, Ryan and McElwee (2000), who conducted a study in Ireland exploring factors inhibiting the recruitment of psychiatric nurses. These authors found that psychiatric students lacked clinical confidence as they perceived themselves to be inferior in terms of their skills base.

#### *Sub-theme 1.2 Organisational culture*

The participants' emotional distress was compounded by the organisational culture. Organisational culture refers to everything that staff in the mental health care setting think, do or make. This includes the ideas, morals, languages, attitudes and feelings which are shared by the staff and are consciously or unconsciously passed on to the students (Silove, 2004). The perceived negative attitude of the clinical staff emanated when students were called derogatory names: *"They [clinical staff] call us licensed to kill"*. Operrario and Fiske (2001) assert that this type of stereotyping is attributed to interpersonal communication that transpires in the mental health care environment. This relates to attitudes and judgements about the students, based on what clinical staff have learnt through communication with others rather than personal experience.

### **Theme 2:** Sociological emotional responses

#### *Sub-theme 2.1 Socio-cultural background*

The participants came from diverse cultural backgrounds which influenced their beliefs about mental illness. Students' socio-cultural background relating to beliefs about bewitchment was influenced by knowledge gained in the theory and practice setting: *"Going back looking at the background where...I was born in Kwazulu Natal...I know that these people are psychiatry people. They were mentally ill. Back that time I always believed that this is witchcraft...If we take them to sangomas [traditional healers] and sangomas will perform everything...you believe that she has been cured."*

Cultural and ethnocentric beliefs appeared to influence students' understanding of mental health. It was evident that the student questioned his cultural background.

The mental health experience evoked a sense of 'rootlessness' as the student felt that beliefs were based on myths rather than facts, as reported:

*"Well, emotionally, it made me feel I don't know where I'm coming from because of the way we do things. The way we judge people because it is not based on any... facts...it is just myths."*

### *Sub-theme 2.1 Youthful age a detriment*

There appeared to be a perception that the students were inexperienced because of their relative youth in terms of their chronological age. Students reported being stigmatised because of their age: *"...because we [students] are young... they [clinical staff] stigmatise you. You're young, you... fresh out of school, you... know nothing about psychiatry or how to...handle the patients"*.

However, cognisance should have been taken of the fact that they were fourth year students with clinical exposure to nursing education and training; they had also followed the same nursing curriculum as their older counterparts. It can therefore be inferred that maturity was linked to age rather than life experiences, implying that older students knew how to manage mentally ill patients.

## **Theme 3:** Physiological emotional responses

### *Sub-theme 3.1 Bodily reactions*

Emotional distress at being overwhelmed by the mental health experience manifested in students' reporting physiological signs and symptoms. Some students reported sleep disturbances such as nightmares and cognitive difficulties, namely the inability to concentrate, as illustrated by the following quotation: *"...I would have nightmares about those patients"* However, some students were unable to detach themselves from the experience and reported experiencing vegetative symptoms such as hypersomnia, insomnia and lethargy which could be linked to depression were reported by students: *"I always want to fall asleep because I am always tired" and "You can't sleep. You always thinking about this and that..."*

Other physiological symptoms experienced by students included loss of appetite, chest pain and behavioural symptoms such as crying when listening to patients' stories. Students reported: *"I don't eat. I don't feel hungry"*

*"She was ....in tears when she told her story...I would end up crying as well"*

A constricting chest pain which resulted from the intense anxiety experienced by a student, in response to the mental health experience is evidenced by the following quotation: *"... you feel some pain from here...the chest. Like you can't breathe"*

This student was booked-off as being ill due to 'stress' at the time of the focus group discussions. She volunteered and participated in the focus group discussion despite her ill-health. The rationale for her participation was that awareness had to be raised about the emotional experiences of students in mental health care settings. This may be interpreted as the student's perception that the focus group discussion was a platform to raise her otherwise 'silent' voice. It may also have been cathartic (self-healing), in view of the student's physiological symptoms at the time of the focus group discussion.

**Theme 4:** Psychological emotional responses

*Sub-theme 4.1: The compromised self*

The self was compromised when students reported experiencing a wide range of negative emotions. These included feelings of fear and anxiety especially when they felt threatened. The fear was based on stories they heard about dangerous patients which may have affirmed students' beliefs about danger and mental illness: "*I was very, very, very [emphasis] scared because I would hear some stories about the nurses being injured by the patient especially in psychiatric hospitals...*" Fear may have emanated from the perceived threat to personal safety. This finding concurs with Fisher (2002) who concluded from a study where critical clinical incidents taken from a cohort of second-year students undertaking mental health practicum, were analysed: 19.7% (n=70) of the students reported intense feelings of fear as the most common feeling arising as a result of the emotional experience.

Students also alluded to the sense of powerlessness they felt at being unable to assist patients, as they felt devalued. A student reported: "*we try to help but we not important enough*". The interpretation thereof may be that students' lacked confidence in their ability to assist patients. The students' sense of dejection may be attributed to clinical inexperience and lack of self-confidence in rendering effective nursing care, which in turn has decreased their self-esteem. This may have contributed to a sense of feeling devalued where students felt that they were "not important enough" to be of assistance to the patients. However, they attempted to assist the patients' although they did not believe they could make any difference in the patient's lives.

They felt that they did not belong as their placement in the clinical setting was transitory. Students worked in the clinical site 24 hours per week. Students reported that they experienced a lack of the sense of belonging: "*You know when it's students, you like outcasts in the field [clinical setting]*" Beyer and Nino (2002) avow that belonging encourages identification with a group (nurses), which according to De Dreu, West, Fischer and MacCurtain (2001) shapes human behaviour. Behaviours, which constitute belonging, according to De Dreu et al.

(2001) include frequent interaction, continuity and stability, mutual concern and being free of negative affect. Thus, when a student feels that he or she belongs to the group (mental health nurses), they portray behaviour such as commitment. Students need to feel a sense of belonging in order to be committed to the nursing profession. When there are real, potential or imagined changes in belonging, then emotional reactions are evoked which lead to students feeling that they are deprived.

Moreover, students reported on how they construed caring as a primary function in nursing. Students reported surface acting (Grandey, 2000) by ‘faking’ the emotion of being in control of themselves and the situation, when in reality they were traumatized.

*“I remember sitting with patients telling me their story...you think, I’ve been through that...but you must keep a straight face and not say...I understand...you must be professional... you can’t be a human being with emotions in front of your patient”*

Researchers (Grandey, 2003; Brotheridge & Grandey, 2002) suggest that ‘faking’ raw emotion may lead to negative experiences and outcomes. Students’ distress increased when being a professional appeared to negate the expression of emotion. The perception that professionalism required a lack of emotion appeared worse when students had similar emotional experiences as the patients they were caring for. The student may have been overwhelmed by own experience, reappraised the situation and rationalised it to be the expectation of the nursing profession on how to care for people who share similar experiences.

#### *Sub-theme 4.2: The self in growth*

Some students’ positive experience of the mental health care environment focused on the knowledge and experience they gained during the mental health care placement. They developed self-awareness into their personal vulnerability which led to self- management as one student mentioned: *“You must know who you are”* On the other hand, being knowledgeable about mental health nursing for another student might mean being able to cope with emotions: *“There’s a positive side [to psychiatric nursing] also because it helps you to cope with your emotions...”*

The student appeared to have utilised the knowledge, attitude and skills gained in mental health theory and practice, to enable her to deal with the mental health experience.

### **Limitations**

Only 10 Black male students participated in the study, with the majority (26) being female - which is not uncommon in nursing as it is a female-dominated profession.



The researcher was of the opinion that although they volunteered to participate in the study their responses were guarded, and attributed this to being interviewed by a female researcher. The researcher, however, attempted to address this perceived limitation after the first focus group interview by recruiting a black male to interview the students, whilst the researcher adopted the co-researcher role. The males were then more vocal and interacted more easily in the following two focus group interviews. The study was conducted and developed using only participants from a university in the Western Cape thus cannot be generalised to other students.

## **Conclusion**

The findings contribute to the body of knowledge regarding the experiences of nursing students during the mental health clinical placement. Whilst the findings alluded mostly to negative experiences, some positive experiences were elicited.

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