Walking on Eggshells
Addressing Nursing Students’ Fear of the Psychiatric Clinical Setting

Nursing students often express anxiety or apprehension regarding patients who are mentally ill. Based on more than 25 years of psychiatric teaching experience, the current authors have found that most students fear two major situations before starting their psychiatric clinical rotation: (a) handling assaultive patients, and (b) communicating with psychiatric patients. Students ask: “Am I safe? Will I get hurt? Have you had any student get hurt during this rotation?” One student interpreted the fear in one sentence: “I am worried I will not know how to talk or handle a patient who is angry or asking self-harm questions.” The authors hope that this interpretation will help nurse educators prepare nursing students so that they will feel ready for this rotation.

BACKGROUND

The need to care for and treat psychiatric patients is undisputed, based on reports from the World Health Organization (WHO; 2016). In 2015, the National Institute of Mental Health (NIMH; 2017) reported that serious psychiatric illness affects 4% of all U.S. adults. This number accounts for approximately 10 million U.S. adults ages 18 and older. Hunter, Weber, Shartell, and Harris (2014) concurred that students’ attitudes toward individuals with psychiatric problems are not consistently positive. Nursing students assume that psychiatric patients are dangerous, impulsive, unlikeable, and incompetent. Some nursing students consider psychiatric clinical rotation stressful and complain about anxiety that stems from false beliefs, fear of violence, fear of the unknown, stories in the media, and listening to stories from peers (Karimollahi, 2012). Happell and Gough Nee Hayman-White (2007) found that nursing students were likely to have a negative view of patients who were mentally ill at the beginning of their psychiatry rotation; however, these views become more positive by the end of the course.

Webster and DiBartolo (2014) established that stigma related to mental illness and its associated aggressive behaviors can be intimidating to nursing students. In addition, there may not be sufficient opportunities for nursing students to experience therapeutic communication to build their skills. Convincing nursing students to pursue a career in psychiatric nursing can be a challenge for nursing professors (Webster & DiBartolo, 2014). Remarks from students on the two themes are described below, as best recollected from experience.

Handling an Assaultive Patient

Comments from students regarding the theme of how to handle an assaultive patient included:

- I am not sure how to deal with a combative patient.
- I would like to know how to handle sudden changes in behavior and mental status.
- Being in a room alone with a psych patient frightens me.
- I also fear that I will not be able to handle certain patient situations effectively if the patient is mentally unstable.
- I am mostly concerned about clinical and safety from mentally troubled patients.
- Being unfamiliar around those with extreme psychiatric conditions and fear for my safety.
- How to communicate with someone who is acting in a way that is potentially aggressive or obscene.
- The main thing I am worried about is upsetting a patient, or having a situation where somebody freaks out, and I don’t know what to do to calm them down.

However, violent behavior among psychiatric patients is not as common as the students believe. The reality is that psychiatric patients are more likely to be sufferers than perpetrators of violence (Desmarais et al., 2014).

Communication

Comments from students regarding the theme of communication included:

- I fear that I will not be able to relate to my patients, which will make it hard to establish common ground.
- My main apprehension going into this clinical is not knowing how to re-
spond or how to react in a certain situation.
- I am nervous to say or do the wrong thing and offend the patient.
- I am slightly nervous about my ability to hold an effective conversation with a patient when emotional subjects come up since this is not something I have had to deal with.
- I feel as though I am not ready to communicate or deal with patients with psychiatric disorders.
- I have never worked with patients with mental disorders, and I am nervous that I will do or say something incorrectly when speaking to them.
- My concern for the clinical portion of the course is making sure I know the right things to say in uncomfortable circumstances.

Communication with psychiatric patients about suicide is one difficult subject for students. Students are taught to ask patients, “Are you thinking of harming yourself? Do you have a plan? What is your plan?” Students may think it is non-therapeutic to ask a fragile psychiatric patient such a loaded question. Students are afraid they will plant suicidal thoughts into patients’ minds. However, patients want to talk to someone, and people at home often will not listen. Usually, patients will tell the truth and express relief that someone cared enough to ask and is willing to listen. Shattell, Starr, and Thomas (2007), in a study of the psychiatric recipients’ experience of therapeutic relationships, described patients’ yearning as “take my hand, help me out” (p. 274). Other remarks expressed by students include, “I fear that I may become triggered by certain topics discussed in class or in clinical, which relate back to my own personal experiences”; and “I am just a little concerned because I feel like this clinical is going to be a lot different from what we have been doing so far. Not knowing what to expect gets me a little nervous.”

CLINICAL PREPARATION AND DISCUSSION
Breaking the Stigma
Psychiatric professors can educate nursing students about potential violence and help break the stigma of mental illness. The psychiatric rotation helps clarify students’ values. They begin the rotation with stigma, fear, and ignorance related to psychiatric patients but find out “they’re just like us” (Stricklin, 2016, p. 297). Krouning (2016) encouraged journaling, role-playing, and simulation in the learning lab before starting the psychiatric rotation to improve clinical experience. In the lab or classroom setting, students can practice therapeutic communication and learn how to respond if a patient becomes violent. In addition, Shattell (2007) asserted, “Engaging nursing students in clinical to see patient experiences within health, illness, and the healthcare system can help them learn about the ‘multiplicity of views on experiences’ and assist students to recognize their patients as individuals” (p. 572).

Using Simulation
Students engage in two simulations (SIMs) in the simulation lab during their mental health rotation. The first SIM is about grief and loss, in which students offer comfort to the daughter of an elderly woman who has just died. The mannequin, representing the elderly woman, is programmed to moan, is nonresponsive, and then has asystole. The instructor plays the role of the daughter. Students prepare by completing several questions based on the case study and then come into the role play in the simulation room. In the patient room, there are four students, the primary nurse, secondary nurse, recorder, and medication nurse. After the role play, students debrief with the clinical instructor, theory instructor, and simulation lab coordinator. Faculty have been trained in using reflective techniques to focus the students in a discussion, which usually takes approximately 45 minutes.

The second SIM is a patient in a hospital room admitted for an overdose. The mannequin is voice activated so the instructor can speak through the mannequin. The student attempts to perform a suicide assessment. The patient is irritable and non-communicative except for statements such as, “Just leave me alone,” “Go take care of your other patients,” and “Get out of my room.” Also noted is contraband in the room, oxygen tubing, a soda can with a top, sharp items hidden in the bed covers, shoelaces, and other items. The patient is verbally resistive to any intervention by the nurse. The desired outcome is to not leave the patient alone, call the physician for a one-on-one order, sit with and watch the patient, and ask with or “offer self” (i.e., show interest in and desire to understand the patient by making oneself available) to the patient. In addition, the patient should be reassured with statements such as: “I am staying with you,”

“I am just a little concerned because I feel like this clinical is going to be a lot different.... Not knowing what to expect gets me a little nervous.”
“Let me know what you are thinking/feeling,” and “If you have questions, let me know.”

Students have indicated that these two SIMs are valuable. In regard to SIM I, many students have not cared for a dying patient. The group processes emotions and personal experiences with death during the debriefing. The focus is on supporting the daughter through touch; remaining at the same eye level as the daughter; offering to call friends, family, pastor, priest, or chaplain; encouraging verbalization; letting the daughter stay with mother; and not rushing post-mortem care.

For SIM II, the discussion centers on the importance of keeping a patient safe despite the patient refusing to engage verbally and giving the message: “Leave me alone.” Students appreciated techniques shared by instructors and classmates who may have had the role of a “sitter” when employed at the hospital as a patient care associate. The outcome is that students are much more comfortable interacting with patients on the psychiatric unit, including patients who are quiet or irritable when approached. They begin to see the importance of presence as therapeutic use of self. Coming from the hustle and bustle of other practice areas, being mindful and showing acceptance by sitting with the patient is validating.

Regarding debriefing after simulation, K.B. Bess, BSN, MA, RN, Professor of Nursing, Kellogg Community College (personal communication, February 7, 2018) stated, “We use Christine Tanner’s (2006) clinical judgment model, which focuses on noticing, interpreting, responding, and reflecting. I have found that it is easily adapted to any level of student that we are working with.” Other clinical simulation debriefing tools are available that can be used to document observer notes during simulation, including critical incident checklist items. Wilson (2012), who developed a clinical simulation debriefing tool, stated, “Initially what went wrong is often the focus and it culminates into what went well. Mistakes are puzzles to be solved, not crimes to be punished” (p. 2). Debriefing should include posing a question to encourage reflection.

**Classroom Orientation**

In the classroom, students are taught verbal and nonverbal communication and crisis de-escalation techniques. Although students are not certified to handle crisis situations, they acquire a basic knowledge of how situations are handled in psychiatric units. Students state that this helps them feel better-equipped for the clinical setting. Other issues discussed are safety rules; it is emphasized that students are not to be alone in a room with a patient. Exceptions are made based on staff and faculty discretion.

Role playing is used in class during the clinical conference, allowing students to work through communication scenarios in a safe, supportive environment. The Varcarolis psychiatric textbook (Halter, 2017) has examples of communication scenarios. A variety of psychiatric diagnoses are discussed, and clarification is given on how communication styles may vary depending on the diagnosis. Students are involved in groups on the unit and can see staff members appropriate therapeutic communication skills. Before starting the clinical rotation, a trained counselor from the College Wellness Center presents a 2-hour suicide prevention training in-service with students, heightening their awareness of how to respond appropriately to a patient with suicidal ideation. The training, known as Question, Persuade, Refer (QPR), provides steps to help prevent suicide.

**Unit Orientation**

Students are not to handle a violent patient; however, they can observe how staff de-escalate an agitated patient. If a patient verbally or physically escalates on the unit, students observe and learn from how staff handle the situation. Staff members at clinical sites are good role models regarding de-escalation, and learning from them helps ease students’ anxiety about violent situations. Students observe staff handling aggressive patients using less restrictive measures, including one-on-one observation, providing an environment with lesser stimulation, using verbal de-escalation techniques, and offering medication as prescribed. All techniques are used before taking the final step of physical intervention. Debriefing with staff and patients after the seclusion or restraint incident was also observed, and students were welcome to attend these sessions.

Reflection at the end of each clinical day is important to emphasize what happened with students and their relationship with their patients. Students are asked to share. When beginning each clinical rotation on the first day of the semester, students are asked to journal their “awfulizing thought”: What is the worst thing that could happen during this rotation? With this information, instructors know what fears, misconceptions, and challenges are ahead for the students and instructor.

Clinical experiences are structured to boost students’ confidence and reduce anxiety. Each rotation begins with the emphasis that safety is the first priority for patients and nurses. Students are reassured that they will not be put in an uncomfortable situation in which they are afraid. Instructors share that students will be amazed at the comfort and skill they will develop over the course of the rotation in moving about the unit. As students attend orientation by the nurse educator, recipient rights officer, and activities director and go through computer orientation, they begin to relax. They tour the unit and observe how the instructor talks with patients. First, they are assigned to complete a mental status assessment on a patient, for which they can work in pairs before they take individual patients. Instructors also go onto the unit with students and engage patients in card games, puzzles, or discussion, and
have students join. Within 3 clinical
days, most students are ready to initiate
interaction on their own. Students are
rotated through each of the care units,
which include the thought disorder,
mood disorder, adolescent, and geriatric
unit. Students also receive outpatient
clinical experiences, such as in a
community mental health clinic, and
attend a support group, such as an open
Alcoholics Anonymous® group.

Instructors have prepared a agenda for
students for each clinical day showing
the daily schedule, clinical assignments
due, post-conference, unit assignment
for each student, and any other important
information for the day. Students are paired with a nurse at least once
during the rotation, whom they follow
through the clinical day. Students at-
tend therapy groups on their respective
units. The instructor is on the unit and
available to students.

CONCLUSION

Other psychiatric clinical instructors in Southwestern Michigan and North-
ern Indiana seem to concur that students
are fearful of and have preconceived
ideas regarding potential violence, are
new to therapeutic communication,
and do not know what to expect. It is
important to educate nursing students
about patient violence, de-escalation,
and communication techniques. Journ-
aling, crisis training in verbal and non-
verbal interventions, role-playing, and
face-to-face clinical experience with
patients are necessary for preparing psy-
chiatric students. This preparation helps
increase student engagement with pa-
tients and decreases their anxiety. Stu-
dents can use this knowledge in any field
of nursing they pursue after graduation,
and will be better equipped to meet the
needs of their patients.

REFERENCES

Desmarais, S.L., Van Dorn, R.A., Johnson, K.L.,
Grimm, K.J., Douglas, K.S., & Swartz, M.S.
(2014). Community violence perpetra-
tion and victimization among adults with
mental illnesses. American Journal of Pub-
lic Health, 104, 2342-2349. doi:10.2105/ AJPH.2013.301680

Halter, M.J. (2017). Varcarolis’ foundations of
psychiatric-mental health nursing: A clinical ap-

Happell, B., & Gough Nee Hayman-White, K.
(2007). Undergraduate nursing students’
attitudes towards mental health nursing:
Determining the influencing factors. Con-
temporary Nurse, 25, 72-81. doi:10.5555/
conu.2007.25.1-2.72

Hunter, L., Weber, T., Shattell, M., & Harris,
B.A. (2014). Nursing students’ attitudes
about psychiatric mental health nursing. Is-
sues in Mental Health Nursing, 36, 29-34.
doi:10.3109/01612840.2014.935901

Karniollahi, M. (2012). An investigation of
nursing students’ experiences in an Iran-
ian psychiatric unit. Journal of Psychiatric
and Mental Health Nursing, 19, 738-745.
doi:10.1111/j.1365-2850.2011.01850.x

nursing students’ mental health clinical rota-
tion. Journal of Christian Nursing, 33(3), E31-
E37. doi:10.1097/CNJ.0000000000000298

imh.nih.gov/health/statistics/mental-
illness.shtml

Shattell, M.M. (2007). Engaging students and
faculty with diverse first-person experiences:
Use of an interpretive research group. Journal
of Nursing Education, 46, 572-575.

Shattell, M.M., Starr, S.S., & Thomas, S.P.
(2007). ‘Take my hand, help me out’: Mental
health service recipients’ experience of the
therapeutic relationship. International Jour-
nal of Mental Health Nursing, 16, 274-284.