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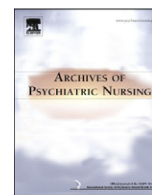

Medical–Surgical Nurses' Perceptions of Psychiatric Patients: A Review of the Literature With Clinical and Practice Applications

Vinette Alexander [a,*], Horace Ellis [b,1], Barbara Barrett [a,2]

[a] Nova Southeastern University, Davie, FL
[b] Jackson Medical Center, Miami, FL

A B S T R A C T

The literature consistently shows that medical–surgical nurses frequently lack the knowledge, skills, and attitudes necessary to render holistic nursing care to patients with severe mental illness (SMI). The negative perceptions often portrayed by medical–surgical nurses towards SMI patients with comorbid medical–surgical disorders must be addressed in order to ameliorate treatment gaps. Current concepts, issues, and challenges associated with the perceptions of nurses who care for patients with (SMI) in medical–surgical settings can prove overwhelming to both nurses and patients, and can result in concerning practice gaps. In accordance with a contemporary model of patient-centered care, it is imperative that medical–surgical nurses acquire the knowledge, skills, and attitudes necessary to work with this high-risk population. Cultivating an environment that promotes apposite attitudes along with effective training programs for medical–surgical nurses, may shift negative perceptions and ultimately meet best practice standards and improve outcomes for patients with SMI.

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There is growing evidence to suggest that individuals with severe mental illness (SMI), such as schizophrenia and other thought disorders, bipolar-affective disorder, severe depression, anxiety, substance abuse, or post-traumatic stress disorder (PTSD), seem to have higher co-morbid rates of cardiovascular disease, diabetes mellitus, respiratory disease, infectious disease, and certain types of cancer than their non-psychiatric counterparts (Iacovides & Siamouli, 2008; Saik, Sheitman, Mann, Stelle, & Osberg, 2007). There is also growing evidence that nurses in the acute care medical settings may cultivate negative perceptions, stereotyped attitudes, and prejudices towards these patients (Arvaniti et al., 2009). Additionally, the epidemic of drug and alcohol abuse, domestic and public violence, and suicidal behaviors adds to the degree of negative perceptions that pose major management problems throughout diverse clinical environments (Hanrahan & Aiken, 2008).

Compared to patients without such co-morbidities, patients with co-morbid psychiatric and/or substance abuse and somatic disorders are more complex to manage and associated with increased cost and poorer health outcomes (Saik et al., 2007). Many are also under-diagnosed and under-treated, or even mistreated, resulting in wide treatment gaps (Kuey, 2008). The prevalence of poorer health outcomes for this population may be attributed to pervasive stigma against the physical health problems of people with SMI, as well as the negative attitudes and perceptions of both the general public and health care workers towards people with SMI (Kuey, 2008). The impact of negative perceptions on somatic treatments for people with comorbid psychiatric and medical disorders is now being viewed as a public-health problem (Kuey, 2008; Saik et al., 2007).

AIMS

This review of the literature serves to explore nurses' perceptions toward the care for mentally ill patients in medical–surgical settings, and to highlight the current issues and challenges associated with such care. Additionally, this paper outlines some of the unique challenges that this special client population often brings to a wide variety of non-psychiatric clinical settings. Contemporary recommendations grounded in a transformative caring approach are presented as clinical applications.

Two epistemological reasons served as the impetus for this review. First, it is important that nurses in the clinical areas become aware that perceptual stigma and labels toward medical–surgical patients with psychiatric diagnoses are pervasive, that they contribute to barriers to care, and that nurses can become change agents in addressing this enormous problem. Second, it is essential for medical–surgical nurses to cultivate positive perceptions toward patients with SMI while developing the basic knowledge, skills, and comfort-level needed to work with persons with SMI. Recent studies exploring factors affecting nurses' perceptions of care processes of persons with SMI are limited in the United States (Zolnierek, 2009; Zolnierek & Clingerman, 2012). This paper can be used as a tool to help correct the existing clinical gap and to add to the literature on how to affect best practice and achieve quality-care outcomes.

Nurses are considered frontline caregivers who make important contributions to the quality of complex and comprehensive care of

All authors participated equally in preparing this manuscript.

* Corresponding Author: Vinette Alexander, DNP, ARNP, 12335 NW 51St., Coral Springs, FL 33076.

E-mail addresses: va213@nova.edu (V. Alexander), hellis@jhsmiami.org (H. Ellis), barbarr@nova.edu (B. Barrett).

[1] 10246 SW 24 Court, Miramar, FL 33025.

[2] 5521 SW 160 Avenue, Southwest Ranches, FL 33331.

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patients and their families, regardless of their diagnoses (Zolnierek, 2009; Zolnierek & Clingerman, 2012). However, results of most studies exploring the care experience from medical–surgical nurses' perspectives to patients with psychiatric comorbidity were less than favorable; here, patients were often viewed as "difficult" and "problematic" (Zolnierek & Clingerman, 2012). Conversely, it is significant to note that individuals with SMI and a medical comorbidity also perceived their care as "difficult" and "problematic" (Meehan & Glover, 2007; Zolnierek & Clingerman, 2012). These phenomena support the hypothesis that the medical–surgical health outcomes of this population will be poorer than their non-mentally ill counterparts (Zolnierek & Clingerman, 2012).

Prevalence of the Problem

It is estimated that 46% (141 million) of the American population will experience some form of mental illness in their lifetime, costing billions of dollars in direct and indirect health care (Galson, 2009). Iacovides and Siamouli (2008) asserts that 50% of psychiatric patients have known medical comorbidities, while 35% have undiagnosed medical conditions that may have caused or triggered their mental conditions. Data suggest that depression and anxiety seem to be related to obesity, asthma, and renal disease, while bipolar disorder has higher rates of comorbid hypertension, hyperlipidemia, type 2 diabetes, musculoskeletal problems, gastrointestinal problems, hepatitis C, and HIV viruses (Iacovides & Siamouli, 2008). Conversely, individuals with a chronic medical condition, such as cardiovascular disease or diabetes, have a greater risk of developing mental disorders such as depression and anxiety (Galson, 2009).

DEFINITION AND CONCEPT OF PERCEPTION

Perception is defined as a person's experience of a phenomenon and how that person takes in information related to that phenomenon (Goldstein, 2010; Harms, 2009). Prior beliefs and expectations might trigger inflexible assumptions making it difficult to formulate personal, social, and professional wisdom congruent with basic human needs (MacNeela, Scott, Treacy, Hyde, & O'Mahony, 2012). For example, claims of human rights violations by individuals with SMI are at times questioned by providers or institutions, as people with SMI are often stereotypically misperceived of having limited intellectual capacity or as being unreliable sources of information (McDonald et al., 2003), though these beliefs have not been supported by the literature (Klin & Lemish, 2008; McDonald et al., 2003). Medical–Surgical nurses have the legal and ethical responsibility to rectify their perceptions and attitudes toward persons with SMI, in order to provide appropriate, non-discriminatory care as well as avoid legal violations of patients' rights.

FACTORS INFLUENCING MEDICAL–SURGICAL NURSES' PERCEPTIONS OF PSYCHIATRIC PATIENTS

Nurses' Perception Factors

Experts in the field of social-cognitive psychology postulate that perceptions influence and shape human attitudes, decision-making, and behaviors (Crowe, 2012). Research also suggests that a lack of knowledge of the causes, symptoms, and treatment options of mental disorders, and a lack of personal contact with persons suffering from those disorders, can lead to misperceptions and care exclusion (Baumann, 2007). Lack of knowledge, skills, and experience in psychiatry among medical nursing staff was also identified as contributing to misperceptions regarding the care process of the mentally ill (Lethoba, Netswera, & Rankhumise, 2006), nurses' self-perceptions of their skills (Mavundla, 2000), and ultimately patient care (Harms, 2009). An example would be misperceiving an anxious patient as agitated, an assertive patient as angry, or psychotic behavior as violent or aggressive, dangerous, or threatening. Reasons for these misperceptions include unfamiliarity with, and lack of understanding of, psychiatric diseases and symptomatology. The consequences of misperception may include care–neglect, segregation or expulsion of patients, seclusion/isolation, or even the unnecessary physical or chemical restraint of these mentally-ill patients (Rose, Thornicroft, Pinfold, & Kassam, 2007).

Nurses Skill Factors

Caring for psychiatric patients requires specialized skills and techniques grounded in the art of therapeutic communication, which lay the foundation for therapeutic relationships. Nurses in the medical–surgical setting frequently express anxiety about working with patients with psychiatric diagnoses or who display behaviors associated with mental health problems (Gilje, Klose, & Birger, 2007). These uncomfortable feelings have been attributed to lack of essential communication skills, fear of being physically hurt, and negative views toward mental illness that are often perpetuated by the media and the general public (Gilje et al., 2007; Harms, 2009; Zolnierek & Clingerman, 2012).

Multiple studies have noted that facilitative communication skills supports general hospital nurses in promoting clear, efficient, and appropriate conversation when caring for mentally ill patients (Chant, Jenkinson, Randle, & Russell, 2002; Lethoba et al., 2006; & Shattell, 2004). However, mastering these skills can be difficult even for the experienced nurse, and can contribute to burnout or even vicarious trauma. It becomes even more challenging for those nurses who lack the ability to incorporate the principles of empathy, active listening, non-judgmental attitude and self-awareness into the paradigm of therapeutic and professional nurse–patient relationship.

Patient Factors

The unique characteristics of psychiatric patients' presentations/symptomatology (i.e. disorganized thought, speech, and bizarre and inappropriate behaviors; incongruous affect and mood) can be intimidating to the unskilled medical–surgical nurse and thus contribute to faulty perceptions towards this patient population, the basis for stereotyping and labeling of mentally ill patients (Hamilton & Manias, 2006). "Difficult" is probably the most frequent label ascribed to psychiatric patients by medical–surgical nurses, which inevitably influences the quality of care provided (Zolnierek, 2009).

Hamilton and Manias (2006) and Mavundla (2000) indicated that perceptive stereotyping often involves generalizations about character traits that usually emerge from unscientific assumptions. In fact, these assumptions are usually formed and molded based on societal or culturally ingrained narratives (Hamilton & Manias, 2006). For example, it is common for persons with SMI to be perceived as violent, manipulative, attention-seeking, inappropriate, pretending, or they "don't look sick" or "not that sick" (Hamilton & Manias, 2006).

It is also often the perception that SMI persons are in fact in control of their behaviors and, therefore, "know what they are doing", though these perceptions have not been empirically validated (Hamilton & Manias, 2006). There is, however, data suggesting an overpowering influence of deregulatory brain chemicals influencing the patient's ability to think, feel, and relate in a rational manner (Neumann, Veenema, & Beiderbeck, 2010). According to work done by Johnson and Delaney (2007), the greater majorities of SMI patients are aware of their thoughts and behaviors but are not in control of them, and in most cases, restless, irritable or agitated behaviors are warning signals as primitively subjective ways of asking for help (Johnson & Delaney, 2007). Unfortunately, these warning signs are often missed by unskilled staff whose negative perceptions and attitudes create risky blind-spots that often result in aggressive behaviors by the patient (Johnson & Delaney, 2007).

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