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Worlds apart in the same town? A qualitative comparison of pre- and post-clinical themes assessing student nurse perceptions of homeless, mentally ill clients

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SUMMARY

Student nurses' negative attitudes towards men who are homeless and mentally ill disrupt development of therapeutic relationships. Without therapeutic relationships these men may feel stigmatized. Assessing student attitudes allows for insights to improve students' abilities to develop therapeutic relationships. The purpose of this research was to assess student nurses' pre- and post-perceptions towards homeless mentally ill clients during a mental health clinical through analysis of pictorial data.

Data was analyzed through a qualitative, phenomenological method. On the first and last days of clinical experience, students were asked to draw a picture in response to the question: "How far apart are you from these men?" We analyzed pre- and post-drawings separately and changes were compared.

Four pre-attitude themes and two post-attitude themes were identified. Pre-attitude themes demonstrated student drawings as geographically distanced from the clients and living in two different worlds. Post-drawings reflected themes where clients and students were under the same roof and often physically touching.

We suggest using this easily reproducible, inexpensive method to gain insights into student attitudes. The difference in the drawings objectively demonstrates the effectiveness of clinical experiences in changing student nurse attitudes towards men who are homeless and mentally ill.

Introduction

Homelessness is a significant issue confronting contemporary society. Approximately 636,000 individuals in the United States were classified as homeless at a given point in time, "while roughly 1.56 million people, or one in every 200 Americans, spent at least one night in a shelter during 2009" (US Department of Housing and Urban Development, 2009). The factors associated with homelessness are multifaceted and complex. A majority of homeless individuals have experienced extreme life stressors such as abuse, childhood trauma, poverty, disease, substance abuse, and mental illness (Martins, 2008).

The plight of people who are homeless and mentally ill is extensively documented (e.g., (Belcher and DeForge, 2012; Law and John, 2012; Martins, 2008; Perese, 2007)). Many in society express anger and are apathetic to the plight of the homeless. Negative feelings such as these can lead to stigmatization. Stigma is a means of socially excluding people who are different from the majority (Reutter et al., 2009). Stigma is the biggest barrier noted in homeless persons being able to have a satisfying life. People who are homeless are aware of being stigmatized and stigma creates hopelessness that things will never change for the better (Belcher and DeForge, 2012). However, stigma, which informs personal attitudes is often very subtle (Parkinson, 2009; Perese, 2007; Zrinyi and Balogh, 2004) making it difficult to detect. When homeless people feel stigmatized they tend to stay stuck (remain homeless) but, having someone reach out to the homeless can lead them forward, off of the streets (MacKnee and Mervyn, 2002).

Nurses are one group of people who can reach out to persons who are homeless and mentally ill. To develop therapeutic relationships which can lead this population forward, nurses must have skills, knowledge, and positive attitudes (Addison and Thorpe, 2004). Attitudes inform how persons perceive other people and situations (Ajzen and Fishbein, 2005). Awareness of perceptions and attitudes is essential in abilities to establish therapeutic relationships. Therapeutic relationships have been defined as "ongoing, meaningful communication that fosters humility and mutual respect and is based on a negotiated partnership between the patient and the practitioner"

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(Krauss, 2000). Nurses learn to develop therapeutic relationships with people during nursing school. Therefore, careful attention to nursing students' skills, knowledge, and perceptions of the homeless mentally ill population, is critical during their education.

Review of Literature

Homelessness

Homelessness is a complex phenomenon that is attributed to multiple factors and is the result of structural or individual causes (Belcher and DeForge, 2012). Individual causes may include mental illness, alcoholism, substance abuse, and lack of personal motivation to succeed. Structural causes include unemployment, lack of affordable housing, societal norms, and poverty. While there are many and layered causes of homelessness, there is no "one size that fits all" way to diagnose and treat the conditions that contribute to homelessness for each individual.

The homeless population exhibits many fragilities which include vulnerability (Craig et al., 1996), stigma and negative perceptions (Addison and Thorpe, 2004; Perese, 2007; Zolnierek, 2009), poverty, disconnectedness (Craig et al., 1996; Perese, 2007), lack of access to healthcare (Parkinson, 2009), premature death, disproportionately higher rates of chronic illness (Martens, 2009; Parkinson, 2009), and risk for victimization (MacKnee and Mervyn, 2002; Perese, 2007). People who are homeless and mentally ill often have negative self-images and display a lack of acceptance for their peers, who are also homeless and mentally ill (Addison and Thorpe, 2004; Rayburn and Guittar, 2013).

While there is no easy solution for treating persons who are homeless and mentally ill, researchers have investigated what seems to assist people transition to more stable living environments and make progress in management of their illness. Stigma was identified as the biggest barrier to a satisfying life, but it is noted that stigma that prevents persons who are homeless and mentally ill from moving forward is often very subtle (Perese, 2007). Persons who were previously homeless indicated that a critical element in getting off the streets was having someone reach out to them (MacKnee and Mervyn, 2002).

Nurses and Barriers to Care for Persons Who are Homeless and Mentally Ill

Nurses are one such group of people who are capable of reaching out to this vulnerable population. Working with the homeless and mentally ill does not just occur on the streets and in mental health care units, but is a recurring theme in nurses' work experience as the homeless and mentally ill have high rates of acute care admissions on all units and an increased use of emergency departments (Martens, 2009; Zolnierek, 2009). While nurses are ethically obligated to advocate for persons who are both homeless and mentally ill, barriers prevent nurses from reaching out to this population in effective ways. Researchers have noted that nurses have: negative attitudes (Happell et al., 2008; Parkinson, 2009), lack of experience (Madianos et al., 2005), and lack of knowledge and confidence in caring for such clients (Zolnierek, 2009).

In addition to the many potential barriers in caring for people who are homeless and mentally ill, nurses and other healthcare providers may also stigmatize this population. A power differential exists between healthcare providers and clients, in general, but the power differential is magnified when clients are homeless and mentally ill (De Jong and Mather, 2009). When there are power differentials, there is a higher potential for stigmatization. Nurses need to be concerned about stigmatization because it leads to negative health consequences and poorer quality of care (Hatzenbuehler et al., 2013; Sharfstein, 2012). In addition, because persons who are homeless and mentally ill know when they are being stigmatized, they often internalize the negative perceptions. Persons who are homeless perceive that others do not understand them, see them as a burden, and deserve what they get (Reutter et al., 2009). From their perspective, when they are stigmatized by healthcare providers, including nurses, they experience negative emotional consequences such as shame, withdrawal, and self isolation (Reutter et al., 2009), increased stress in an already overly stressful life (Hatzenbuehler et al., 2013; Reutter et al., 2009), resistance to seeking care, and nonadherence to treatment (De Jong and Mather, 2009).

When considering the complexities associated with persons who are homeless and mentally ill and the barriers that exist to giving quality care, nurse educators must reflect on the best ways to introduce and educate student nurses about this particularly vulnerable population. In working with this population, clinicals should be designed so students have opportunities to develop knowledge, gain experience, and dispel negative perceptions, while acquiring positive attitudes towards homeless and mentally ill clients. It is through careful thought in designing curriculum that nurse educators may hope to combat stigma.

Student Nurse Attitudes and Homeless Mentally Ill

Like much of the rest of the public, undergraduate students lack knowledge about mental illness (De Jong and Mather, 2009). People often rely on what is seen in the media or what they learn through societal norms to make determinations about mental illness. When there is a lack of knowledge and misconceptions about mental illness the response is to avoid that which is feared; in this case, people who are homeless and mentally ill (De Jong and Mather, 2009). It is logical to suspect that student nurses may harbor stigmatizing perceptions and attitudes towards clients who are homeless and mentally ill. If student nurses have negative attitudes about persons who are homeless and mentally ill, their perceptions of them and behaviors towards them may convey stigmatization. Suggestions to combat such negative perceptions include: self-reflection, awareness of privilege (Bednarz et al., 2010), awareness of implied blame of the victim and society's winner/loser perspective (Belcher and DeForge, 2012), the societal desire to hide and separate the homeless and mentally ill populations from general society (Belcher and DeForge, 2012; Martens, 2009; Martins, 2008; Rayburn and Guittar, 2013), and to gain experience, and knowledge specific to this culture such as the language and behaviors commonly used by persons who are homeless and mentally ill (Law and John, 2012).

Although several studies have demonstrated that quality clinical experiences influence positive attitudes in mental health nursing (Happell et al., 2008; Keane, 1991; Loewenson and Hunt, 2011; Polgar et al., 2009), the ways in which development of positive attitudes or perception changes are measured are not consistent and at times lack objectivity. Furthermore, the available literature is limited in its examination of the relationship between clinical experience and nursing student attitudes towards individuals who are homeless and mentally ill.

Evidence of reliable measures of student nurse's attitudes is inconsistent. Student attitudes towards homeless mentally ill clients and students' perceived preparedness for the mental health field were positively impacted by the clinical experience. Additionally, clinical exposure to homeless mentally ill populations improves students' ability to recognize the symptoms of mental illness in select cases (Madianos et al., 2005). As an example, when compared, nursing student attitudes before and after completion of a module on social inclusion and exclusion indicated that while most students held marginalized clients in a positive or neutral regard, a small majority held stereotypical views of marginalized clients which could potentially jeopardize access to or quality of health care (Parkinson, 2009; Wray et al., 2008). While overall, a majority of students' attitudes