Variations on the Theme Mental Health in Nursing

By RUTH E. SIMONSON, R.N.

ON a Sunday morning in March 1955, I opened the *New York Times* to the article, "Nebraska Fights Mental Illness."

As I read the description of the many innovations to enhance the treatment potential of mental patients, and the discussion of the part the institute could take in solving the problem of mental illness, my thoughts turned to what the Nebraska Psychiatric Institute could mean to nursing.

I visualized the new institute as providing an opportunity not only to advance our knowledge about psychiatric nursing but also to apply the knowledge to general nursing.

At this, the dedication of the institute as a research center in the care of the mentally ill, it is appropriate to consider some of the opportunities for psychiatric nursing which are specific to this setting. Psychiatric nursing is being redefined, and the imperative need for both independent study and collaborative research is recognized.

For example, the statement of Dr. Arthur P. Noyes (*1*), that the nurse should be a psychotherapist in her limited but definite field, indicates that the breadth as well as the limits of psychiatric nursing must be made increasingly clear. The nursing profession itself must assume the responsibility for identifying its area of function and for describing and justifying what is done.

Psychiatric nursing needs exploration and study as to how it can enrich the profession of nursing. I do not question that psychiatric nursing leadership will do the exploring and at the same time safeguard its responsibility. My concern is with the enrichment of general nursing.

Will the schools of nursing, the nursing services, and community nursing programs, in their day-to-day work with the ill, take advantage of the opportunity to study psychiatric content?

Will general nursing work collaboratively with psychiatric nursing in applying psychiatric content to the care of the general patient?

Nursing and Mental Health

At its annual conference with State mental health authorities in December 1954, the Asso-

Miss Simonson is mental health nurse consultant for Public Health Service Region II, New York City. *Her speech on mental health in nursing, in its original form, was part of the observance of Mental Health Week, May 1–7, 1955, when the Nebraska Psychiatric Institute, Omaha, was dedicated. Miss Simonson is a member of the council of the newly established mental health section of the American Public Health Association and vice chairman of the Interdivisional Council on Mental Health and Psychiatric Nursing of the National League for Nursing.*

ciation of State and Territorial Health Officers gave formal recognition to the importance of mental health in nursing. At that meeting the association recommended that the principles of psychology be incorporated into all nursing and, particularly, into the community aspects of nursing (*2*). The health officers also recommended that each State mental health authority employ one or more mental health nurses to help carry out this recommendation.

The nursing profession shares the abundant interest in mental health evident in other professional groups. By its very nature, nursing is a personal and individual service which fosters close relationships. The nurse herself inevitably affects the mental health of the patients and families with whom she works.

The setting in which nursing is practiced offers its own unique opportunity for the promotion of mental health. The setting may be a hospital, a home, a clinic, a school, or a factory. The responsibility may be to the sick, to the convalescent, to the healthy. Yes, the nurse has opportunities in every phase of the mental health program. She shares in the prevention of mental illness, in the treatment of the mentally disturbed, in the rehabilitation of the mental patient.

Mental health in nursing lends itself to many variations. We accept that nursing has the potential for working constructively in mental health. Let us think of ways to nurture this potential.

The Use of Self

In nursing, we have tended to look at ourselves as outside the patient's problem. But little by little we have begun to tear down the wall that we built around ourselves. We are beginning consciously to take into account what the nurse, in her use of self, brings to a situation that changes it. The fact that there has been a shift in nursing research from functional studies in nursing service to a concern with nursing care which emphasizes nurse-patient interaction is proof of this change.

The report on "Favoritism in Personnel" in the February 1955 issue of *Nursing Research*, published the not-surprising conclusion that nurses like certain patients better than others and that this factor makes a difference in the nursing care she gives. Her approach to the preferred patient is warm and friendly. He is respected as a person. The approach to the nonpreferred patient is more routine and business-like. He is treated as a patient (*3*). Recognition of this hitherto vaguely sensed bias is but the first step in its correction. The next step must be the development of appropriate methods to help the nurse meet the basic need of every patient to be treated as a person whether he is preferred or nonpreferred.

We have been content too long to emphasize the importance of recognizing the emotional components of nursing care. We have paid too little attention to the development of the skill that helps us apply the knowledge we have accumulated. Unfortunately, knowledge cannot be transferred directly and automatically to appropriate situations, for learning does not develop in that way. It is fostered in a climate where new approaches to traditional tasks can be tried out and modified.

Dr. George E. Gardner, writing in *Mental Hygiene* about higher education and mental health, makes the point that the development of emotional maturity is the first mental health task of the student. In that sometimes elusive search, he says, it is of primary importance to establish a realistic concept of one's self—one's ability and one's potentiality—and to establish a realistic appraisal of the responses to be expected from others (*4*).

Self-awareness, insight, and the realistic appraisal of responses come to the nurse as she works directly with her patients. That step in the learning process is hastened with competent guidance.

In a study completed in 1954 for the Public Health Service, Frances Kreuter and Marguerite Kakosh have developed criteria for qualitative appraisal of nursing care. I have been in fairly close touch with the part of their study concerned with communication as nursing skill. The graduate nurse students who participated were studying at the university and having field experience in a generalized hospital as part of it. They kept detailed diaries of daily patient care experiences. This included verbatim accounts of some of the conversations with patients for

whom they cared. With conscious attention they studied what the patient said and their own replies.

From subsequent discussions of the recorded conversations, it became apparent that nurses need to learn the skill of listening and to listen as nurses. Although the discussions showed intellectual acceptance of the value of encouraging expression of feeling, the students found it difficult as nurses to permit, let alone encourage, expressions of hostility or of any negative feeling when they were face to face with a patient. In fact, they shied away from any feeling which evoked uncomfortable feelings within themselves. This was not lack of concern for the patient but rather inability to allow any discussion that would interfere with the harmonious atmosphere nurses have been taught to consider essential.

One nurse, in reporting her experience with a patient, saw the problem in nursing care as one of uncooperativeness in following the physician's orders. Her real difficulty was in her effort to understand the basis for what seemed like deliberate perverse behavior. It was even more difficult for her to analyze her own feelings.

When she was asked, "Do you feel drawn to this patient?" she said "No," and, "Were you with him in your feeling?" she also replied "No." Then, when asked "Did you feel that you were against him in your feeling?" she replied, "Yes, but this is the first time I have ever looked at it this way. This is hard to face."

The process of looking objectively at one's self in a situation and gaining some understanding is indeed slow and sometimes painful. To do so requires supportive help. Perhaps this process can be illustrated best by two real situations.

Case Illustrations

Mr. Brown was referred to a public health nursing service after his dismissal from a rather prolonged hospitalization for a heart attack. His physician requested that he be encouraged and supported in increasing activity. Mr. Brown's condition and potentialities were reviewed with the nurse. She was familiar with the philosophy that the management of a cardiac patient is directed toward improved physiology and that therapy combines judicious use of rest, activity, and modification of diet and daily living.

The nurse found Mr. Brown's family in a flurry of excitement at having him home again. His wife and his teen-age daughter, Marjory, hovered about trying to anticipate his every need.

He protested mildly, saying, "I've been doing a lot of things for myself at the hospital, Marjory. You make me feel like an invalid."

At this point, the nurse cautioned against "too much activity" and gave approval to Marjory's doing for her father the things he had been doing for himself. Throughout that first visit, as she carried out the appropriate techniques of nursing care, she admonished Mr. Brown to be careful. As she left, he remarked, "I thought coming home was a good idea, but I'm afraid that I came home too soon."

She was uneasy about the visit. She was aware of her reluctance to encourage increased activity for Mr. Brown although she accepted, intellectually, that it was important for his recovery. Through discussion she became more aware of what had happened during her visit. She realized that she had not supported Mr. Brown's movement toward health but had actually reactivated his feeling of helplessness and dependency. She recognized that she had reinforced the anxiety of the mother and daughter. She said, "I tried to reassure them, but they seemed more worried when I left."

On being encouraged to explore her own feelings about heart disease and talk about them, she recalled an experience as a student nurse.

She told of a cardiac patient on complete bed rest who openly defied the doctor's instructions and the nurse's admonitions by occasionally getting out of bed. One day he walked out into the hall to make a telephone call and died in the booth. "It was almost as if Mr. Morris were prompting me over my shoulder to keep Mr. Brown quiet."

This is an illustration of what I mean by saying that self-awareness and insight come as the nurse works directly with patients when she is helped to recognize how her own feelings influence the care she gives the patient.

Let's take another illustration. Bob, a 15-year-old, had been in the hospital with rheumatic fever for 2 weeks and on complete bed care for that time. He often looked unhappy, and the nurses tried to cheer him up by telling him how lucky he was that his heart condition had been discovered early and that he was under such good care. He was instructed in the necessity of "being careful when he went home" and "not to overdo."

On being dismissed from the hospital, Bob was referred to a public health nursing service. The doctor wanted him to have bed rest for a time, then graduated activity. The nurse's responsibility was to demonstrate and give nursing care and to help the mother carry out the doctor's orders. After several visits, the nurse came to the supervisor with this story:

"That kid just won't pay any attention to what he's told. He gets out of bed. He doesn't want me to give him his bath. He won't pay any attention to his mother; she's getting all worn out. The doctor told the father that he would be a cardiac cripple if the situation continued. His father is irritable with the mother and impatient with the boy. The boy won't pay any attention to his father either. And the young sister—she was such a nice kid—is turning into a regular pest. The whole household is at sixes and sevens."

This was a situation in which increased understanding of the adolescent was essential, first for the nurse, and then for the family: the need of the adolescent, for example, to be self-directing and to have some part in the planning that affects him, to be considered an individual in his own right. The need of the other members of the family and the implications of the illness were reviewed. The nurse was given help in ways in which she might involve Bob and his family in plans for his care. She was supported in her work with the family, and encouraged to express and analyze her own feelings about the way Bob behaved. Open discussion gave her a better appreciation of the emotional factors in the situation.

This example is given to show how certain mental health concepts become real as the nurse is helped to make practical application in her work with families. The unhappy and rebellious boy who was making his illness worse became very much interested in the therapeutic regimen as he was brought into the planning and in himself had a measure of control. The nurse felt that for the first time she had seen the implication of an illness for a family in relation to herself, with its possible implications for herself. She, too, had learned a measure of control by the conscious use of self.

In Touch With Others

With respect to freeing the potential of the nurse, it is important to emphasize the responsibility of administration for providing a setting in which quality nursing can be practiced.

Administration articulates and communicates the values in any institution or system. They may not be clearly articulated, but they will be communicated. If respect and concern for the patient is all important, that attitude will be communicated, and service, research, and training of personnel will reflect it. If, however, the development of specialized treatment is the only goal, and the patient is merely an accessory for research, that attitude, too, will be communicated. In that event, the system virtually prohibits nursing dedicated to the comprehensive care of the patient.

In addition to providing the environment for nursing care, administration has the responsibility of seeing that nursing is fully utilized in the service, research, and training activities of the institution. Though we are accustomed to think of research advances in other disciplines which may contribute to the preparation of nurses, how often do we think in terms of what nursing can contribute to other professions? The new climate in some of our teaching and research centers is making it possible to identify and describe some of the ways in which nursing can contribute to other disciplines so that they can be consciously used.

Dr. John Rose of the Philadelphia Child Guidance Center has written in an unpublished report:

"The nurse-family-child interaction is of primary importance in its own right. It is our experience, however, that the nurse is the only person who can fill certain gaps in the resident's experience." Dr. Rose was referring to his

own experience in the preparation of pediatric residents.

It is not enough to recognize that mental health is an integral part of all nursing or that the nurse should deal effectively with the emotional aspects that are a part of every situation she meets. Recognition, when we lack the knowledge and skill to function effectively, is immobilizing. The nurse must be helped in the use of self. That is her great potential.

Anne Morrow Lindbergh says it so simply for us in Gift from the Sea (*5*): "When one is a stranger to one's self, then one is estranged from others, too. If one is out of touch with one's self, then one cannot touch others."

It is our privilege to be in touch.

REFERENCES

(*1*) Noyes, A. P.: The nurse as a therapeutic agent. Presented at the 8th nursing conference, Mayview, Pa., June 1949.

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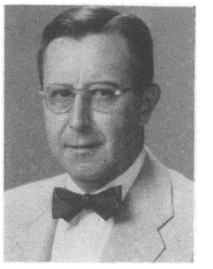
(*3*) Morimote, F. R.: Favoritism in personnel—Patient interaction. Nursing Research 3: 109–112, February 1955.

(*4*) Gardner, G. E.: Higher education in mental health. Ment. Hyg. 37: 354–364, July 1953.

(*5*) Lindbergh, A. M.: Gift from the sea. New York, Pantheon Books, 1955.

New Members of the PHR Board of Editors

Miss Arnstein



Mr. MacKenzie

Dr. Simmons

The 3 most recent appointees to the 13-member Board of Editors of *Public Health Reports* are introduced below. The new members, whose 3-year terms end in 1958, replace Dr. Justin M. Andrews, Dr. Ruth Freeman, and M. Allen Pond.

Margaret G. Arnstein, R.N., M.P.H., chief of the Division of Nursing Resources, Public Health Service, began her public health nursing career in Westchester County, N. Y. Subsequently, she served as consultant to the New York State Department of Health, first in the communicable disease field and later as district consultant for New York City. During the 3 years spent as director of the program for public health nurses at the University of Minnesota, she collaborated with Dr. Gaylord Anderson on the book "Communicable Disease Control." In charge of nursing for the UNRRA Balkan Mission, Miss Arnstein spent 15 months in the Middle East, where she organized nursing care in 2 Greek and 3 Yugoslav refugee camps and laid plans for work in the 3 Balkan countries under the mission.

Vernon G. MacKenzie is assistant chief for research and development, Division of Sanitary Engineering Services, Public Health Service. After graduation from Massachusetts Institute of Technology in 1927, Mr. MacKenzie served 9 years in sanitary engineering research and design for the city governments of Chicago and Detroit. In the American Mission for Aid to Greece, he was deputy director of the Public Health Division. From 1948 to 1954 he was officer in charge of the Robert A. Taft Sanitary Engineering Center of the Public Health Service, Cincinnati.

Leo W. Simmons, Ph.D., is professor of sociology at Yale University, with a joint appointment in the department of psychiatry. He is also doing research under the auspices of the Russell Sage Foundation. Dr. Simmons was awarded his doctorate at Yale in 1931 and returned to the university in 1936 as a research assistant in sociology. Following field studies of the Hopi Indians in 1938 and 1941, he edited "Sun Chief," an autobiography of a Hopi Indian, 1942, and wrote "The Role of the Aged in Primitive Society," 1945. His study of the social aspects of medical care in hospital settings at Cornell Medical Center 1950–52 is reported in "Social Science in Medicine," with Harold G. Wolff as co-author.