ADAPTING A MODEL FOR STUDENT SUPPORT FROM A CHRONIC TO AN ACUTE MENTAL HEALTH SETTING

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The aim is to adapt Janse van Rensburg’s (2010) model for student support from a chronic to an acute mental health context. The objective is to explain the adaptation process through deconstruction and reconstruction. Janse van Rensburg’s (2010) model was a qualitative study, developed for a chronic setting in a health care facility for persons with mental retardation. The proposed adapted model involves a process of de- and reconstruction. Data collection involved deconstruction of data elements of Janse van Rensburg’s (2010) model. Data analysis involved reconstruction through a literature review and application to the acute mental health context. Findings reflected on the key aspects of facilitation of student support through various phases of adjustment to an acute mental health context. Recommendations of the adapted model involve the implementation of student support in an acute mental health context. Psychological support during experiential learning can contribute to the enhancement of professional development.

Keywords: Student support, Acute mental health context, Model adjustment.

Introduction

This paper reports on the need for a model to enhance student support in the acute mental health contexts. A model was developed by Janse van Rensburg (2010) to assist preceptors in supporting students during placement in the chronic mental health context. The model was developed based on findings that students experienced emotional discomfort while working with mentally challenged individuals (Janse van Rensburg, Poggenpoel & Myburgh 2012). Although this model was developed to support students in the chronic mental health context, students are placed in chronic and acute mental health settings. This paper provides an overview on acute and chronic settings. It focuses on students’ experiences of the acute setting and describes patients’ behaviour in this setting to demonstrate the need for support in the acute mental health context. The gap in literature on student support in the acute mental health context is highlighted. In light of the existing gap a suggestion is made to adapt Janse van Rensburg’s model (2010) from a chronic mental health care setting to an acute mental health care setting through a deconstruction and reconstruction process.

Students’ experience of the mental health context can influence their career choice. According to Salvage (2007) the limited financial incentives and the stigma surrounding mental health hinders the recruitment of mental health nurses. The Atlas: Nurses in Mental Health (2007), a report from the World Health Organization indicated the number of mental health nurses per 100 000 population in Africa as 0.32 (Salvage 2007). Reflecting on the shortage of mental health nurses and the challenge of recruitment into the mental health context, first exposure plays an important role in the experiences of students. Their
experiences of first exposure may influence their choice on becoming a mental health nurse. A negative experience results in not considering mental health as a career choice (Happell 2008). Clinical exposure and experience can assist the student in dealing with their fear and misconceptions resulting in a positive experience and professional growth. According to Happell (2008) preceptors play a crucial role in supporting students during placement in the mental health context. Support may enhance students’ experiences of first exposure, resulting in more students choosing to become mental health nurses. This may alleviate the shortage of mental health nurses.

Background

The background will be described in terms of students’ experience of the mental health context and the acute versus chronic mental health context.

Students’ Experience of the Mental Health Context

Students need psychological support during experiential learning to enhance their professional and personal development. First exposure to the mental health context is often feared by students despite provision of theoretical knowledge and can be experienced as traumatic (Charleston & Happell, 2005; Hung, Huang & Lin, 2009). Different aspects influence students’ preconceptions about the mental health setting. These aspects can include their perceptions towards patients diagnosed with a mental illness, including stigma as well as their own experiences earlier in life (McCann, Lu & Berryman, 2009). Students may view patients diagnosed with a mental illness as unpredictable, aggressive and violent. Students’ experiences of exposure to experiential learning in the mental health context can be explained by the application of the model generated by Granskär, Edberg and Fridlund (2001). This model depicts that students’ first exposure can be categorised according to student nurses qualities (own needs versus patient’s needs) and patients’ behaviour (rejection versus willingness to form a relationship with students). Student nurses who focus on their own needs want to address their personal expectations while students who focused on the patients’ needs want to address the patient’s expectations, accepting the person behind the illness. Patients’ behaviour influenced these students’ experience of their first exposure in the mental health context. Patients who rejected the students were labelled by them as being ‘self-absorbed’ and resulted in the students feeling helpless. Patients who willingly formed a relationship with these students contributed to the students’ experience of feeling confirmed and proud (Granskär et al. 2001). Patients in the acute phase of their mental illness may reject students due to their symptoms. These patients might be admitted to be stabilised on medication. They might not be in contact with reality and may suffer from delusions and/or hallucinations. Patients in the acute mental health context may display disruptive and unpredictable behaviour that may be viewed by students as rejection. Students who experience rejection and feel helpless might need additional support to move beyond their own needs to acknowledge the needs of the patients as patients in this context need additional care.

Acute Mental Health Care Settings

Acute wards in the mental health setting resembles a high intensity of nursing care and treatment for patients with a risk of aggressive behaviour, suicidal tendencies, harm to self or others, refusal of medication and tendencies to abscond (Bowers, Brennan, Flood, Lipang & Oladapo 2006). The function of acute wards were summarized by Bowers et al (2005) as to admit patients in the acute phase of their mental illness who are at risk to harm themselves or others; or who are suffering from a severe mental illness; and/or when the family or community struggle to cope with them due to limited support. The role of acute wards was to provide safety to patients; assessment and treatment of illness and providing for basic physical and emotional needs (Bowers et al 2005).
South African Perspective on Acute Mental Contexts

The South African context divides the acute mental health contexts into two settings. The first setting refers to the 72-hour emergency management procedure in a general hospital context. The second setting refers to acute wards in a mental health care institution.

The Mental Health Care Act (2002) in the South African context introduced a 72-hour emergency management procedure where patients with acute symptoms are observed for 72 hours in a regional and district general hospital. According to Burns (2002) the 72-hour emergency management procedure was planned to exclude medical illnesses and to prevent unnecessary admission to tertiary hospitals where some of the symptoms (acute trauma, substance intoxication or withdrawal and brief psychotic episodes) clear up within 72 hours. However inadequate facilities, training and support of general service providers affects the quality of care provision (Peterson & Lund 2011; Ramlall, Chipps & Mars 2010). A patient subjected to the 72-hour emergency procedure can be discharged when stabilised within a period of 72 hours or transferred to a mental health care institution to be managed in an acute ward.

Acute wards can be a stressful and challenging environment for students resulting from emergency situations and unpredictable patient behaviour due to their mental status (Hanrahan, Aiken, McLaine & Hanlon 2010). Patients diagnosed with severe mental disorders may display disruptive behaviour resulting in occupational stress for nurses (Dean, Gibbon, McDermott, Davidson & Scott 2010:16; Edwards & Burnard 2003:196; Gibb, Cameron, Hamilton, Murphy & Naji 2010:838). Psychiatric nurses experience their work as ‘mentally strenuous’ as indicated by Koivunen, Kontio, Pitkänen, Katajisto and Välimäki (2012:45).

The acuteness of a mental illness is not limited to the mental health context alone. An example of a mental illness in a general hospital setting involves psychosis due to alcohol withdrawal as a patient might be admitted for a general procedure and go into withdrawal when without alcohol for a period of time. Students and nurses should have the skills to deal with an acute psychosis in any context.

Students’ Experience of the Acute Mental Health Context

Placement in an acute mental health context can place emotional demands on students resulting in negative experiences during placements, influencing their career choice. The acute mental health context can cause acute stress for the students due to the unstable and unpredictable nature. In the African context mental illness is often linked with cultural belief systems. According to Uys and Middleton (2004) disease can be viewed as caused by witchcraft, sorcery or by displeasing the ancestors in the African context. A person with a mental illness is often labelled as ‘being bewitched’ or possessed by an evil spirit (Uys and Middleton 2004; Ngubane 1977 in Uys and Middleton 2004). Exposure to the acute mental health context confronts the students with their own views/beliefs surrounding mental illness. Students might view the patient as ‘being bewitched’ resulting in them fearing the patient. According to Janse van Rensburg et al. (2012) students working with patients’ diagnosed with a mental illness experiences emotional discomfort, fear and uncertainty that causes stress for them. Stress relates to a negative emotion that can hinder the students’ learning abilities due to an increase in their anxiety levels. Anxiety narrows a person’s ability to give their full attention affecting one’s learning ability (Carver 2003) and can be demotivating (Benson 2010). Support can lower students’ stress levels and facilitates a positive experience. According to Efklides and Petkaki (2005) positive emotions/experiences increases a person’s interest in what is learnt and less energy is invested in the learning process resulting in the person feeling confident about what was learnt and satisfied with the skills gained. Therefore it is crucial to provide adequate psychological support during placements in the acute mental health context to enhance positive experiences to improve the students’ learning abilities.

Chronic Mental Health Care Settings

Chronic settings compose of patients diagnosed with chronic severe mental illnesses. A chronic mental illness is classified as a ‘chronic severe mental illness’ and defined by Kessler, Chiu, Demler and Walters
(2005: 618) as follows: “a 12-month suicide attempt with serious lethality intent; work disability or substantial limitation due to a mental or substance disorder; positive screen results for non-affective psychosis; bipolar I or II disorder; substance dependence with serious role impairment [. . .]; an impulse control disorder with repeated serious violence; or any disorder that resulted in 30 or more days out of role in the year”.

The chronic mental health context might be viewed as an area where the patients are stabilised on medication while the acute setting exposes students to patients in the acute phase of their illness, in need for stabilisation. The chronic mental health context was influenced by decentralisation in South Africa. The Mental Health Care Act (2002) moved mental health care closer to rural communities to relief the burden on urban tertiary hospitals (Burns 2008). Mental health care was planned to be integrated in primary health care to facilitate the treatment of patients near their homes and communities (Burns 2008). This resulted in limited availability of chronic wards for student placements, increasing placements in acute settings.

The experiences of student nurses working in a chronic mental health context included emotional discomfort, engagement on a deeper level with patients with mental retardation; students’ process of personal transformation and their journey towards self-discovery and meaning (Janse van Rensburg, Poggenpoel & Myburgh 2012).

However the model of Janse van Rensburg (2010) addresses the chronic mental health context while support for students is lacking where it is most needed in the acute mental health context. Therefore this model for the chronic mental health context should be adapted to an acute mental health context to enhance psychological support and professional development of students.

Design and Method

A qualitative, exploratory, descriptive, contextual and theory-generative design was used to develop Janse van Rensburg’s model (2010). The purpose of the study was to enhance the mental health of student nurses through the identification and expression of their emotions while working with mentally challenged individuals. The context of the study was a specific rehabilitation facility for mentally challenged individuals in Gauteng. The facility had 120 residents, many of whom were mentally and physically profoundly challenged children and adults in need of special and/or total care. The sample included 13 student nurses purposively selected from a specific higher educational institution in Gauteng. Student nurses were in their fourth year of study and placed at this facility for 90 hours. Data was collected with two focus group interviews, reflective journals, a reflective letter, naïve sketches, drawings and field notes. Data was analysed with Tesch’s descriptive method of open coding and theme analysis.

The research was presented in two phases. Phase one explored the experiences of student nurses working with mentally challenged individuals (Janse van Rensburg et al. 2012). During the second phase a model was developed based on the first phase and a literature review to enhance support provided by advanced psychiatric nurse educators to student nurses working with mentally challenged individuals (chronic context). Figure 1 illustrates the role players and the process of the model (relationship-, working- and termination phase).

The model (Janse van Rensburg 2010) was developed by utilising the steps of theory generation as discussed by Dickoff, James and Wiedenbach (1968) and Chinn and Kramer (2008). For the purpose of clarity there will be referred to Janse van Rensburg’s model (2010) as the ‘existing model’ for student support in a chronic context and the ‘adapted model’ to enhance the psychological support for students in an acute mental health context.

The adapted model will be developed based on the need to support students in the acute mental health context as discussed in the background. The researcher became aware through literature searches that a gap exists in terms of support for students in the acute mental health setting. As the context of the acute setting was described previously it illuminates the dire need for psychological support as students feel uncertain, hopeless and are confronted with fear linked to pre conceived beliefs when faced with the acute phase of the patient’s illness.
The main research question for the development of the adapted model is: How can the existing model for the chronic mental health context be adapted to enhance support by preceptors to students in an acute mental health context? Adapting the model will include a process of model deconstruction by comparing the chronic and acute contexts.

The phases of Janse van Rensburg’s model (2010) (view figure 1) and the adapted model will be briefly described as part of the methodology of this article.

Janse van Rensburg’s model (2010) consisted of different role players and components. The role players included advanced psychiatric nurse educators (educators with a master’s degree in Psychiatric Nursing) and student nurses placed at a facility for mentally challenged individuals (chronic context). The term educator will refer to the advanced psychiatric nurse educators in the text. The term mentally challenged individuals will refer to a person diagnosed with mental retardation. The components involved the phases of the model that included a relationship, working and termination phase (view Figure 1).

The adapted model will consist of role players that include the preceptors and students in an acute mental health context. The term preceptor will include a qualified mental health care worker and the term student will refer to a person studying in the health sciences discipline and being placed at an acute mental health context as a clinical requirement for their studies.

Similarities exist between the relationship and termination phases of Janse van Rensburg’s model (2010) and the adapted model. Therefore for the purpose of this article, the focus will be on the working phase. However the other phases will be mentioned briefly.
The relationship phase of Janse van Rensburg’s model (2010) focuses on forming a therapeutic relationship with student nurses to enhance their learning encounter. The level of engagement of the educator with the student nurses is high in terms of support, level of empathy and availability. The educator explores the emotional discomfort of student nurses during placement at the facility for mentally challenged individuals through the facilitation of group discussion. The level of engagement of the student nurses with the educators in the relationship phase is low as the therapeutic relationship based on trust is still developing. Student nurses are faced with a choice of engagement or non-engagement with the educator and mentally challenged individuals. Student nurses who choose non-engagement return to the emotional discomfort and are not able to move to the working phase. These students remain emotional distant and aloof as they choose not to engage with the educator. This may hinder their personal and professional development and they avoid the mentally challenged individuals, providing only basic nursing care (Janse van Rensburg 2010). This correlates with a statement by Menzies (1960) in McCrae (2014) that nurses use defence mechanisms to protect themselves from their own anxiety by remaining emotionally uninvolved in their nursing practice. Defence mechanisms are used to adjust to stressful situations by creating emotional awareness and balancing conflicts (American Psychological Association 2000). Defence mechanisms are classified into primitive, immature, neurotic and mature domains (Beresford 2012 in Beresford 2014). Primitive, immature and neurotic defence mechanisms can block effective learning and self-growth as it hinders stress resolution (Beresford 2014). It is unclear according to the literature what defence mechanisms are used by students in chronic and acute settings and how they may differ between these two settings.

During the relationship phase of the adapted model the support by the preceptor is more intense. The preceptor role models a therapeutic relationship by demonstrating empathy, positive regard and availability towards students. According to Purkis (1996) the ‘ideal image’ of nursing involves being co-present and in close proximity. The preceptor’s being co-present with the student should be demonstrated by valuing the students’ experiences in the acute mental health context. Being co-present will refer to the preceptor being knowledgeably and comfortable with the acute mental health context. The preceptor should be aware of the acuity of the context linked to the acute phase of the patients’ mental illness. This awareness will assist the preceptor to facilitate teachable moments within the acute mental health setting. Teachable moments should be created in the acute context by using role play as a teaching strategy to demonstrate the management of challenging behaviours of patients. These behaviours can include aggression and the management of psychotic patients. The preceptor should encourage reflection as a learning principle in the acute context to ensure theory and practice integration. According to Suwanbamrung (2015) reflection assists students to link their knowledge to nursing practice, enhancing problem solving skills through reviewing their clinical experiences.

During the working phase of the existing model the educator’s and student nurses’ level of engagement is moderate. The educator facilitates empowerment in the working phase by providing unconditional acceptance and positive regard by creating a platform where student nurses can reflect on their experiences without being judged. The nurse educator facilitates group discussions to create emotional awareness and reflect on learning opportunities. Group discussions create a sense of universality and belonging within the group of students. As student nurses become aware of their emotional processes, they become more empowered by their ability to engage with the patients while the educator’s level of engagement with the student nurses decreases and are adjusted according to the needs of the student nurses. (Janse van Rensburg 2010).

The working phase of the adapted model will be discussed in detail under the findings of this article as it will form the theoretical framework of the adapted model and indicate the theory derivation (Walker and Avant 2005).

During the termination phase of the existing model the educator facilitates transformation and the start of a journey towards the discovery of meaning through self-reflection and awareness of meaning creation. The level of engagement from the educator with the student nurse is on a low level as student nurses strive to become more independent. The student nurses’ engagement with the mentally challenged individuals is on a higher level as they seek the person beyond the illness. The educator will facilitate
self-reflection practices as student nurses are encouraged to write about their experiences in the acute mental health context in reflective journals. Awareness of the role of meaning and enhancing opportunities to create meaning in one’s professional life will be addressed in the termination phase. Meaning can be linked to inter- and intrapersonal relationships (Janse van Rensburg 2010).

Findings

The findings of this article reflect a theoretical framework of the adapted model. The purpose of the adapted model will be to enhance psychological support from preceptors for students in an acute mental health context. The adapted model consists of a relationship-, working- and termination phase. The relationship and termination phase were discussed briefly as part of the methodology section of this article. The focus of this article will be on the working phase as a process of enhancing support for students in an acute mental health context.

The working phase will focus on empowerment of students with knowledge and skills applicable to the acute mental health context. The preceptor will model the therapeutic use of self to the students. The use of self includes effective communication skills, self-awareness and self-disclosure (Jones 2012). The preceptor will create a safe space where students can reflect on action about their experiences of working with patient’s in their acute phase of their mental illness. Reflection can be described as one’s critical, conscious review of experiences by exploring one’s own practice in order to change future practice in a positive way (Bulman 2008 in Bulman, Lathlean & Gobbi 2012; O’ Donovan 2007). According to Bulman et al. (2012) it entails a way of ‘being’ as it includes affective and motor elements. In mental health, the health care worker is using her/himself as an instrument when working with patients diagnosed with a mental illness. The preceptor should create a space where positive opportunities are provided to make sense of interactions that took place in the acute mental health context. Due to the acute setting, teachable moments might be lacking in the here-and-now, therefore the preceptor can use reflection to enhance future practice of students. The preceptor will provide psychological support as needed to alleviate students’ feelings of fear, rejection and helplessness. Students will be able to engage more effectively in learning once their emotional discomfort is addressed (Efklides & Petkaki 2005).

One-on-one supervision becomes a challenge as undergraduate student numbers increases. Group supervision can increase the efficient utilisation of resources as one preceptor can provide support and supervision for 8-10 students. Group supervision and support enhances learning from others and enhances self-reflection through peer learning (Kolb 1984; Schon 1987). The preceptor should utilise the group process and dynamics to generate group discussions, self-awareness and facilitate change in students. Teachable moments can be created through group discussions, role play and reflection. Group discussions can create a platform to voice experiences within a safe context. Group discussions or supervision will be referred to as group support for the purpose of this article. The method of group support will be discussed based on Howie and MacSporran’s (2010) group development stages. These stages includes the i) preparation and orientation stage; ii) dissatisfaction stage; iii) resolution stage and iv) production phase.

The preparation and orientation phase will form part of the relationship phase of the adapted model and will include the structural components of the group support. The structural component will include group membership as 8 to 10 students will form a group. The group will be divided into smaller groups of four to five members for case management discussions and role plays. The group meetings should be scheduled at specific times to create a sense of containment and predictability for students within the unpredictability of the acute mental health context. The preceptor should display a non-judgmental attitude and clarify the purpose of group support, goals and expectations of all stakeholders. This process includes the facilitation of ground rules of respect, boundaries, commitment and confidentiality to ensure that contributions of all students are valued and respected. During this stage, the preceptor should explore positive and negative emotions related to the acute mental health context. The dissatisfaction, resolution and productive stage will form part of the working phase of the adapted model to support students in the acute mental health context.
During the **dissatisfaction stage**, student may voice their dissatisfaction with the group support or the acute mental health context. The purpose of the groups support should be clarified and a space created by the preceptor to explore and ventilate any negative emotions, including fears and concerns. The dissatisfaction stage should be resolved before moving forward to the resolution stage.

The **resolution stage** focuses on the group processes and group dynamic. The preceptor facilitates these processes and dynamics by engaging all the group members and reflecting on the here-and-now of the group process. Group cohesion can be enhanced through applying the principle of universality where students realise that their experiences are not unique and they are able to learn from one another by brainstorming possible solutions for problematic scenarios.

During the **production stage** the students are able to engage with the learning content and take responsibility for their learning. Themes for group discussions will be provided for the groups based on the learning outcomes and student needs (Howie & MacSporran 2010). Themes may include the therapeutic self, risk assessment and management of violent behaviours.

**Recommendations**

It is recommended that the adapted model be applied in acute mental health context to provide psychological support for students. The model consists of a relationship-, working and termination phase.

The adapted model can be used to provide structured group support and supervision to enhance the learning experiences of students in the acute mental health context.

It is recommended that the adapted model be implemented with students at an acute mental health context and research be done to explore the students’ and preceptors’ experiences about the effectiveness of group support within this context.

The adapted model can be utilised by health care workers in the acute context and applied to students studying in the health care field who are placed in an acute mental health care context.

**References**