NURSING STUDENTS' EXPERIENCES IN MENTAL HEALTH PRACTICUMS:
A NARRATIVE INQUIRY

by

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ABSTRACT

Mental health challenges are one of the leading global health concerns, yet health care for people experiencing these health issues is severely lacking, in both accessibility and quality. Nurses are uniquely positioned to provide direct care to this population, however nurses' attitudes towards individuals with mental health challenges are frequently characterized by stigma and misconceptions. Mental health practicums within nursing school are a key venue for student learning, development, and experience in working with this population, yet research demonstrates that students frequently hold negative attitudes toward mental health nursing as a career path and do not feel adequately prepared to work with individuals with mental health challenges in any health care setting. To address gaps in understandings of these issues, this qualitative study explored students' experiences within mental health practicums through a narrative inquiry approach. Individual interviews were conducted with 15 nursing students following their practicum experiences. Findings describe the narrative of resistance within the students' practicums that emerged from participant stories of their experiences. The students identified this practicum as fundamentally different from others, and as such, their pre-engagement included particular preparation strategies to maintain their emotional well-being through the practicum, and critical engagement with societal stereotypes around mental health. Within the practicum, the students' recognized the ways in which nursing care of patients was characterized by power relations, enacted through disengagement and unsafe and unethical practices. Participants enacted resistance through connecting with patients, enacting ways of knowing that contrasted with dominant nursing practices, and drawing on their student role to justify their resistance. Informing participants' enactment of resistance, narratives spoke to the complex interplay of empowerment and disempowerment in the setting, shaping their

experiences in the practicum and expectations of future nursing practice. Study implications include theoretical contributions to the concept of resistance within nursing education. Additionally, this study supports the need for increased educator support for students in advance of, and during, their mental health practicums; findings further speak to the need for systemic changes in the practice environment to support safe and effective patient care.

LAY SUMMARY

Mental health challenges are one of the leading health care concerns today, and while nurses should be well-positioned to provide care to this population, research demonstrates that nursing students are not adequately prepared for this role. To better understand the reasons contributing to this gap, this study explored nursing students' experiences within their mental health practicums. Study findings demonstrated that the students observed nurses holding power over patients and frequently providing inadequate or unsafe care. The students resisted power within this setting by connecting with patients, drawing on other forms of learning to inform their patient care, and justifying these actions through being in a student role. However, the students also described feeling disempowered in the setting, which shaped their experiences of the practicum and their expectations of future nursing practice. Study findings speak to the need for further development of practice, education, and research strategies to support students.

PREFACE

This thesis is original, unpublished, independent work by the author, Allie Slemon. This study was granted ethical approval by the University of British Columbia Behavioural Research Ethics Board – Certificate Number: H16-03321.

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CHAPTER ONE: SITUATING THE PROBLEM

Introduction

Canadian undergraduate nursing education programs are tasked with preparing students with the "knowledge, skills, and personal attributes" required to meet the provincial and national regulatory and practice requirements of the profession (Canadian Nurses Association, 2017). Nursing programs are comprised of both theoretical classroom-based education and clinical practicums, which in combination aim to develop students' ability to provide competent patient care (College of Registered Nurses of British Columbia [CRNBC], 2013; Pijl-Zieber, Barton, Konkin, Awosoga, & Caine, 2014). Students complete practicums across a variety of health care settings where nurses practice, and most nursing programs in Canada include student practicums in hospital, long-term care, and community settings (Canadian Association of Schools of Nursing [CASN], 2015a). Practicums provide students with exposure to a wide variety of nursing practice areas and experience in managing patient care in unpredictable situations (CASN, 2015a), and as such, are characterized as preparing students for "the realities of the nursing profession" (Hartigan-Rogers, Cobbett, Amirault, & Muise-Davis, 2007, p. 6).

The Canadian Association of Schools of Nursing (CASN) identifies care of individuals with mental health challenges[1] as a necessary component of nursing education and articulates that skill and knowledge relating to mental health is a competency "all nurses should possess…regardless of where they are employed following graduation" (CASN, 2015b, p. 2). Preparedness for nursing care of individuals with mental health challenges is a concept that has not been extensively developed in the research (Happell, 2008a; Walsh, 2015). Within this study,

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[1] The term mental health challenges is used throughout this document to describe a range of experiences that impact mental well-being, which may or may not include a diagnosed mental illness. The use of this term is further described in the Background section below (pp. 3-4).

preparedness is taken up as a multi-faceted concept including not only knowledge and skill, but also holding attitudes and perspectives to provide ethical, compassionate, and respectful care (Lindh, Severinsson, & Berg, 2008). CASN, which accredits nursing programs, does not mandate that nursing programs offer a practicum in mental health settings; however, most nursing programs in Canada include a mental health practicum to develop student preparedness for working with this population (Smith, Corso, & Cobb, 2010; Smith, Spadoni, & Proper, 2013). Yet, the literature demonstrates that students may frequently view this practicum as an overall distressing and difficult experience, related to factors such as witnessing unethical nursing practices and experiencing anxiety and fear in providing care to people who experience mental health challenges (Jansen & Venter, 2015; Stevens et al., 2013; Thongpriwan et al., 2015). Many students graduating from nursing programs do not feel confident nor adequately prepared in knowledge, skills, or attitude to provide care to individuals with mental health challenges, even after undertaking a practicum in this area (Alexander, Ellis, & Barrett, 2016; Hunter, Shattell, & Harris, 2015; Waite, 2006). Consequently, mental health nursing is consistently found to be the least desirable career path for graduating nurses, primarily due to students' residual anxiety and lack of confidence and competence in providing care to this population (Happell & Gaskin, 2012; Hastings, Kropowski, & Williams, 2017; Stevens, Brown, & Graham, 2013).

Such findings speak to critical gaps in the effectiveness of mental health nursing education, and suggest that mental health practicums are not adequately preparing students for the realities of practice in mental health settings or in working with this population in any nursing role (Curtis, 2007; Walsh, 2015). However, while practicums have been identified as a potentially negative experience, little is known about how students interpret their experiences

and reflect on working with individuals with mental health challenges in future nursing practice (Happell, 2008a). To address this gap, this study takes up a methodological approach of narrative inquiry to explore how students describe, interpret, and contextualize their experiences in mental health practicums. In this chapter, I situate this study in the context of stigmatizing attitudes toward individuals with mental health challenges in society and in particular, in health care settings. The context of stigma in nursing care speaks to important educational gaps in preparing nurses for working with this population, and demonstrates the need for increased understanding of students' experiences in mental health practicums: how students reflect on interactions with clients and staff, and how these experiences inform their interpretations and understandings of mental health nursing practice. First, I provide definitions of mental health and mental health challenges to establish consistent terminology. Then, to contextualize the need for further research on understanding students' experiences in mental health practicums, I briefly outline the national and global need for mental health care, nurses' role in mental health care provision, and the research evidence on the issue of nurses' stigma toward this population, which suggests that mental health practicums are are not adequately preparing students for the realities of mental health nursing practice. Lastly, I describe the study purpose including the research question and objectives.

Background

'Mental disorder' and 'mental illness' are commonly used terms describing states "characterized by a combination of abnormal thoughts, perceptions, emotions, behaviour and relationships with others" (World Health Organization [WHO], 2017); however, such terminology has been critiqued as medicalizing normal human behaviour, emotions, and responses, and as creating a binary between mental health and mental illness (Aneshensel,

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Phelan, & Bierman, 2013; Rogers & Pilgrim, 2014). This study draws on the definition of mental health proposed by the WHO (2014), described as a "state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community". Galderisi and colleagues (2015) further contribute to this definition the description of mental health as "a dynamic state of internal equilibrium" (p. 231) as opposed to a fixed, absolute state that is either experienced or not. 'Mental health challenges' is an emergent term used to describe a range of experiences that threaten this state of equilibrium, which may or may not include experiences consistent with a standardized diagnosis (Southwick, Litz, Charney, & Friedman, 2011). Though the experience of mental health challenges may also not necessitate or result in interactions with the health care system, for the purpose of this study focusing on nursing students, 'mental health challenges' will be the term used to describe experiences of individuals that have led to health care provider contact. The term mental health challenges is used, as opposed to mental illness, as not all individuals who access even acute mental health services will have a diagnosis that constitutes mental illness or mental disorder; further, the language of such diagnoses may further marginalize individuals seeking health care (Roberts, 2009).

In 2013, the WHO developed a Mental Health Action Plan 2013-2020 in response to a global need for treatment and prevention of 'mental disorders', which they report accounted for 13% of the global burden of disease (p. 7-8). Vigo, Thornicroft, and Atun (2016) argue that historically, such figures have been significantly underestimated and the true prevalence of mental health challenges is likely much higher. Access to mental health care is severely lacking, with between 35-85% of the global population experiencing mental health challenges receiving no treatment (World Health Organization, 2013). In Canada in 2012, 17% of Canadians (4.9

million people) self-reported a need for mental health care in the past 12 months, with 10.1% of the population (2.8 million people) reporting symptoms of a major mental health or substance use disorder (Statistics Canada, 2013). Only 67% of this population reported their health care needs being met, with 1 in 5 individuals with unmet needs citing unavailability of services as the primary reason for not receiving care (Statistics Canada, 2013). Globally and within Canada, mental health care needs are high, yet access to care is insufficient. An important contributor to the lack of accessible health care for this population is stigma and discrimination. Individuals with mental health challenges face workplace and housing discrimination and exclusion from family and social groups (Hatzenbuehler, Phelan, & Link, 2013), and nearly half of Canadians state that they "would not socialize with a friend with a mental illness" (Canadian Medical Association, 2008). Research further demonstrates that public stigma is greater toward those who have sought professional help for mental health challenges, and suggests that the stigma of seeking help may be a potential detractor from contact with the health care system (Corrigan, Druss, & Perlick, 2014; Jorm & Oh, 2009).

The profession of nursing is well positioned to provide direct care in hospital and community settings for individuals with mental health challenges, with nurses contributing to mental health promotion, crisis management, and treatment across various health care environments (Canadian Nurses Association [CNA], 2012). Yet, despite a large proportion of nurses receiving mental health training during their nursing education and working closely with individuals with mental health challenges in practice, nurses' attitudes towards people who experience these challenges are comparable to general public opinion, characterized by stigma and fear of unpredictability and violence (Björkman, Angelman, & Jönsson, 2008; Jorm & Oh, 2009; Ross & Goldner, 2009). Although negative attitudes toward individuals with mental health

challenges are not universal amongst nurses (Munro & Baker, 2007), Mårtensson, Jacobsson & Engström (2014) argue that nursing subcultures contribute to the perpetuation of negative attitudes and stigmatized knowledge, such as misconceptions about treatment and recovery, amongst this group. While some research suggests that mental health practicums reduce students' stigmatizing attitudes (Happell, 2008; Thongpriwan et al., 2015), Linden & Kavanagh (2012) found no difference in mental health stigma between students and mental health nurses, with negative attitudes toward this population in both groups. Further, students' stigma toward people living with mental health challenges contributes to anxiety and fear in interacting with patients, both during the practicum and following graduation (Bennett & Stennett, 2015; Fisher, 2002; Hung, Huang, & Lin, 2009). Students' residual stigma after undertaking mental health practicums speaks to gaps in mental health nursing education in effectively preparing students for practice, and to the need for further research that increases understanding of student experiences within these practicums.

The publication *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* (Mental Health Commission of Canada, 2012), identifies the improvement of inpatient mental health care as a national priority, and notes barriers to this goal such as lack of patient access to care and ineffective coordination between inpatient and community services, leading to relapse and hospital readmission (p. 69). To support the goals of the national strategy for mental health care, nurses must be prepared through effective education for meeting the needs of individuals with mental health challenges. However, research demonstrates that patient care within inpatient mental health settings may not be consistently safe, ethical, and therapeutic. Rao and colleagues (2009) demonstrate that health care providers working across health fields hold increased stigmatized views toward individuals who are patients in acute mental health hospital

settings as compared to individuals receiving health care in less acute environments. Further, of health care providers working in mental health settings, hospital-based staff hold more stigmatizing views as compared to staff in community settings (Linden & Kavanagh, 2012). Shattell, Andes, & Thomas (2008) report that the inpatient mental health environment is viewed as jail-like by both nurses and staff alike, and studies exploring patient care in these settings consistently describe humiliating and dehumanizing practices such as arbitrary rule enforcement or unnecessary punishments (Larsen & Terkelsen, 2014; Loukidou, Ionnidi, & Kalokerino-Anagostopoulou, 2010). While a large body of research explores the impact of nursing stigma on health care accessibility and health outcomes for individuals with mental health challenges (Clarke et al., 2014; Hatzenbuehler et al., 2013), less is known about the ways in which nurses' attitudes and practices, and the inpatient environment, may impact students' practicum experiences (Jansen & Venter, 2015; Wojtowicz, Hagen, & Van Daalen-Smith, 2014). To address this gap, this study specifically focuses on students' experiences within mental health practicums in inpatient settings, to explore the ways in which students describe and interpret their practicum experiences within the challenging and complex context of the inpatient environment.

Study Purpose

There is nascent evidence that nursing students do not feel adequately prepared to provide nursing care for individuals with mental health challenges, even after practicum experience (Happell et al., 2008b; Hunter et al., 2015; Walsh, 2015). Their practicum experiences may often be negative, though there is limited research in this area. These findings are supported by nurses' ongoing stigmatizing attitudes toward this population across mental health and other health care settings, which further suggest that mental health practicums do not

fully support nursing students for providing competent mental health nursing care. Further research is needed to understand the nature of students' experiences in mental health practicums and how students make meaning of their experiences, particularly in the context of the challenges of inpatient mental health settings. Addressing this gap in understandings is key for the development of strategies for addressing students' negative experiences and perceived lack of preparedness, and more broadly, for avoiding the perpetuation of stigma and discrimination toward individuals with mental health challenges in future generations of nurses.

This study aims to fill this gap in the literature by exploring undergraduate nursing students' experiences of such practicums within a generalized nursing program in British Columbia, Canada, through an inquiry into the research question: How do undergraduate nursing students describe, contextualize, and interpret their experiences in their mental health practicums? The specific objectives of this study were to: 1) describe how students navigate and reflect on their experiences in this setting; 2) explore how students' life experiences, beliefs, and attitudes affect their interpretation of their experiences; 3) understand the ways in which sociocultural contexts, of both the practicum setting and the broader social world, influence students' experiences in mental health clinical environments; and 4) explore how students reflect on their perceptions and expectations of providing care for this population across health care settings in their future nursing practice.

Thesis Overview

In the introductory chapter, I have explored the background for this study, including the need for further research into students' experiences in mental health practicums. Chapter Two further explores the context for this study through a literature review on research related to inpatient mental health settings and mental health practicums. Chapter Three describes the the

methodology, theoretical framework, and study design, including sampling, data collection, and data analysis. This study takes up narrative inquiry as a methodological approach addressing the research question and objectives, positioning student stories as central to gaining qualitative understanding of their practicum experiences. In Chapter Four, I present study findings, first describing the study sample, then exploring the emergent theme of students' resistance to power within the mental health clinical setting. This document concludes with Chapter Five, a discussion of the study's findings, situating this study in the broader literature on the mental health nursing practice, education, and research.

CHAPTER TWO: LITERATURE REVIEW

Introduction

This chapter presents a review of the literature regarding students' experiences in mental health practicums. The literature review focused on the primary research on this topic; additionally, reviews of secondary research such as discussions and research syntheses informed the review process and the identification of key themes. I begin by describing the process through which I conducted this review. I then give a brief overview of research on inpatient mental health settings, including the environment, nursing practices, and nurse and patient perspectives on mental health care in these settings. Next, I discuss the literature that pertains to the study problem as described in Chapter One: students' negative experiences in mental health practicums and their preparedness in providing care for individuals with mental health challenges. This review also discusses the literature that situates students' experiences within a health care context characterized by stigmatizing attitudes toward the group of interest. Specific themes within this literature review are outlined below. Taken together, the literature presented in this chapter provides important background of what is known about students' experiences of mental health practicums and establishes the context for this study's narrative inquiry into student descriptions and interpretations of their experiences.

To examine the current state of the research examining nursing students' experiences in mental health practicums, I conducted a comprehensive search of the literature in CINAHL, PubMed, and PsychINFO databases as well as Google Scholar. Firstly, to understand the environments in which students complete their mental health practicums, I reviewed the research literature on inpatient mental health settings, exploring research on nursing practices and perspectives, and patient experiences. Next, I conducted a broad search to capture a wide range

of studies relating student experiences within these settings, using search terms such as "nurs*", "student*", "mental health" and "psych*". In selecting articles for inclusion, I drew primarily on research from industrialized nations to maximize applicability to the Canadian context in which this study was conducted. A substantial portion of the reviewed literature is from Australia, including the research contributions from Happell, a leader in the field who has contributed to many of the articles reviewed for this study. Additionally, much of the literature is from the United Kingdom and United States, though there is a dearth of research on this topic in Canada. Some articles from non-industrialized countries (e.g. Bvumbwe, 2016) were included after a close reading of the text to assess relevancy to this study's context.

Following a preliminary review of results, which included theoretical and clinical education of nursing students both within and outside of mental health settings, I reviewed primary research articles relating specifically to mental health practicums. Within this literature, I identified three themes: 1) students' practicum experiences; 2) clinical preparedness, which explores students' perceptions of their preparedness in working with individuals with mental health challenges within and following their practicums; and 3) students' career planning, which explores the impact of students' practicums on their expectations of working with individuals with mental health challenges after graduation and their reflections on mental health nursing as a career. Following identification of the three themes, I conducted additional database searches using relevant keywords for the latter two themes, as the literature for the first theme was captured through the broad search. For the second theme I used the search terms, in conjunction with those listed above, "prepar*", "*graduat*", and "new" (to capture research on student experiences through graduation, and newly graduated nurses). For the third theme, I used the search terms "career", "profession", "job", and "work". Through this process, three sub-themes

within the first theme (students' practicum experiences) were identified: navigating stigma and understanding, stress and anxiety, and witnessing unsafe and unethical practice. Literature informing an understanding of these themes is presented in this chapter.

Inpatient Mental Health Settings

This study explores the experiences of nursing students undertaking mental health practicums in acute inpatient settings. To contextualize students' experiences, this section presents an overview of the history of inpatient mental health care and a brief summary of the literature on the current context of inpatient settings and the nursing practices in these environments. Today's inpatient mental health care is informed by the history of institutionalized mental health settings, in which individuals with mental health challenges were contained and often subjected to harmful practices that were framed as treatments (Beer, 2007; Ernst, 2016). While many of these practices, such as hard labour, starvation, and medical procedures including lobotomies and hysterectomies, have been reframed as abusive, unethical, and non-therapeutic (Ernst, 2016), other practices originating in institutionalized settings continue to be utilized, including environmental confinement through the use of locked doors, use of isolation rooms (also called 'seclusion'), and physical restraints (Ashmore, 2008; Bullock, McKenna, Kelly, Furness, & Tacey, 2014; Gooding, 2016). Deinstitutionalization, beginning in the 1950s, led to the closing of institutionalized settings for mental health care, and a reconceptualization of mental health treatment practices toward ethical treatment and community-based care provision (Novella, 2010; Sealy, 2012). However, Loukidou, Ionnidi, & Kalokerinou-Anagnostopoulou (2010) describe nursing practices in today's inpatient mental health settings as remaining 'institutionalized'. The authors argue that nurses in these settings continue to demonstrate many of the attitudes and behaviours from the era of institutionalization, and that hospital settings in

many ways mirror psychiatric institutions; they conclude with a call for deinstitutionalizing

mental health nursing *practices* as well as the settings in which these practices occur, stating that

nurses must "un-learn their old ways of working and re-learn new ones" (p. 830).

The institutionalized nursing practices described by Loukidou et al. (2010) include those

described in the literature as 'containment' and 'coercion'. Containment practices encompass

interventions that restrict the actions and behaviour of patients, and may include locking of units,

use of seclusion, and constant observation of patients (Bowers et al., 2009; Muralidharan &

Fenton, 2006; Stewart, Bowers, & Ross, 2012). Coercion refers to forced interventions to which

a patient does not have to provide consent, frequently utilized in instances of acute agitation or

violence. Coercion may include administration of medications, physical restraint, or the use of

seclusion (which is considered both containment and coercion), as well as a threat of any of these

interventions (Larsen & Terkelsen, 2014; Paterson, McIntosh, Wilkinson, McComish, & Smith,

2013). Though all of the above interventions are used frequently in inpatient mental health

settings (De Santis et al., 2015; Johansson, Skärsäter, & Danielson, 2013; Vruwink et al., 2012),

patient perspectives consistently characterize such practices as distressing, harmful, and

traumatic (Breeze & Repper, 1999; Kontio et al., 2012; Muir-Cochrane et al., 2012). Nurses'

perspectives however, are often conflicted: nurses frequently support the use of interventions

consistent with containment and coercion as necessary for control and safety (Happell & Koehn,

2010; Muir-Cochrane et al., 2012; VanDerNagel, Tuts, Hoekstra, & Noorthoorn, 2009), however

also experience moral distress and guilt after utilizing such interventions (Larsen & Terkelsen,

2014; Stevenson, Jack, O'Mara, & LeGris, 2015).

In response to both patient and nurse concerns regarding common practices within

inpatient mental health settings, recent research has explored new directions for nursing

approaches to mental health care. Internationally, hospitals are introducing initiatives to reduce the use of seclusion and restraint, though with varying rates of success (Bullock et al., 2014; Madan et al., 2014; Paterson et al., 2013). Isobel (2015) explored integrating principles of trauma-informed care into nursing practices in the inpatient setting through reviewing unit rules to ensure their appropriate justification with policy and ethical principles and the consistency of their application in patient care; this initiative represents a shift in practice from the often arbitrary and restrictive application of unit rules, which both patients and nurses view as representative of nurses' control and power (Shattell, Andes, & Thomas, 2008). Further, Safewards, a recent a multi-faceted model for changes to inpatient mental health environments and practices, provides direction for nursing managers in implementing unit-level change with the aim of reducing containment and coercion (Bowers, 2014); Safewards is being implemented in many inpatient mental health settings internationally, including in Canada (Centre for Mental Health and Addictions, 2016; Tuck, 2017; Whitmore, 2017). However, such systemic shifts in practice are still emergent, and nursing practices in inpatient settings remain largely reflective of principles of containment and coercion.

Both patients and nurses characterize many interventions utilized in the setting as representative of power and control enacted through containment and coercion practices, and multiple barriers remain to nurses' provision of safe, appropriate, respectful, and ethical care of individuals with mental health challenges. Understandings of the inpatient mental health setting, including nursing practices, and nurse and patient perspectives on inpatient care, provides important context for nursing students' practicum experiences within these settings in suggesting that students may complete their practicums in environments where patients experience

unethical, non-therapeutic care through institutionalized nursing practices that position them as dangerous and thus needing to be controlled.

Students' Practicum Experiences

This section explores three sub-themes in the research literature on nursing student experiences in these inpatient mental health practicums: stigma and understanding, stress and anxiety, and witnessing unsafe and unethical practice. The research discussed within each of these sub-themes provides context for this study, and is explored in detail to examine what is known about student experiences in these practicums, and what gaps remain.

Navigating Stigma and Understanding

Research suggests that in advance of mental health practicums, nursing students hold stigmatizing beliefs and attitudes toward individuals with mental health challenges, including fear of violence and unpredictability (Henderson, Happell, & Martin, 2007; Koskinen, Mikkonen, & Jokinen, 2011; Melrose & Shapiro, 1999), and concerns regarding potential interactions with this population in their home neighbourhoods (Markström et al., 2009). Students who personally knew someone, such as a relative, friend, or co-worker, with mental health challenges prior to nursing school are more likely to hold positive attitudes toward this population, yet may still hold stigmatizing views such as believing that individuals with a history of mental health challenges cannot be trusted with serious responsibilities (Schafer, Wood, & Williams, 2011; Surgenor, Dunn, & Horn, 2005). While research suggests that many nursing students hold stigmatizing beliefs in advance of mental health practicums, such beliefs are significantly reduced amongst students who have completed a practicum (Happell, 2008b; Thongpriwan et al., 2015). Students' stigma is frequently measured through surveys administered to students in nursing programs; for example, Markström and colleagues (2009)

surveyed 1001 students across multiple health disciplines including nursing, utilizing the

Attitudes to Persons with Mental Illness ("Changing Minds") questionnaire and the inventory of

fear and behavioural intentions (FABI) administered at three time points including prior to and

following students' practicums. The researchers found significant reduction in stigmatizing

beliefs post-practicum for all disciplines. Surveys conducted specifically within nursing

programs utilizing similar measures likewise found both a reduction in stigma following

practicums, and significantly lower stigmatizing beliefs in students who completed mental health

practicums compared to students who had not (e.g. Happell, 2008b; Surgenor et al., 2005;

Thongpriwan et al., 2015). A systematic review of the effectiveness of clinical placements in

changing student attitudes suggests that these survey findings are consistent across studies (Bte

Abd Malik, Kannusamy, & Klanin-Yobas, 2012). In qualitative studies, students report that

through their mental health practicums, they "learn[ed] not to judge" (Henderson et al., 2007, p.

169), increased empathy (Koskinen et al., 2011), and gained respect for mental health patients

(Melrose & Shapiro, 1999). A qualitative phenomenological study by Hung, Huang, and Lin

(2012) suggests that students' pre-practicum beliefs, often gleaned from media representations,

include the perception that mental health challenges are associated with violence and arson.

While students described feeling initially afraid of interacting with patients in the mental health

clinical setting and engaging in strategies to avoid contact, this fear was ultimately reduced

through building trusting relationships.

Literature on student stigma suggests that 'understanding' is a factor in reducing stigma.

The concept of understanding is often not explicated in research but frequently includes a broad

range of experiences and attitudes, including hearing patients' stories, gaining knowledge about

mental health symptoms, observing improvement and recovery, and gaining awareness of the

false and discriminatory nature of stigmatizing attitudes (Hung, Huang, & Lin, 2009; Markström et al., 2009; Perlman et al., 2017). The shift from stigma to understanding is a common theme in research on mental health practicums, although this shift may not occur for all students, or represent the complete elimination of stigmatizing beliefs and attitudes. Amongst 30 Masters-level, pre-licensure nursing students, 97% of participants reported that their clinical experience engendered better understanding of mental health (Hunter et al., 2015). Further, in a survey conducted by Henderson and colleagues (2007) of 229 nursing students in which comments were analyzed qualitatively, the primary positive learning experience in mental health practicums was an increase in understanding of mental health, which students described as contributing to their ability to engage in therapeutic relationships (Henderson et al., 2007). To date, few studies have been conducted that contribute to insight into the specific aspects of the clinical experience that enhance understanding and reduce stigma. A Finnish qualitative study utilizing critical incident reflection identified that through students' active participation in mental health nursing care, specifically listening to life stories and experiencing complex care situations, students gained self-awareness of their own beliefs regarding mental health challenges, and in response, increased mental health nursing skills such as empathy and therapeutic interaction (Koskinen et al., 2011). Henderson et al. (2007) suggest that mental health practicums increase nursing students' personal awareness, including reduction of judgmental attitudes, though this research is survey-based, and as such does not seek insight into the nature of the experience, or in what ways students' awareness was increased.

Recent studies have explored new approaches to mental health clinical delivery, in comparison to practicums in inpatient mental health settings, as strategies for further reducing student stigma toward this population. For example, a study by Moxham and colleagues (2016)

evaluated the effect of a student placement at "Recovery Camp", an outdoor camp at which staff and clients participate in activities together and share meals and accommodation, as compared to traditional practicum settings. The authors measured stigma in both groups, prior to and after the clinical experiences, through a social distance scale, which measures participants' desire for geographical and interpersonal distance from individuals with mental health challenges as an indicator of stigmatizing attitudes. Findings included significant differences in stigma pre- and post-practicum in the intervention group, and between intervention and control groups post-practicum. Notably, pre- and post-practicum measures demonstrated no change in social distance in the control (typical practicum) group, suggesting that not all practicum experiences may lead to a reduction in students' stigma. In a follow-up qualitative article on this intervention, students described the Recovery Camp experience as providing the opportunity to hear clients' experiences of mental health challenges and of societal stigma, and consistent with other studies, suggested that understanding of mental health challenges contributed to their questioning and shifting their own stigmatizing beliefs (Perlman et al., 2017). The findings of research on mental health practicums outside of the inpatient setting, such as Recovery Camp, suggest that practicums in inpatient mental health settings may not effectively shift student stigma toward this population; however, such alternative approaches remain limited and further research into non-inpatient practicums are needed to further explore the impact of a variety of clinical delivery approaches on student's attitudes and beliefs.

Although some research indicates that through mental health practicums, students may reduce stigma and develop understanding, even after these practicums, some nursing students continue to endorse views grounded in stigma and desire for social distance. In a cluster analysis of nursing students surveyed after their mental health practicums, Gough and Happell (2009)

clustered students into three groups, each representing a third of the sample, based on their attitudes toward mental health nursing in their survey responses. Clusters 1 and 2 held more positive attitudes toward individuals with mental health challenges and mental health nursing, though only Cluster 1 indicated interest in pursuing a career in this field after graduation. Cluster 3 demonstrated significantly lower survey scores than the other clusters on multiple sub-scales which include knowledge of mental health diagnoses and symptoms, negative stereotypes toward individuals with mental health challenges, and the belief that mental health nurses provide a valuable service – a finding that suggests that many students (in this survey, a third) may continue to hold stigmatizing attitudes toward mental health following the practicum. Additional survey studies conducted following practicums demonstrate that students continue to hold stigmatizing beliefs, including that individuals with mental health challenges are unpredictable, cannot handle responsibility, and are more likely to commit violent crimes (Bennett & Stennett, 2015; Poreddi, Thimmaiah, Chandra, & BadaMath, 2015). Even in student groups with reduced stigmatizing views following mental health practicums, some contradictions remain: in one study that demonstrated a reduction in student stigma, over half of the nursing student participants stated following their practicums that they would tell someone they were experiencing a mental health challenges only if 'absolutely necessary' (Hunter et al., 2015). Residual stigma following the mental health practicum speaks to the need for further research that explores students' reflections on and interpretations of their experiences in these settings, and how their beliefs and attitudes, and the sociocultural context of stigma more broadly, may affect these experiences. Further, this literature speaks to educational strategies to inform educational strategies that address the sources of this residual stigma.

Stress and Anxiety

Students' experiences of stress during nursing school is common, with primary stressors including academic workload and concerns regarding clinical placements (Pulido-Martos, Augusto-Landa, & Lopez-Zafra, 2012; Timmins, Corroon, Byrne, & Mooney, 2011). Nursing students experience higher levels of stress than non-nursing undergraduate students, and while specific sources of stress within nursing programs have not been fully explored, the challenges of the clinical practice environment is speculated to be an important contributor (Bartlett, Taylor, & Nelson, 2016; Melincavage, 2011). Literature on mental health practicums demonstrates that this particular component of nursing school is a source of unique stress and anxiety, including fear of patient violence and concerns relating to personal safety in the clinical setting (Ganzer & Zauderer, 2013; Thomas & Bhattacharya, 2012). In a qualitative focus group study conducted by Jansen and Venter (2015), every group of nursing students, all of whom were in their final year of their program, endorsed the view that individuals with mental health challenges are unpredictable and potentially dangerous. While participants were purposively selected for their lack of interest in pursuing mental health nursing as a career, this finding is concerning, as nurses encounter individuals with mental health challenges in all areas of practice (Alexander, Ellis, & Barrett, 2016; Rao et al., 2009). Karimollahi's (2012) qualitative phenomenological study suggests that students' anxiety in mental health practicums is attributable to students' perceptions of mental health. The study findings demonstrated that students' initial anxiety in entering the clinical setting was grounded in their fear of violence, which the researchers ascribe to the students' erroneous beliefs, such as the perception that individuals with mental health challenges are 'uncurable'. In a survey of 116 nursing students conducted by Happell, Platania-Phung, Harris, and Bradshaw (2014), anxiety was likewise connected to negative stereotypes explored

through Likert scale measurements of statements such as "people with mental illness are more likely to be violent". Fisher's (2002) seminal study of students' fear in mental health settings analyzed 260 critical incident reports written by students during practicums, and reported that over half of students had witnessed situations involving actual or threatened violence by patients during their practicums. Feelings evoked by these incidents as described by the students in their reports included fear, discomfort, and feeling upset, further contributing to their anxiety within the clinical setting.

Studies exploring students' anxiety in mental health practicums suggest that in addition to fear of violence, students experience other sources of anxiety in the clinical setting, such as the concern of feeling responsible for patients yet being unable to help. Mun's (2010) analysis of written narratives uncovered students' worry of saying 'the wrong thing' and of potentially harming patients through inexperience, while findings from Melrose and Shapiro's (1999) descriptive case study of 6 nursing students included a theme of anxiety regarding their perceived inability to help patients due to lack of therapeutic skills. A study focusing on nursing students' experiences of stress further suggests sources of clinical anxiety as related to student workload, particularly on units with staffing shortages, and unit nurses' negative attitudes toward students (Galvin, Suominen, Morgan, & O'Connell, 2015). In addition to the personal impact of stress on nursing students, anxiety in the clinical setting is a concern for patient care: studies suggest that students frequently respond to their feelings of anxiety by distancing themselves from patients, including avoiding interaction (Hung et al., 2009; Karimollahi, 2012). Further, Law, Rostill-Brookes, & Goodman (2009) found that students across health disciplines, including nursing, who reported increased anxiety in response to a vignette of adolescent self-

harm demonstrated less willingness to help and increased endorsement of the use of containment and coercion interventions such as seclusion.

Literature suggests that students are often able to cope with the stressors of mental health practicums through building therapeutic relationships with patients and gaining knowledge and skills related to mental health nursing (Koskinen, Mikkonen, & Jokinen, 2011). Karimollahi (2012) describes the coping with stress as a process of continued engagement with and connection to patients in this setting, termed 'maturation'. However, many studies suggest that students frequently experience challenges in coping with clinical stressors despite experience working with this population. Many participants in Galvin et al.'s (2015) study reported difficulty finding time to practice self-care, and some reported utilizing self-identified negative coping strategies such as alcohol. Similarly, in another qualitative study exploring nursing students' perspectives on their mental health practicums (Jansen & Venter, 2015), participants expressed concerns of emotional over-involvement, and difficulty coping with patients' mental and emotional challenges. Participants' distress regarding the perceived emotional burden of mental health nursing work was further exacerbated by a belief that individuals with mental health challenges face poor prognoses, and students expressed observing limited improvement in mental health in the patient population in the duration of their mental health practicums, as compared to patients encountered in medical or surgical practicums – a finding corroborated by Henderson et al. (2007). In attempting to cope with clinical stressors, many students may utilize strategies that in fact aggravate anxiety, such as avoidance (i.e. avoiding rather than attempting to resolve clinical challenges) or emotion-based coping strategies such as wishful thinking and self-blame (Alzayyat & Al-Gamal, 2016; Galvin & Smith, 2015). Further, Galvin et al. (2015)

suggest that anxiety may be exacerbated, rather than reduced, within the practicum, particularly by experiencing complex and acute care situations without adequate support and debriefing.

To support educators in preparing students for coping with practicum anxiety, multiple research studies have evaluated the efficacy of simulation, and have suggested that simulations of nursing assessments, acute care situations, and patient experiences of symptoms may reduce student stress (Fossen & Stoeckel, 2016; Goh, Selvarajan, Chng, Tan, & Yobas, 2016; Sarikoc, Tangul Ozcan, & Elcin, 2017). Hermanns, LuAnne Lilly, & Crawley (2011a) evaluated a simulated crisis on a mental health unit to prepare students for navigating acute care situations in their practicums. "Behind the Door" is an interactive case study that presents the care emergency of a patient suicide by hanging, with objectives including emotional preparedness and planning for individual and team interventions. The authors describe that the experience of some anxiety through the simulation process is an intended outcome in order to normalize stress during actual medical emergencies; while the simulation may be potentially triggering and stressful for students, the authors reported no negative comments regarding the simulation experience (2011b). In addition to simulated clinical experiences, Ganzer and Zauderer (2013) further suggest that student fears can be dispelled in advance through self-reflective learning exercises guided by instructors that focus on working through anxieties.

The extensive literature on student anxiety in mental health practicums, and on potential strategies for reducing student anxiety, demonstrates that many students experience anxiety that is not always alleviated through the practicum (Thomas & Bhattycharya, 2012). As a result of this anxiety, students may utilize harmful coping strategies, and may experience anxiety in future nursing care of individuals with mental health challenges, a theme taken up further in the Clinical Preparedness section below. As the literature suggests that anxiety regarding mental

health may contribute to students' reduced willingness to help patients, and their endorsement of coercive nursing practices, strategies that support students in addressing their anxiety are needed. However, gaps in understanding remain as to how current strategies, such as simulation, may be augmented or others may be developed. This literature speaks to the need for further research on students' experiences within the practicum and their subsequent reflections on these experiences, including how students perceive providing nursing care for individuals with mental health challenges in their future nursing practice.

Witnessing Unsafe and Unethical Practices

Research exploring nursing students' experiences across all practicum settings demonstrates that students frequently witness nursing practices that they find concerning, and are often unsure whether and how to report such practices to their instructors or unit managers, contributing to further distress (Cornish & Jones, 2010; Ion, Smith, Nimmo, Rice, & McMillan, 2015). Examples of such practices include verbal abuse and humiliation of patients, breaches to dignity, such as requiring patients to undress without privacy, and failing to obtain patient consent (Erdil & Korkmaz, 2009; Monrouxe et al., 2014; Rees et al., 2015). Literature on this topic frequently utilizes the term 'poor practices' to describe the variety of nursing actions and behaviours that students identify as concerning or inappropriate (e.g. Bickhoff, Sinclair, & Levett-Jones, 2017; Ion, Smith, & Dickens, 2017). However, this term has not been sufficiently defined in the literature, and may include a range of practices loosely characterized as 'poor care', any practices creating moral dilemmas for students, and nurses' abuse and neglect of patients (Ion et al., 2017). Within this study, such practices are conceptualized as nursing actions and behaviours that are not consistent with "safe, compassionate, competent, and ethical care" as outlined in the Canadian Nurses Association's (CNA) Code of Ethics (2008) and in the College

of Registered Nurses of British Columbia's (2013) professional practice standards. This definition of best practices, including ethical practice[2], provides a framework for conceptualizing nursing actions that are inconsistent with these mandates as 'unsafe and unethical', and adds clarity and specificity to the concept of 'poor practice' as utilized in the literature.

Within mental health settings specifically, students frequently report observing nurses' lack of involvement and connection with patients, including spending the majority of time in the nursing station and interacting minimally with patients (Fisher, 2002; Galvin et al., 2015; Rungapadiachy, Madill, & Gough, 2004). Examples of this lack of involvement with patients also included nurses avoiding patient interaction, such as making social work referrals or giving medications rather than discussing patient concerns (Wojtowicz, Hagen, & Van Daalen-Smith, 2014). In an extreme example, students reported witnessing highly unprofessional behaviours including nurses leaving the unit when not on assigned break and drinking alcohol on shift (Jansen & Venter, 2015). Further, studies note that nurses in mental health settings often do not provide adequate supervision and support for students, which negatively impacts students' perceived ability to meet their learning objectives related to knowledge and skill acquisition (Henderson et al., 2007), and contributed to students' perception of being "treated like an extra pair of hands" – viewed as members of the staff rather than learners – particularly when units were short-staffed (Galvin et al., 2015, p.77).

Though literature suggests that the unsafe and unethical practices witnessed by nursing students in mental health practicums, particularly nurses' non-involvement with patients, may differ from those witnessed in other clinical settings (Wojtowicz et al., 2014), few studies

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[2] In this study, ethical practice is taken up as it is conceptualized in nursing practice standards determined by regulatory bodies and professional associations, and is not explored in depth as a theoretical construct.

explore nursing students' responses to such practices specifically within mental health practicums. While earlier literature contended that students are unable to identify unsafe and unethical nursing practices as such in the clinical setting due to their relative unfamiliarity with nursing care, current literature suggests that students are able to differentiate between theoretical classroom learning that supports best practice and the unsafe and unethical practices they witnessing in practicums (Bickhoff, Levett-Jones, & Sinclair, 2016; Ion, Smith, & Dickens, 2017). However, despite being able to observe theory-practice gaps, witnessing unsafe and unethical nursing practices may have negative emotional impacts on students, including anger, anxiety, sadness, and moral distress (Gunther, 2011; Monrouxe et al., 2014; Rees et al., 2015). Yeh, Wu, and Che (2010) conducted focus groups with 44 Taiwanese nursing students and identified a common theme of powerlessness, with students describing distress at not knowing how to manage observed unethical practices in the clinical setting in the context of their lower status in the hierarchy of the practice environment. Though research suggests that students frequently experience moral distress and powerlessness when exposed to unsafe and unethical practices in the clinical setting, students do not always report incidents to instructors, unit nurses, or managers (Bellefontaine, 2009; Ion, Smith, Moir, & Nimmo, 2016). Bickhoff, Sinclair, and Levett-Jones (2017) conceptualize acting in response to poor practices as 'moral courage', arguing that students feel a moral obligation to act, yet often do not feel able to do so out of fear of personal consequences such as receiving a failing grade or affecting relationships with nursing staff. Similarly, participants in Lindh, Severinsson, and Berg's (2008) qualitative study described a "voice of conscience" guiding their reactions to unsafe and unethical practice, but frequently felt unable to act due to disempowerment and lack of authority in the clinical setting.

While students' witnessing of such practices and their subsequent responses within complex and hierarchical settings emerged as an important theme in the literature on students' experiences of mental health practicums, this area of research remains under-developed, particularly regarding students' reactions and responses to observed unsafe and unethical practice within mental health settings. This study contributes to addressing this research gap in focusing not only on students' experiences in mental health practicums, but also how these experiences are contextualized in their particular practicum settings. Inquiry into how students navigate challenges relating to nursing practices within the practicum, and how students make meaning of these challenges and their responses, is timely and relevant in the context of unsafe, unethical nursing practices within these environments and nurses' stigma toward individuals with mental health challenges.

Clinical Preparedness

Research suggests that nursing students are not adequately prepared for working with individuals with mental health challenges across mental health and other clinical settings (Bvumbwe, 2016; Clinton & Hazelton, 2000; Nolan & Brimblecombe, 2007). As described in Chapter One, preparedness is a multi-faceted concept, including knowledge, skills, and attitudes to support nursing practice and patient care. Hayman-White and Happell (2005), through their Psychiatric/Mental Health Clinical Placement Survey for First Day of Placement, articulate preparedness for mental health practice as encompassing an understanding the role of the mental health nurse, having theoretical knowledge of mental health and mental health care, and having confidence in providing care to individuals with mental health challenges. While this survey was originally designed to measure students' self-reported preparedness at the outset of mental health practicums, it has frequently been adapted to assess preparedness for nursing practice following

mental health placements (e.g. Hastings, Kropowski, & Williams, 2017; Thongpriwan et al., 2015). Hunter and colleagues (2015), in a questionnaire-based study of pre-licensure Master's-level nursing students, found that following a mental health practicum, less than half of students felt prepared for mental health nursing practice, and only 34% reported "feeling confident in their ability to care for persons with mental illness" in any setting. Qualitative inquiry into student preparedness supports this finding: for example, Waite (2006), through individual interviews with 15 nursing students, found that almost all participants did not feel prepared for mental health nursing practice, and articulated gaps in their preparedness as confusion surrounding the role of the mental health nurse, concerns regarding maintaining therapeutic communication in instances of verbal abuse, and insufficient knowledge of different diagnoses and psychopharmacology. Walsh (2015), in a questionnaire study exploring both students' and nurses' perceptions of student preparedness for mental health nursing practice, suggests that practicing mental health nurses similarly perceive students as unprepared for working with individuals with mental health challenges. Though nurses believed students were adequately prepared to provide holistic care, develop positive relationships, and complete nursing assessments, they perceived students as lacking confidence in working with individuals with mental health challenges, and unprepared to manage instances of violence or aggression or work with particular populations, such as individuals who are suicidal, have diagnosed personality disorders, or experienced childhood sexual abuse.

In the international context in which mental health nursing content delivery varies widely and mental health practicums are not always mandatory, multiple studies have explored the role of the mental health practicum in supporting student preparedness (Happell, 2008a; Hastings et al., 2017; McCann, Lu, & Berryman, 2009). To address concerns regarding preparedness, some

studies have explored opportunities for improving student preparedness through classroom interventions, though such research remains limited. Curtis (2007), in the context of inadequate preparation reducing student selection of mental health nursing as a career path, explored a pre-clinical program for students involving role playing and problem-based learning taught collaboratively by nursing instructors and clinicians. Following implementation of the program, students reported feeling more prepared for mental health practicums, and selection of mental health nursing as a career path increased, however data was not available on preparedness for mental health nursing practice as a factor in selecting this career path, nor on students' preparedness in working with individuals with mental health challenges in other settings after graduation. Treloar, McMillan, and Stone (2017) explored utilizing stories from experienced mental health nurses to prepare students for the realities of practice. The authors identified three levels of stories – surface, middle-depth, and deep – with surface stories involving humorous or interesting incidents but having limited educational impact, middle-depth stories as nursing anecdotes with simple educational messaging, and deep stories involving nurses' navigation of complex practice challenges including difficult decision-making, working through mistakes or themselves feeling insufficiently prepared for complex practice situations. Findings suggest that deep stories were particularly effective at preparing nursing students for working with patients with mental health challenges in their practicums. However, as this study focused primarily on the impact of stories on students' preparedness for practicums, as opposed to preparedness for practice, there are still gaps in understandings of how such stories, or students' various practicum experiences, may contribute to their confidence and competence in working with this population as practicing nurses.

Nursing students' preparedness for working with individuals with mental health challenges across settings has been identified in the literature as an important practice concern, yet gaps remain in understandings of how to adequately prepare students for working with people who experience these challenges in dedicated mental health settings and across all areas of nursing. In particular, there are notable gaps in the research on how to address students' preparedness through mental health education and within the practicum. Research on student preparedness indicates that students may feel unprepared for mental health nursing practice across all aspects of this concept: knowledge, skills, and attitudes. As such, this study explores how students describe their experiences within the practicum, and how they interpret these experiences in relation to their perceptions and expectations of future nursing practice. Further understanding of students' reflections on the many facets of preparedness in relation to their practicum may contribute to strategies to support nursing students within the practicum, and in preparing to provide care for individuals with mental health challenges as practicing nurses in any clinical setting.

Students' Career Planning

Students' challenging experiences in mental health practicums combined with lack of perceived preparedness in working with individuals with mental health challenges has contributed to the emergence of a substantial body of literature exploring the impact of mental health practicums on students' career decisions (Happell & Gaskin, 2012; Harrison, Hauck, & Ashby, Hastings, Kroposki, & Williams, 2017; Stevens, Browne, & Graham, 2013). In a systematic review of students' attitudes toward mental health nursing, Happell and Gaskin (2012) found that across studies, mental health was consistently among the least preferred career options for graduating nurses, even in the context of attitudes toward mental health nursing

improving after practicum experiences. Explanations for mental health as the least desirable career option vary across the literature: Happell and Gough (2007) suggest that students' perceived lack of preparedness is connected to decreased interest in pursuing a mental health nursing career, while other studies argue that residual anxiety is the most significant contributor (Happell, 2008b; Happell, Platania-Phung et al., 2014). Studies from outside of the Australian context, in which the majority of career selection research is conducted, further suggest that low social prestige may be a contributor to disinterest in the career path (DeKeyser Ganz & Kahana, 2006; Hoekstra, van Meijel, & van der Hooft-Leemans, 2010). Ross and Goldner (2009) discuss the complexities of mental health stigma in nursing: as a population, nurses have tended to hold negative and stigmatizing views toward individuals with mental health challenges, yet individual nurses with mental health challenges themselves are stigmatized by fellow nurses and in society. Mental health nursing is frequently viewed as a low-prestige career compared to other fields of nursing and nurses working in mental health settings may be stigmatized in relation to their choice of practice area, in a phenomenon referred to as stigma-by-association (Delaney, 2012; Gouthro, 2009). Edward and colleagues (2015) suggest that prior experiences individuals with mental health challenges, including personal connections or work with this population outside of nursing, may increase likelihood of pursuing a career in mental health nursing.

Quantitative research suggests that many students hold the belief that recovery for individuals with mental health challenges is unlikely or impossible (Markström et al., 2009), with Stevens et al. (2013) connecting this belief to reduced interest in pursuing a career in mental health nursing. Henderson and colleagues (2007) suggest that satisfaction with mental health practicums is lesser when students do not observe patient improvement, and Happell et al. (2013) further explore this connection, arguing that education on recovery approaches, which involves

critical analysis of the concept of 'recovery' and strategies for supporting recovery, may increase interest in mental health nursing. Though qualitative inquiry into nursing students' perceptions of mental health nursing as a career path are limited, Jansen & Venter's (2015) qualitative research in South Africa increased understanding of the experiences of nursing students who, after mental health their practicums, were not choosing to pursue mental health nursing as a career. While personal preference was a factor in some students' decisions, many cited challenges of the working environment including witnessing unprofessional behaviour and concerns regarding personal safety in the clinical setting as detracting from their interest in the field. Some participants in Wojtowicz and colleagues' (2014) study similarly suggested that their moral distress and feelings of helplessness in observing non-therapeutic nursing practices, such as medications being utilized in place of conversation, contributed to their decision to not pursue mental health nursing in their careers. While available qualitative research provides some understanding of students' perceptions of mental health nursing as a career, literature exploring this topic in depth remains limited.

While many studies explore why nursing education may not adequately support student interest in pursuing mental health nursing as a career, in one study of 31 students interviewed in focus groups, one of the four groups of students reported being *less* likely to pursue mental health nursing following their practicums (Adams, 1993). Supporting this finding, in a longitudinal study involving a career preferences survey administered annually at three points throughout students' nursing program, students' perceptions of pursuing mental health nursing as having a negative effect on career pathways increased from 25% to 54% following practicum experiences, with students citing lack of long-term career prospects and the perception of the field as not as skill-based as other areas of nursing as primary concerns (Stevens et al., 2013).

Further, a pre-/post-practicum survey of career preferences from New Zealand found that interest in mental health nursing fell from 10.7% in advance of mental health clinical experience to 9.3% following – while statistical significance was not calculated for this decrease, practicums did not serve to increase mental health nursing interest (Surgenor, Dunn, & Horn, 2005). Though the potential for practicums reducing students' interest in mental health nursing has not been fully explored in the literature, some researchers suggest that nursing instructors' encouraging students to pursue medical-surgical nursing after graduation to develop nursing knowledge in skills may contribute to students deciding not to practice in what some consider to be 'specialty' areas as new graduates (Nadler-Moodie & Loucks, 2011). The lack of consensus in the research on how practicums may effect students' career preferences speaks to the need for further research that contributes to understandings of how students interpret their experiences within the practicum, and how they contextualize these experiences in mental health nursing and health care more broadly. Further, the focus on career preferences in the research may obscure nuances in nursing students' expectations of working with individuals with mental health challenges within *or* outside of mental health environments.

As research demonstrates that this population experiences stigma and discrimination across health care settings (Clarke, Usick, Sanderson, Giles-Smith, & Baker, 2014; Hatzenbuehler, Phelan, & Link, 2013; Lawrence & Kisley, 2010), further research is needed that explores the nuances of students' reflections on working with this population beyond career decision-making. As such, this study focuses on students' descriptions and reflections on their practicum more broadly, and seeks understanding of how students make meaning of their own experiences in relation to and outside of career planning. Further, the study objectives include inquiry into how students reflect on their perceptions and expectations of working with

individuals with mental health challenges in *any* setting following their practicum – an aim that expands on previous research that has focused predominantly on students' choices regarding particular areas of nursing. Understandings of nursing students' reflections on working with patients experiencing these challenges across health care environments are limited in the research, and this study may therefore contribute to the development of strategies that address gaps in student interest in and preparedness for mental health nursing. Further, such understandings may help to provide nuance to the research finding that mental health is the least desirable field for graduating nurses.

Summary

Research on mental health practicums has positioned nursing education in this area as crucial for the development of students' knowledge, skills, and attitudes for providing safe, ethical, and competent care for this population. Individuals with mental health challenges experience stigma and discrimination in health care settings, speaking to the need for non-judgmental, compassionate, and respectful care within inpatient mental health environments. Yet, nursing practices in these settings have been described as 'institutionalized', and may perpetuate mental health stigma, and harm to patients. In this context, literature has highlighted the importance of mental health practicums for shifting students' beliefs and attitudes regarding individuals with mental health challenges, and contributing to their preparedness in providing nursing care for this population. However, the research also demonstrates ongoing challenges: students' moral distress in witnessing unsafe and unethical practices within these practicums, residual stigma toward individuals with mental health challenges following their practicums, and anxiety and lack of perceived preparedness in providing mental health nursing care as students or practicing nurses. Limitations in the literature on mental health practicums include a limited

variety of methodological approaches to this research topic, which has impacted the breadth and depth of understanding of student experiences. Studies in this area predominantly survey-based, and though they provide important knowledge on student perspectives and experiences, are not designed to provide depth or nuanced understanding of the nature of students' reflections on their experiences. While many studies contribute qualitative understandings to areas explored through survey-based research, gaps in qualitative literature remain, such as students' reflections on and reactions to witnessing unsafe and unethical practices within mental health settings, and their perceptions of preparedness for providing care for mental health challenges across health care environments other than mental health settings. In the context of these gaps, this study aims to further explore nursing students' experiences within mental health practicums, using a narrative approach to support students' sharing of their stories that shaped their experiences and reflections. This study takes up the question of how students describe, interpret, and contextualize these experiences to contribute to research understandings of how student nurses experience mental health education, and identification of practicum challenges that may contribute to the context of stigma in inpatient mental health care, and students' fear, anxiety, and lack of preparedness as explored in the literature.

CHAPTER THREE: RESEARCH DESIGN AND APPROACH

Introduction

The research question guiding the design and methodology for this study is: how do undergraduate nursing students describe, contextualize, and interpret their experiences in their mental health practicums? The specific objectives of this study were to: 1) describe how students navigate and reflect on their experiences in this setting; 2) explore how students' backgrounds, beliefs, and attitudes affect their interpretation of their experiences; 3) understand the ways in which sociocultural contexts, of both the practicum setting and the broader social world, influence students' experiences in mental health clinical environments; and 4) explore how students reflect on their perceptions and expectations of providing care for this population across health care settings in their future nursing practice. To address the study research question and objectives, I utilized a qualitative methodological approach of narrative inquiry. A central tenet of narrative inquiry is that human experiences are inherently narrative: experience unfolds in time, embedded in the larger narrative of an individual's life, as well as in collective, social narratives (Clandinin & Connelly, 2000). In narrative inquiry, researchers centre individuals' experiences and draw from their narratives to inform understandings of the nature of these experiences as well as the multitude of individual and societal factors that shape and affect experience (Clandinin, 2013). A narrative inquiry approach supports the aims of this study to both understand nursing students' experiences and to explore the contexts for these situated experiences.

This chapter describes this study's design and methodological approach in depth. Firstly, I outline the theoretical framework of the study as informed by Foucault's conceptualization of micro-power and resistance. I then discuss narrative inquiry as a methodology, including ways in

which this study takes up critical narrative approaches. Subsequent sections describe the sample, data collection and analysis processes, data security, ethical considerations, rigour, and usefulness of the research.

Theoretical Framework

The exploration of nursing students' experiences in mental health practicums was informed by Foucault's conceptualization of power and resistance. Foucault states that power "is a way in which certain actions modify others" (1982, p. 788); enacted through individuals, power constrains and alters the behaviour of others toward a particular objective. The means through which some individuals and groups come to enact power over others is based in society's "system of differentiations", a system through which those with privilege and status hold power and perpetuate power relations (Foucault, 1982). Yet, while power relations are determined through differentiations of individual characteristics, Foucault also describes power as non-subjective, in that it operates beyond the individual who exercises power (Heller, 1996). This study takes up Foucault's concept of micro-power, as explored in "Panopticism" in *Discipline and Punish* (1979), to inform the framing of power in the mental health clinical setting. Micro-power is described as "tiny, everyday, physical mechanisms…that guarantee the submission of forces and bodies" (p. 222) and within "Panopticism", is explored through the institution of the jail, in which inmates' bodies and actions are governed by micro-power as it is played out in disciplinary power relations within this space. Goffman's (1961) concept of total institutions, taken together with Foucault's micro-power, suggests ways in which power relations operate within other institutional settings, including religious and military institutions, and 'asylums' (contained and often remote spaces in which individuals with mental health challenges were formerly institutionalized). Goffman describes total institutions as spaces in which all aspects of

an individual's life are controlled and contained; within the asylum context, he argues that institutional norms such as requiring standardized clothing, restricting access to basic needs (such as food and toiletries) to distribution by staff, and re-framing freedom of movement and action (such as day-passes) as 'privileges' all serve to reinforce the construction of difference between inmates and staff and reinforce control. In Foucauldian terms, these institutional mechanisms are representative of micro-power as taken up in the interactions between staff and inmates. In the context of this study, inpatient mental health settings are conceptualized through Foucault's lens of micro-power, which illuminates the ways in which power relations between staff and patients – and between staff and students – constrain and alter behaviour through everyday mechanisms.

Kincheloe and McLaren (2000) state that while power affects our beliefs, perspectives, and nature of our experiences, "we are all empowered and we are all unempowered" (p. 283); intersecting privilege and oppression determine the ways in which individuals are situated within society, yet also offer opportunities for agency and subversion of power. Foucault speaks to this subversion as resistance, and explores the inevitability of resistance to power in *The History of Sexuality* (1978), stating: "where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power" (p. 95). Pickett (1996) further describes the way in which resistance to power emerges: "power is only accepted to the extent that it is hidden. Therefore, unless it is a relatively invisible power it will provoke resistance by what it has produced" (p. 459). This study is informed by ways in which power operates and is variously hidden and visible in mental health settings, and takes up Foucault's conceptualization of power and resistance to analyze how students describe, contextualize, and interpret their experiences within these settings.

Methodology

Narrative Inquiry

The methodology of narrative inquiry is grounded in Bruner's (1986) conceptualization of the role of narrative in human experience; he theorizes that people interpret experiences in their lives through narratives, or stories, and that these narratives are contextualized in previous experiences as well as personal and societal beliefs and values. In *Actual Minds, Possible Worlds*, Bruner (1986) contrasts the *paradigmatic mode* of human cognition in which experiences are organized categorically in order to draw logical conclusions, with the *narrative mode*, in which individuals draw meaning from their experiences through stories. Narrative thinking enables an individual to produce understanding of events, drawing meaning through contextualizing these events socially and within their own experiences. Polkinghorne (1988) takes up Bruner's notion of narrative in his text *Narrative Knowing and the Human Sciences*, and develops the concept of narrative knowing: the idea that hearing the narratives of another is central to understanding their experiences, motivations, and behaviours. While most of Polkinghorne's work discusses the application of narrative knowing to the clinical practice of psychology, he also suggests the importance of narrative knowing in the effort to understand human experience through research.

Narrative knowing thereby provides one of the foundations for the development of narrative inquiry as a methodological approach (Clandinin & Connelly, 2000). Undertaking narrative inquiry as a qualitative methodology involves exploring meaning in participant narratives including, yet also extending beyond, a story's content. Clandinin and Connelly (2000) describe that just as events are made meaningful through narrative, individual narratives are "given meaning in terms of the larger context, and this meaning will change as time passes"

(p. 19). Narratives are influenced not only by an individual's history and societal factors but also by the contextual factors of the narrative retelling: the listener(s) and the context in which the story is told. To frame the analysis of context in narrative inquiry, Clandinin (2013) describes narrative as comprised of three dimensions, from which researchers draw out the meaning of experience: temporality, sociality, and place. Temporality addresses the nature of experience unfolding in time, with the retelling of experience likewise involving attention to time through exploring the past, present, and future events, contextual factors, and interpretations that contribute to the participants' understanding of experience. Sociality involves the exploration of the context in which an individual's experiences and their interpretation of experiences occurs; personal narratives intersect with sociocultural narratives, both of which must be explored by the researcher. Place attends to the physical environment in which experience occurs, and how environments (such as the institution of the mental health setting explored in this study) shape the nature of experience. The theoretical framework for this study positions narrative inquiry within an analysis of power and resistance. Foucault describes power as non-subjective, operating through the individual but informed by institutional and societal power relations; similarly, through its focus on temporality, sociality, and place, narrative inquiry seeks to explore the ways in which individual experiences are shaped by context.

Narrative inquiry as a methodology is well-suited to the study of nursing, as narrative is also embedded in nursing practice. Sandelowski (1994) argues that narrative knowing is central to nursing practice – in telling stories, patients provide nurses with information about their experience of illness, and understanding of health. Nurses engage with these narratives to connect with patients as individuals, and utilize meaningful and relevant nursing interventions that contribute to health and wellness. Narrative inquiry has been used across health care settings

in order to understand nurses' experiences of their work and of their interactions with patients: for example, hearing disclosures of child abuse (Finn, 2011), responding to patient humour (Haydon & van der Riet, 2014), managing the experience of an unexpected patient death (Palese, Petean, & Cerne, 2013), and implementing Gestalt therapy in mental health care settings (Kelly & Howie, 2007). Further, narrative inquiry has been utilized in the scholarship of nursing education to understand students' perceptions of learning and learning experiences, pedagogical methods, and educational institutions (Naber, Hall, & Schadler, 2014; Petty, 2017). Narrative inquiry studies of student experiences of mental health nursing education have demonstrated the efficacy of the methodology in understanding students' development of knowledge and understanding of the lived experiences of individuals with mental health challenges (Balen, Rhodes, & Ward, 2010), student experiences and reflections on hearing voices simulation (Wilson et al., 2009), and how nursing students draw on educational experiences to challenge their own assumptions related to mental health challenges (Schwind, Lindsay, Coffey, Morrison, & Mildon, 2014). Demonstrating the efficacy of narrative inquiry in understanding the experiences of nursing students in mental health clinical environments, Koskinen, Mikkonen, and Jokinen (2011) utilize narrative critical incident writing in order to explore what elements of the clinical experience supported and did not support student learning. The broad use of narrative inquiry across nursing and nursing education scholarship reflects the use of the methodology for understanding students' interpretations of learning experiences, and supports my own use of narrative inquiry in exploring how students make meaning of their experiences within mental health practicums.

Critical Narrative Approaches

The intersections of narrative inquiry within a framework of power and resistance was further informed by Hickson's (2016) critical narrative approach, in which researchers aim to explore the ways in which sociality, temporality, and place in participant narratives are informed by societal oppression and discrimination. Within this study, drawing on a critical narrative approach involved an examination of how micro-power and power relations shaped the nature of students' experiences within the complex environments of their mental health practicums. This approach involved two processes, both of which are explored in this section: 1) reflexivity regarding power relations between researcher and participant across the various stages of the study, and 2) drawing on principles of critical narrative analysis to inform which stories are centered, by both participants and myself, and how underlying assumptions about health, illness, power, equity, and agency affect narrative storytelling and researcher interpretations and analysis (Souto-Manning, 2014).

Critical Reflexivity: A fundamental principle of narrative inquiry is reflexivity: attention to the relationship between researcher and participant, which requires the researcher's self-reflection on their own experiences, context, and interpretations (Clandinin, 2013). Green (2013) states that while narrative inquiry affords the researcher an insider view into the lives of participants, narratives emerging from interviews are interpreted through the researcher's own lenses. Rather than positioning oneself outside of the narrative looking in, in search of objective truth, researchers undertaking self-reflexive narrative inquiry acknowledge that "we are part of the storied landscapes we are studying" (Clandinin, 2013, p. 24). It is due to the researcher's embeddedness in participant narrative that Clandinin describes narrative inquiry as a 'relational' methodology inherently concerned with how researchers and participants relate to each other in

the interview and how this relationship informs researchers' understandings of how participants relate to the world around them. Critical reflexivity regarding my engagement with participants included reflection before, during, and after each interview on how my own position in the world and in relation to the participant may have impacted the participant stories. Specifically, self-reflexivity involved acknowledging my background as a nursing instructor in the space of the interview (explored in detail in Ethical Considerations, below). Within interviews, I at times drew on my experience as an educator and my knowledge of the particular practicum settings in formulating follow-up questions, and in understanding mental health nursing terminology. However, I also made efforts set aside my own interpretations of student experiences to centre the participants' narratives; following principles of qualitative interviewing, such as asking open-ended questions grounded in curiosity, contributed to this aim (Weiss, 1994). Within some interviews, students' experiences of particular inpatient units, or interpretations of certain nursing practices, offered a different perspective from those that I developed through my experiences as a nurse and clinical instructor. In these instances, and conversely, when participant stories resonated with my own experiences, I attempted to approach the conversation with openness and curiosity, while also understanding that no conversation is neutral and my perspectives inevitably influenced how I related to each participant. My approaches to participant interviews is described further in the Data Collection section below. As well as informing interaction between researcher and participant in the space of the interview, critical reflexivity shaped all stages of the research process from study design to the writing of this thesis. Therefore, aspects of critical reflexivity are addressed throughout this chapter, including in discussions of the study sample, data analysis, ethical considerations for undertaking the study, and rigour.

Critical Narrative Analysis: A critical narrative approach additionally informed my data analysis process and the preparation of study findings for presentation within this document. Narrative inquiry understands stories as constructed by the teller for a specific purpose, such as entertainment, persuasion, or explanation (Green 2013; Riessman, 2008). Critical approaches to this methodology further recognize that these constructions are not apolitical; they provide researchers with insight into the beliefs, values, and underlying assumptions held by participants that inform their narratives. Kincheloe, McLaren, and Steinberg (2011) state in their reflection on critical pedagogy and research that "all thought is fundamentally mediated by power relations that are social and historically constituted" (p. 164). As such, this study is framed by Foucault's conceptualization of micro-power, as described above, and explores the ways in which power relations are taken up and navigated within students' narratives. In this way, Foucault's micro-power dovetails with Clandinin's narrative constructs of temporality, sociality, and place: critical narrative analysis in this study is informed by an exploration of power relations in the 'everyday' situated experiences of nursing students in the mental health setting. The ways in which analysis of the data in this study specifically took up critical narrative approaches is discussed in further detail in the Data Analysis section below.

Sample

In studies utilizing narrative inquiry methodology, sampling is frequently purposive, as researchers select participants whose narratives will provide insight and perspective into the topic of study (Wells, 2011). For this study, I sampled from the University of British Columbia's (UBC) Bachelor of Science in Nursing (BSN) program. This program is 20 months in duration and considered an accelerated program, compared with a standard 3- to 4-year nursing program. Applicants to the UBC program must have completed a minimum of 48 credits of post-secondary

education, equivalent to two years of study. As a result, students in this program are typically older and with more education and previous work experience than students in other nursing programs in the province (UBC School of Nursing, n.d.). The choice for UBC nursing students was intentional for several reasons. Students in this program completed one mandatory six-week mental health foundational course titled "Nursing 335 (N335): Professional Nursing Practice with Adults Living with Mental Illness and their Families" (UBC, 2016-2017), which was comprised of both classroom learning and clinical experience. Thus, this was a program that provided a realistic and feasible group from which to recruit. The BSN cohort of 120 students was divided into six groups, each of which completed N335 in rotation between January and December (UBC School of Nursing, 2016). Thus, all participants within the study had similar exposure to mental health content and clinical experience. Within each group of 20 enrolled in the N335 course, students were assigned to one of three practicum sites. Each site was at a hospital with two to three inpatient mental health units. Students submitted ranked preferences to the School of Nursing for assignment between the three hospital sites, and specific unit assignment within the hospital was determined by each site's clinical instructor; in many cases, students selected units of their choice, navigating their preferences with other students in the clinical group. Each inpatient mental health unit had a patient census of approximately 15-25, with patients admitted to each unit from the surrounding neighbourhoods of the hospital as well as from across the city and province. Of the three hospitals, two had locked units, while at the third, units were unlocked. All three hospital sites had seclusion rooms on one or more of the mental health units.

A further rationale for sampling within the UBC BSN program was that participants drawn from this group were expected to offer rich reflective narratives relating to their mental

health experiences; students in this program completed three levels of Relational Practice courses, which were intended to build students' reflexivity and critical analysis of "opportunities and challenges of relational practice across multiple diverse health experiences" (UBC, 2016-2017). Relational practice as a nursing concept describes nurses' interactions and relationships with patients as informed by trust, respect, and compassion, and situated within the personal and social contexts of both the patient and the nurse; as such, relational practice invites self-reflexivity and critical reflection on patient care (Doane & Varcoe, 2007). All three Relational Practice courses were completed by students at the time of data collection. Lastly, my own role as a clinical instructor within the program provided me with insight into the program structure and content as well as assisted the process of negotiating entrée. See Ethical Considerations below for a more detailed discussion of navigating my two roles of researcher and instructor within the UBC School of Nursing.

Recruitment for this study was undertaken through three strategies. Firstly, flyers describing the study were posted on message boards within the School of Nursing. Secondly, classroom presentations were held in two BSN classes, in which the study was introduced and business cards were handed out. Lastly, one month following the beginning of recruitment, a short recruitment advertisement was placed in an email newsletter to all UBC BSN students and included in the BSN blog. These recruitment strategies resulted in a total sample of 15 participants. Inclusion criteria for participants included: 1) undergraduate nursing students in the Bachelor of Science in Nursing (BSN) program at UBC; and 2) BSN students who have completed the N335 Mental Health course, including the associated clinical placement, in the past 12 months (from January 1 – December 31 2016). At the beginning of the study, exclusion criteria included students who 1) have completed N335 clinical placements with me as their

clinical instructor; or 2) completed N424, an advanced Mental Health course in the BSN

program, which ran January 1 to February 28, 2017. N424 was taught by Dr. Emily Jenkins (co-

supervisor for this study) and I was a clinical instructor for seven of the students in this course.

However, despite statements detailing the inclusion and exclusion criteria across recruitment

strategies, many students who were excluded from the study requested permission to participate.

Additionally, after 12 interviews had been conducted, preliminary data analysis revealed a gap in

understanding of experiences of students who intended to pursue nursing work in dedicated

mental health settings – a group likely not captured by this study due to the nature of the

exclusion criteria. Therefore, in order to promote equal access to research for all UBC BSN

students and to augment study findings, an ethics amendment was submitted and approved, and

the final 3 interviews were conducted with students who previously met exclusion criteria but

who had come forward requesting inclusion.

Data Collection

I conducted in-depth individual interviews with each participant, which ranged in

duration from 40-65 minutes. While some narrative inquiry approaches involve participants

telling stories through diaries or other written exercises (Clandinin & Connelly, 2000; Koskinen

et al., 2011; Riley & Hawe, 2005), in-person interviews allowed for dialogue between myself as

the researcher and participants, including asking follow-up questions to further explore the

nature of experiences, contextual factors, and perspectives. The foundational structure of the

interviews (see Appendix A for the Interview Guide) was based on the research aim of gaining

insight into how students describe, contextualize, and interpret their experiences of the inpatient

mental health setting. Questions were designed to attend to the three dimensions of narrative

inquiry, exploring students' interpretations of temporality, sociality, and place within their

practicums and narratives. For example, interview questions included prompts to describe the clinical site environment, their first impressions of the practicum, and discussions with fellow students and family members regarding the practicum.

Throughout the data collection process, reflexivity informed my approach to conducting the interviews. While the interview guide provided structure, participants frequently provided expansive responses to questions, with multiple stories or further reflections that were sparked by their initial responses. As such, in the moment, I frequently drew on reflexivity in listening and responding to narratives, which informed my decision-making on whether to probe further into a story, to return to the interview guide, or to circle back to a previous story about which I had further questions. To facilitate this reflexive approach to formulating follow-up questions, I wrote short notes (one or two words, so as to not interrupt the flow of conversation) of ideas or questions to return to. This note-taking often informed follow-up questions that may otherwise have been forgotten as a result of subsequent conversation. Further, reflexivity guided my formulation of follow-up questions based on participants' responses to questions from the interview guide. These follow-up questions were formulated in the moment, and differed between interviews, so as to be responsive both to participants' personalities and communication styles, and to the nature of their stories. For example, in one interview, I was surprised when a participant articulated a description of the practicum environment that differed significantly from previous participants' narratives. As she told this story, I reflected on the importance of validating her experience but also probing further into her reflections to draw out some of the factors that informed her impression. As such, I formulated follow-up questions that were open-ended, but also invited further description of her experiences, such as: "what was it like being a student in that environment?" and "how specifically did that [observation] play out for you?"

Ultimately, in her responses to these follow-up questions, she articulated perspectives that were congruent with other participants', but which she initially had not expressed as she did not want to "be critical". In this way, reflexively approaching interviews with participants in formulating my responses and follow-up questions both provided a safe and non-judgmental space for participants to speak about their experiences. This reflexivity additionally contributed to the rigour of the study in that the interview data more accurately reflected participants' experiences and opinions than if I had not probed further into their initial reflections.

Most interviews took place in a private room in the School of Nursing at UBC. Some interviews were conducted a coffee shop upon request from a participant; in these cases, participants were asked to confirm their level of comfort with speaking about their experiences in a public location, and private rooms were offered as an alternative. Data collection took place between February and May, 2017. Each interview was audio recorded with participant consent, and I subsequently transcribed all interviews and checked them for accuracy.

Data Analysis

Narrative analysis is an approach in which researchers aim to preserve the individuality of stories through analyzing single narratives in depth before gathering themes across participant narratives (Polkinghorne, 1995). Reissman (2008) describes narrative analysis as grounded in a case-centered approach in which researchers maintain focus on participant narratives by analyzing each in depth, then extending data analysis beyond individual cases to generate categories and draw comparisons. As such, in undertaking narrative analysis for this study, I analyzed each interview transcript individually, first drawing out themes within the narrative before comparing across participant narratives. I annotated each individual interview using Microsoft Word tracking tools, which allowed for analysis of themes while remaining grounded

in one participant's narrative. Further, this process ensured the preservation of participant stories as 'units' by analyzing them in full, as they were situated in the interview as a whole, as opposed to extracting them from their context (Reissman, 2008). After annotating each interview, I wrote a 1-2 page memo summarizing the participants' narrative and exploring its emergent themes (Birks, 2008; Dey, 1993). At this stage in the data analysis, these themes were predominantly descriptive: for example, participants' descriptions of the clinical environment, their expectations of the practicum, personal experiences of mental health challenges, or reflections on mental health nursing as a career.

As discussed in the Methodology section above, this process was informed by a narrative approach of exploring sociality, temporality and place in participant narratives, and by critical reflexivity in how I as a researcher interpreted the data (Clandinin, 2013; Hickson, 2016). At this stage in data analysis, I attempted to remain grounded in individual narratives and explore how each participant reflected on, interpreted, and contextualized their experiences. This was particularly important for this study, as many participants shared practicum sites, or had completed the mental health practicum in the same clinical group as other students who participated in the study. For example, three participants from the same clinical group recounted stories of the same incident, at which they were all present; however, each differently interpreted the event and variously contextualized their interpretations in their beliefs, backgrounds, and previous experiences. In another example, two participants who had been placed at the same practicum site, though at different times, reflected on the same nursing practice of nurses collectively introducing themselves to patients, which one student articulated as welcoming and the other viewed as oppressive and representative of nurses' control. Analyzing each interview individually allowed me to situate students' experiences and interpretations of their experiences

within their own narratives, as opposed to in relation to others' experiences or to my own. The process of writing memos further required critical reflexivity to ensure that the themes that were described resonated with participant narratives, rather than those that best fit with my interpretation of what *should* be centered. To facilitate accurate memos contextualized in participants' experiences, I analyzed each interview in one sitting to immerse myself in each narrative; I then wrote each memo immediately following, with a break between each interview analysis.

Following annotating and analyzing each interview separately and writing memos for each, I compared memos across interviews to analyze similarities and variations in themes. This involved re-reading each memo multiple times, and returning to the interviews as needed for further clarification or inclusion of previously missed themes or individual narratives relating to a theme. This process was informed by critical narrative analysis within a framework of power and resistance. In comparing memos and developing emergent themes between each interview, I analyzed instances in which participants explicitly spoke to power, oppression, discrimination, and stigma in their framing the context for their stories, in their interpretation of their practicum experiences. Further, I analyzed narratives for ways in which power and resistance implicitly informed and contextualized participants' reflections and interpretations on their experiences. This process involved re-reading and comparing memos and interview data to analyze the ways in which narratives were informed by their experiences of empowerment and disempowerment, or their own critical reflection on their own care approaches, observed nursing practices, and patient experiences in the practicum. Additionally, my co-supervisors both listened to the audio recordings of selected interviews and read the transcriptions of interviews, and provided reflections and insights on the data. Through regular meetings with my committee, we

collaboratively identified emergent themes in the data, determined data analysis approaches, and finalized the themes from the analysis to constitute study findings. As a final step in data analysis, I returned to the original data for further analysis of students' narratives within the framework of identified patterns and themes, manually arranging students' stories into themes and sub-themes within the overall narrative of resistance, as explored in Chapter Four.

Data Security

Research data from this study is stored in two forms: audio files from digital recording, and transcripts of the audio files. All electronic files are encrypted and stored on a password-protected secured server accessible only by members of the research team. All hard copy files including consent forms are stored in a locking cabinet. Only the members of the research team (Dr. Victoria Bungay, Dr. Emily Jenkins, Dr. Helen Brown, and myself) have access to the data. All research data, including electronic files and hard copies, will be stored for a minimum period of five years at the UBC campus as discussed above: in a locked filing cabinet, and on a secure server. After the five-year period, all electronic files may be deleted and hard copies may be shredded, or may be securely kept as described above (The University of British Columbia Board of Governors, 2013).

Each participant is identified within the transcript and in file names by a pseudonym or interview number. Additionally, when participants stated identifying information, such as patients' names, within the interview I replaced these with pseudonyms in the transcript. In presenting findings, identifying characteristics have been aggregated across the participant group, or only stated if relevant and if they are not unique identifiers. Additionally, when participants named or stated identifying characteristics in describing patients who were in their

care during mental health clinical placements, these individuals were given pseudonyms, and all identifying characteristics have been removed and/or replaced.

Ethical Considerations

In preparation for data collection, I obtained approval for this study from UBC's Behavioural Research Ethics Board (BREB) through the completion of the Human Ethics application. Additionally, I have completed the TCPS2: CORE (Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans – Course on Research Ethics) and utilized its content to guide this research. This section explores ethical considerations that I reflected on in completing the TCPS2 and BREB application, and took into account throughout the study process. The specific ethical considerations explored in this section include: conflicts of interest, informed consent, confidentiality, and financial incentives.

Conflicts of Interest

Ferguson, Myrick, and Yonge (2006) acknowledge that conflicts of interest can easily emerge in research undertaken within nursing programs, as researchers frequently undertake studies aiming to improve curricula and pedagogical methods through study of their own program's students. The risk of conflicts of interest increases in studies in which researchers are in a teaching role that includes evaluation of student participants (Clark & McCann, 2005). Within the TCPS2, dual roles are identified as a type of conflict of interest that may "create conflicts, undue influences, power imbalances or coercion" and may affect researcher relationships with participants and/or participant consent (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2014, p. 95). As such, one ethical consideration in this study was the navigation of the potential for a conflict of interest related to my dual roles as a

student researcher and clinical instructor within the UBC BSN program. An additional potential for conflict of interest from dual roles arose from the thesis committee, in that interview data is available to thesis committee members. Dr. Bungay had not taught within the BSN cohort. All participants were taught by Dr. Brown in a theoretical course, and many participants were taught by Dr. Jenkins.

To mitigate potential harms from these dual roles, all participants were aware of the research team members and their confidentiality within the study, and provided informed consent to participate in the study in this context. Further, to minimize the impact of dual roles on inter-relationships within the interview, participants were informed that classroom experiences were not the focus of this study, and students were not asked to speak to their experiences of nursing education from thesis committee members. In changing the exclusion criteria of this study, participants who have been taught by myself within the clinical setting specifically explored within the study were only included following their specific request, and recruitment efforts were not undertaken within this particular group. Due to the timing of the interview, following completion of mental health coursework, neither I nor members of the research team had any further control over the academic outcomes of the student participants. The inclusion of participants whom I had previously taught was carefully considered through discussion with my committee, and involved reflection on ethics and on the study approach of critical reflexivity. Though the conflict of interest between my dual roles raised potential concerns in these areas, as described, including students who had requested to participate recognized their agency in decision-making and their desire to have their experiences reflected in research. As critical reflexivity includes reflection on which stories are centered and how power affects whose voices

are heard (Souto-Manning, 2014), the decision to include all interested participants from the study sample also reflected the methodological and philosophical frameworks of this study.

Informed Consent

Due to the physical and intellectual demands of academic programs and the nursing profession, nursing students are not considered a vulnerable population, and are deemed fully able to personally and ethically evaluate requests for participation in research (Clark & McCann, 2005). However, informed consent remains a necessary ethical consideration of all research (Canadian Institutes of Health Research et al., 2014). To promote informed consent, all recruitment materials and verbal discussion of the study reinforced the voluntary nature of participation. The consent form for this study listed the full research team, procedures for the study, and potential risks and benefits, with the aim of supporting students' knowledge and understanding of the nature of their participation. As the sample for the study was drawn from the same School of Nursing in which the study was situated (in the Master of Science in Nursing program), consent for this study was obtained verbally, with no requirement of signed consent (Canadian Institutes of Health Research et al., 2014, p. 44). The aim of verbal consent was to further protect the confidentiality of participants and to foster trust between participants and the research team. In studying student populations, a frequent issue relating to informed consent is ensuring that voluntariness of the study is not jeopardized by incentives in the form of additional learning opportunities – for example, additional classes or access to instructor time (Canadian Institutes of Health Research et al., 2014; Ferguson et al., 2006). All interviews for this study took place after students completed their mental health courses (the foundational N335 course, and where applicable, the higher level N424 course) to avoid incentivizing participation through exclusive learning or debriefing opportunities.

Confidentiality

Particularly in context of committee members' dual roles, as discussed above, the protection of confidentiality was specifically addressed at all stages of recruitment and data collection. The consent form detailed the confidentiality measures utilized in the study, including the use of pseudonyms or interview numbers as opposed to participant names, and the data security measures as described above (also see Appendix B: Consent Form). This concept was additionally verbally reinforced to ensure that participants were aware that my role as an instructor, or the roles of committee members', did not impact their confidentiality in this study. Additionally, due to the relatively small size of the cohort (120 persons), confidentiality of participants was an important consideration for this study, as participant demographic information, backgrounds, or particular stories or experiences may be easily recognizable by peers and/or instructors. Therefore, while aggregated participant demographics are presented to describe the sample, quotations from participants drawn on in Chapter Four are written without direct or indirect identifiers (e.g. name, or personal characteristics such as practicum location, age, etc.), except when necessary for context (Canadian Institutes of Health Research et al., 2014, p. 56).

Financial Incentives

Seidman (2013) differentiates remuneration from token payment, arguing that while financial remuneration may bias potential participants and jeopardize informed consent, providing a token gift of appreciation serves as an act of respect for a participant's time. To prevent financial incentive from constituting undue influence jeopardizing voluntariness (Canadian Institutes of Health Research et al., 2014, p. 95), a small token of $25 in the form of a gift card was given to participants in thanks for their time dedicated to the study. Participants

were given this gift card regardless of the length of the interview, and were informed that their withdrawal from the study would not impact their gift of appreciation.

Rigour

As discussed in this chapter, the methodological approaches of this study, including design, data collection, and analysis, are grounded in the literature on narrative inquiry and qualitative methods more broadly, in order to support rigorous research. While this study aimed for rigour as understood across qualitative methodologies, it is important to reflect on the nature of rigour within the particular approach narrative inquiry (Loh, 2013). Extending from Lincoln and Guba's (1985) conceptualization of rigour in qualitative methodology as "trustworthiness", in narrative inquiry the concept of narrative truth is central to a study's rigour or quality. In exploring truth in narrative inquiry, Webster and Mertova (2007) state that "narrative research does not claim to represent the exact 'truth' but rather aims for 'verisimilitude'" – researchers' understandings of participant narratives reflecting participants' actual experiences as accurately as possible (p. 4). Barrett and Stauffer (2012) extend the importance of researcher understanding in their concept of "resonant work" (p. 8), which frames the aim of narrative inquiry as the researchers' presentation of narratives that resonate with the reader – narratives that ring true. Thomas (2012) argues that narrative inquiry serves to question the nature of truth itself, demonstrating the subjective, situated, and relative nature of experience; while experience is a kind of truth, it does not represent a singular truth. Therefore, addressing rigour in the methodology of this study was toward the aim of most accurately representing the individual stories and experiences of the participants and producing resonant, trustworthy findings that increase understanding of nursing students' experiences in mental health clinical environments. Approaches to data analysis of participant narratives were further informed by this study's

theoretical framework of micro-power and resistance. In using a theoretical framework in data

analysis, a key consideration in producing rigourous research is the consistency between

methodology, theoretical frameworks, and data analysis (Fereday & Muir-Cochrane, 2006). This

chapter has described the points of connectivity between critical narrative approaches to the

methodology and Foucault's micro-power, and the ways in which these frameworks together

informed the data analysis process. As such, the theoretical framework of Foucault's concepts of

micro-power and resistance to power both represented a rigorous approach to analysis and the

development of study findings, and provided a framing of participant narratives that enhanced

their resonance with social processes and theoretical concepts. Specific strategies that

contributed to rigorous research and to the development of resonant and trustworthy findings

included relational engagement and reflexivity, each described below.

Relational Engagement

Clandinin (2013) describes narrative inquiry as "relational research" (p. 81) in that

narratives inherently exist in relation: the telling of stories necessitates a listener. The nature of

the relationship and the level of rapport between researcher and participant impacts not only

what stories are told, but also how narratives are framed and unfold (Clandinin & Connelly,

2000). To build rapport in my relationships with participants, I drew from Doane and Varcoe's

(2013) concept of relational inquiry in nursing practice: an intentional practice that is centred on

interrelationships between nurse and patient, with curiosity driving nurses' inquiry into the

complexities and contexts of the life of another. To facilitate a relational approach within

narrative inquiry, the researcher constantly renegotiates relationships, seeking new collaborative

engagement with and reflections on participant stories, similarly utilizing curiosity to drive

questioning (Clandinin & Connelly, 2000; Green, 2013). Within each interview, I approached

participants with a genuine curiosity for their stories, and a desire to create a non-judgmental relational space for participants to tell these stories. I further drew on my genuine interest to probe further into participant narratives and seek explanation of contexts in the pursuit of understanding an individual's narrative truth outside of my own biases. However, throughout the interviews, I framed this interest as an invitation to share their stories, rather than a mandate. I developed the interview guide and engaged in the interview in a manner where participants could centre the narratives that mattered to them and in which participants could guide the flow of the interview with their narratives, with my probing into specific areas for follow-up. These approaches contributed to the rigour of the study through attempting to centre participant narratives and experiences, and minimize my role in directing their stories.

Reflexivity

A key component of undertaking narrative inquiry research in relation is reflexivity. Green (2013) describes the telling of stories within a researcher-participant interaction as "re-storying", as the story is shaped and changed by the conversation that unfolds in the context of the research even if this story has been told before. Narratives are heard and understood through interpretation, with the researcher's own lenses and perspectives shaping their understanding and reactions (Thomas, 2012). Eliminating the personal in approaching research is impossible; as a researcher I instead attempted to acknowledge and reflect on my own perspectives throughout the research process. Clandinin (2013) states that this process begins with asking "who am I?" within the particular study, a question which involved acknowledging my dual role as a researcher and a clinical instructor, and extended to an examination of the ways in which my particular orientations and beliefs as a nurse, teacher, graduate student, and individual inform my understandings of student narratives. For example, this process involved reflecting on and

attempting to set aside many of my previous understandings of student experiences in mental health practicums as informed by my clinical instructor experiences, and previous conversations with students while I was differently in relation to them, occupying a different role. Further, within this study, I aimed to engage in reflexivity, independently and in conversation with my thesis committee, within each stage of the research process: regarding interviews, relating to power and inequality (Clandinin & Connely, 2000); in analysis, regarding the balance between interpreting and contextualizing participant narratives and leaving stories intact (Thomas, 2012); throughout writing, a process that raised questions of authorship of narrative and selection/privileging of stories to be included and highlighted (Green, 2013); and in planning for dissemination of findings, which necessitated a personal and ethical inquiry into the impact of the research (Resisman, 2008).

Usefulness of the Research

Each year, one in five Canadians experience mental health challenges, making mental health a leading care concern nationwide (Mental Health Commission of Canada, 2013; Statistics Canada, 2013). Nurses are a key component of health care provision for individuals with mental health challenges, and knowledge and skill in working with patients with mental health challenges is necessary for nurses working in any health care environment, in care of individuals with mental health challenges. Despite the centrality of nurses' mental health competency in national documents and standards (e.g. Canadian Association of Schools of Nursing, 2015b), nursing students continue to feel unprepared to work with this population, expressing lack of knowledge, ability, and confidence even after education and training (Melrose & Shapiro, 1999; Hunter, Weber, Shattell, & Harris, 2015). Research into students' experiences of mental health nursing demonstrates that stigma toward individuals with mental health challenges may be both a

contributor to negative practicum experiences and to students identifying mental health nursing as the least desirable career choice (Happell, Platania-Phung, Harris, & Bradshaw, 2014). However, nursing students must be prepared with the knowledge, skills, and attitudes to provide safe, ethical, and effective nursing care to individuals with mental health challenges regardless of their chosen career path. Mental health practicums have been demonstrated to increase understanding of mental health and reduce stigma, however the ways in which these processes occur and how students interpret their practicum experiences is relatively unknown (Henderson, Happell, & Martin, 2007; Hunter et al., 2015; Thongpriwan et al., 2015). As such, the usefulness of this study lies in its unique contribution to the literature in exploring how students describe, interpret, and contextualize their experiences in mental health practicums. In conducting an iquiry into student experiences through a methodological approach of narrative inquiry, I aim to add nuance and depth to current understandings of the challenges in mental health nursing education and nursing care for individuals with mental health challenges. Specifically, understandings of students' experiences gained through this study can contribute to development of strategies to support students' preparedness for providing mental health nursing care, knowledge of students' perceptions of working with patients with mental health challenges in any health care setting, and nuanced understandings of students' reflections on mental health nursing as a career, all of which may contribute to addressing the issue of nurses' stigma toward individuals with mental health challenges, which mental health practicums have to date not effectively mitigated. Contributions to practice, education, and research are explored further in Chapter Five.

Summary

This study is situated within the theoretical framework of Foucault's micro-power, which informs examination of the ways in which power is operationalized through everyday mechanisms in an environment – within this study, nursing students' mental health practicum settings. Foucault's conceptualization of power further incorporates resistance as an inherent and ever-present counterpoint to power, and as such, this study analyzes students' narratives within the framework of both power and resistance to power. Exploration of students' experiences within these practicums is methodologically grounded in narrative inquiry. Drawing on understandings of human experiences as unfolding in narrative, or stories, narrative inquiry is informed by researchers' aim of making meaning of narratives through exploration of the temporality, sociality, and place that emerge in participant narratives. In reconciling micro-power with narrative inquiry, this study is further informed by critical narrative approaches to methodology, including critical reflexivity through all stages of the interview process, and critical narrative analysis of the data. This study sampled from an undergraduate nursing program, and 15 individual interviews were conducted with participants. Subsequently, I conducted a narrative analysis of the data within an analytical approach informed by the theoretical framework. Findings from this analysis are presented in Chapter 4.

CHAPTER FOUR: FINDINGS

Introduction

This chapter presents the study findings, focusing on narratives of resistance that emerged from nursing students' stories of their experiences in mental health practicums. Four interrelated narratives of resistance are presented. I first describe student narratives of pre-engagement with the practicum, including conceptualizing the mental health setting as unique from other clinical settings and therefore as involving particular challenges. Secondly, I introduce the ways the students' recognized power in the 'everyday mechanisms' of nursing practices in the clinical setting. Thirdly, I illustrate the students' narratives of enacting resistance to power in the practicum through connecting with patients, integrating and enacting multiple ways of knowing in their own nursing practice, and drawing on the student role to resist power and justify their acts of resistance. Finally, I discuss how students reflected on resistance, including how students' narratives of disempowerment in the clinical setting shaped their experiences of the practicum, informed their retelling of their narratives of resistance, and influenced their expectations of future nursing work with individuals with mental health challenges.

As described in Chapter Three, Clandinin (2013) conceptualizes narratives as comprised of three dimensions: temporality, sociality, and place, each of which shape how events are both experienced and retold. Due to the nature of the interview guide and my approach to the interviews, participant narratives rarely unfolded temporally according to the chronology of the practicum experience, and participants frequently recalled and told stories in conversation based on thematic or conceptual link to the narratives that emerged from responses to questions in the interview guide. Consistent with Kelly & Howie's (2007) temporal structuring of findings in

narrative analysis, the students' narratives of resistance are presented in this chapter in temporal sequence from the beginning to the end of the practicum, following the temporality of the experience as opposed to the temporality of the interview. Sociality and place are explored through the students' narratives of power relations within the clinical setting and how their resistance was shaped by the environment, their inter-relationships with staff and patients, and their observations of the actions and behaviours of others within the space. Narratives of resistance in this study are explored not only as they were *explicitly* stated by participants but also in how power and resistance shaped their experiences in the clinical setting in implicit ways, identified through the data analysis process. As described in Chapter Three, this study takes up power as conceptualized by Foucault (1979) in "Panopticism": operationalized through small, everyday mechanisms and thus termed micro-power. In describing nurses power over patients (and at times, over students) within the mental health setting, I utilize the term 'power relations' to describe mechanisms of micro-power that operate through interpersonal interactions, in contrast to those that operate through the clinical environment, for example.

The approach to the analysis and presentation of findings in this chapter is consistent with Foucault's (1982) view of resistance as a "starting point" for analyzing power – or as Bradbury-Jones and colleagues (2008) summarize: "power should be studied from the bottom up rather than the top-down" (p. 261). Therefore, in focusing analysis of the students' narratives on resistance, the study findings offer a starting point for understanding not only their enactment of resistance but also the power relations within their practicum environments more broadly. However, given the purposes of this study and the scope of a master's thesis, the focus was on student narratives, and other voices, such as those of patients and unit staff, are not represented and their experiences of power relations are not explored. As such, the presentation of these

findings is not intended as a criticism of individual nurses, particular units, or hospitals; as Foucault states, "any individual, taken almost at random, can operate the machine" (1979, p. 202). Rather, the findings presented in this study offer a critical analysis of student experiences of power relations and their resistance to power within the clinical setting.

Participants

Twelve participants identified as female, and three as male. The mean age of the participants was 29 years, with a range of 21 to 40. Five participants had completed Master's degrees, nine completed Bachelor's degrees in programs other than nursing, and one had partially completed a Bachelor's degree. Thirteen (87%) of the participants self-identified as "white", "Caucasian", and "European", one identified as Chinese, and one as Eastern European.

Interviews were conducted with twelve of the fifteen participants during their final four months of their nursing program, and with three participants in the three weeks following completion of their final preceptorships. Participants completed their six-week practicums at different times throughout the previous year (January to December). Four participants completed the practicum between January-April (one year prior to data collection), six between May-July, and five between September-December. Practicums were completed in one of three inpatient mental health clinical sites, each with two or three separate mental health units at each site (seven total units). Ten participants were placed at Site A, two at Site B, and three at Site C.

While a semi-structured guide shaped the interviews, many participants' narratives unfolded from broad introductory questions with participants centering particular stories and experiences. Follow-up questions served to further explore details of participants' experiences, and also their reflections and interpretations of these experiences, which are explored in this

chapter through the presentation of narratives of resistance: pre-engagement, recognizing power, enacting resistance, and narratives of disempowerment.

Pre-Engagement with Resistance

This section presents participants' narratives of pre-engagement with resistance through their emotional preparation and critical engagement with their expectations of mental health and mental health care. First, I discuss managing emotional well-being, and describe the strategies students drew on in advance of the practicum to support their emotional and mental health. Then, I present student narratives of resisting damaging stereotypes, illustrating the ways in which students utilized critical reflection on societal discourses of mental health to inform their expectations of the practicum and lessen their fear of working with this population. This section on students' pre-engagement with resistance provides temporal and narrative context for how students contextualized, prepared for, and ultimately experienced the practicum, including how they came to enact resistance within the setting.

Managing Emotional Well-Being

In the student narratives focused on engaging with their expectations of the mental health setting, the practicum was articulated as different from other clinical environments in its focus on conversation, therapeutic relationships, and mental as opposed to physical health. As one student described, "we're not talking anymore about asking when they last pooped – we're talking about their emotions…and that's a lot more personal." Many students shared that these anticipated differences caused "stress and turmoil", and that they expected to feel "uncomfortable" asking what were described as "hard questions". These 'hard questions' reflected those of a more personal nature, such as regarding suicidal ideation or traumatic events, and were considered by the students to be more challenging to broach. One participant, in describing her expectations of

engaging with patients, stated: "I felt awkward asking about suicide, like 'oh gosh, I have to ask them if they want to kill themselves'! I found that part really tough."

In response to their expectation of the practicum as presenting unique emotional challenges, the students engaged in particular preparations, including self-reflecting on maintaining their own well-being during the practicum and organizing support from others, including peers, family and friends, and clinical instructors. For example, one individual described anticipating the need for developing strategies to support her own emotional well-being throughout the practicum:

> I've heard people saying that they were exhausted all the time, emotionally. So it's just thinking okay, what can I do to set systems in place. Like, if I'm just "oh my god, I can't handle this day, what the heck", you know? So I just thought through that a lot and was just like, okay, I'm kind of a systematic person, and I like to think plans through, think up a plan to implement if something goes wrong.

She further described her planning in advance of the practicum as involving two strategies: reaching out to fellow students to discuss their experiences in the mental health practicum, and identifying peers who she could continue to approach if she experienced emotional challenges during her practicum experience. Many participants similarly described approaching peers, friends, and family members in advance of the practicum in anticipation of emotional challenges. Another student described speaking to a friend in a different health discipline with the aims of receiving "some reassurance" and advice on "how to maintain my own mental health." She further reflected that she found it helpful "just being honest about how nervous I was feeling". Participants frequently anticipated experiencing emotional challenges in the practicum, yet addressed these concerns by self-reflecting and reaching out to others – strategies that developed their capacity to maintain their emotional well-being.

While many participants shared stories of engaging with their expectations of emotional

challenges in the practicum, some individuals anticipated the additional challenge of navigating

the practicum in the context of their own mental health challenges. All students who shared a

personal history of mental health challenges expressed concern that the practicum would not

only lead to personal discomfort in interacting with patients experiencing similar challenges, but

also potentially cause a recurrence of symptoms. One participant explained:

> I have a history of a little bit of depression, which kind of comes and goes… and it's all
> managed quite well, it has been for years. But I did have this sense of "to hell with the
> patients, I'm gonna do whatever doesn't trigger me"… If talking about depression,
> talking about suicide, makes me sort of relapse to some degree, that was a concern for
> me… Certainly when I went in, that was kind of what concerned me the most – how am I
> gonna react to this? How's my body gonna react, even if my mind's like "it's okay, it's
> okay".

In response to these concerns of being triggered, this participant approached their clinical

instructor for advice on managing well-being throughout. Other participants experiencing (or

with a history of) mental health challenges described feeling "nervous about having a really hard

emotional experience" or "a little concerned about it – I'm not sure how I'm gonna react". In

navigating these anticipated challenges, one participant intentionally avoided a particular unit on

which individuals who shared her diagnoses were frequently admitted, reflecting "I just didn't

want to put myself in that situation." Another participant's similar strategy was to select a unit

that she had heard described as "more stable", and on which a fellow student she connected with

would also be placed: "I knew that she would be somebody that I could like really talk to about,

you know, all of these things". In each of these participant stories, the students anticipated

experiencing unique challenges in the practicum, which they believed may jeopardize their

emotional well-being and mental health. The students' pre-engagement with the practicum

included not only self-reflecting on their expectations, but also taking particular actions – such as

reaching out to others and making decisions about practicum sites – that they believed would protect themselves during the practicum experience.

In undertaking such strategies, the students sought to protect themselves, but also to prepare themselves for providing nursing care for their patients. Many participants described becoming "comfortable with being uncomfortable" as their goal in undertaking emotional preparations for the practicum, and discussed the importance of overcoming their discomfort for engaging meaningfully with patients and conducting thorough assessments. In this way, students' strategies for managing emotional well-being also developed their capacity for maintaining their own ability to provide good patient care, which ultimately informed their enactment of resistance to unprofessional and unethical nursing practices.

Resisting Damaging Stereotypes

Participants described how stigmatizing and stereotypical societal discourses about individuals with mental health challenges variously impacted their expectations of the environment and of working with this population, and the ways they resisted these stereotypes in advance of the practicum. Across participant interviews, a narrative of fear emerged from participant stories of preparing for their practicums, yet the students described critically engaging with stereotypes they identified as perpetuating their fear. Participants frequently described being "nervous" or "scared", and attributed their apprehensions to having heard stories of violence or unpredictability about patients in mental health care settings. One student reported hearing staff in her previous medical/surgical rotation describe patients with mental health challenges as "hard to work with" and reflected in the interview on how this informed her own expectations that working with this population in the mental health practicum might be "really difficult". Another student shared: "I was kind of expecting the worst. Just because of everything I heard…".

However, participants described critically reflecting on these expectations to resist their own fear and apprehensions. One student acknowledged feeling "a tiny bit scared" having heard stories from peers about the unit on which she was placed, yet also described attempting to reject stereotypes of "what we think of mental health sometimes – 'oh, aggressive patient, blah blah blah'". In grappling with her expectations, she stated she intentionally adopted a "non-judgmental" attitude as a strategy for resisting damaging stereotypes regarding this population. Similarly, another student discussed critically reflecting on the impact of media representations of mental health on her expectations of the practicum, and likewise resisted integrating such portrayals as reflective of what to expect in her own experience:

> I had *no* idea what to expect… I've obviously seen things that are played up on TV of really extreme mental state prisons and that kind of thing, but I don't think I had any good or bad impressions going in.

In recognizing media portrayals as 'played up', this participant framed media portayals of individuals with mental health challenges as inaccurate stereotypes, neither representative for the broader population nor indicative of her practicum experience. For another participant, grappling with expectations of the practicum involved reflecting on a story told to her by a friend who works as a nurse, in which she was "hit over the head with an object and knocked out by a patient" on her first day of her own mental health practicum. This participant described how ultimately, her friend's experience did not inform her expectations of working with patients with mental health challenges:

> So I think that like, these types of stories kind of travel… I think people think mental health, and sometimes they think aggression… I think that you could get hit over the head in med/surg. I think that you could get hit over the head by, you know, an angry woman who's giving birth to her first baby, you know what I mean?… I just feel like all nursing students have a funny story about something ridiculous that happened to them in nursing school and I think that was just her story.

In retelling her friend's story and discussing her reaction to it, this participant recognized that stigma of mental health challenges impacts how particular stories of violence are highlighted and given meaning in society, and critically reflected on these narratives in preparing for her practicum. Ultimately, her critical engagement with her friend's story contributed to her entering the practicum without fear of experiencing violence. While many students acknowledged feeling afraid of their upcoming practicums, within this narrative of fear was also resistance to the societal narratives underlying their own apprehensions. In advance of the practicum, students grappled with societal stigma and stereotypes and drew on critical reflection to inform their expectations and in many cases, lessen their fears. This critical engagement with stigma and stereotypes frames how students reflected on mental health in entering their practicums, and situates students' later resistance within the practicums in a particular context of self-reflection and resistance to fear.

Recognizing Power as Resistance

Participant narratives of their practicum experiences illustrated their recognition of the power held by staff, particularly nurses, and the ways in which this power operated through the 'everyday mechanisms' Foucault (1979) describes in his discussion of micro-power. In telling stories from the practicum, the students described how the enactment of power was evident in both the clinical environment and in the nursing practices, including both attitudes and behaviours toward patients, they observed in the practicum. The students' narratives speak to how micro-power impacted their own experiences, and further, shaped patients' behaviours, actions, and reactions. In recognizing power, the students 'made visible' micro-power as it operated within the clinical setting, an act which is characterized by Foucault as in itself an act of resistance. This section describes the different manifestations of power that the participants

recognized within their practicums: institutional environments of the practice setting, nurses'

disengagement from patients, and the unsafe and unethical practices the students observed by

nurses.

Institutional Environments

Two of the participants were placed on units that they described as feeling less "clinical"

than other hospital environments, and in which attempts were made to increase the "homey" feel

such as through carpeting or artwork. Yet overall, the students characterized the environments of

their practicum sites as institutional. While a few participants specifically utilized this

terminology, many of the descriptors were consistent with its meaning: environments

reminiscent of mental institutions, also termed asylums, during the era of institutionalization in

which individuals with mental health challenges were separated from the general public and

confined in prison-like institutions in frequently unsanitary conditions (Beer, 2007; Goffman,

1961). Participants described their impressions of the physical environment of their units as

"dark and dreary", with "blue lighting" and few windows to bring in natural light. While one unit

was purpose-built for mental inpatient health care, most units were re-purposed medical units

with long corridors and small common areas which students described as contributing to a

"closed" and "disconnected" feel. The units were frequently poorly kept and outdated, with "old

aesthetics" and insufficient bathrooms for the number of patients. One student said of the unit

she was placed on: "it didn't feel like somewhere you'd want to be for your own mental health,

let alone the people who are trying to heal." Others corroborated this understanding of the

environment as non-therapeutic and not conducive to healing, and many posed the question of

whether the clinical environments were a detractor to the mental health of patients: "immediately

to me I thought like, how are people supposed to get better here?…This place is terrifying."

In descriptions of the clinical environment, participants frequently drew comparisons to prisons and mental health facilities from the era of institutionalization. These comparisons demonstrated the ways in which students recognized power operating through the environment to reinforce patient disempowerment, and their descriptions of the non-therapeutic environment underscored societal stigma positioning individuals with mental health challenges as less than, requiring containment rather than treatment. Student narratives also reflected how the environment impacted their experiences of the practicum, with some individuals recalling attempts to secure a placement on a particular unit on the basis of the environment, and others describing the daily negative impact of an institutional environment on their own well-being. Through descriptions of the clinical environment, students recognized the ways in which power operated through place to shape their own experiences of the practicum and the experiences of their patients within the health care setting.

Disengagement from Patients

Students consistently recognized disengagement from patients as a hallmark of the nursing attitudes and behaviours' toward patients. Disengagement took many forms, as described in this section, from limiting time spent engaging with patients to overt rejection of contact. In all its forms, this approach to care was reflective of micro-power: disengagement differentiated patients from nurses and reflected the operationalization of power through everyday practices, such as nurses' retreating to restricted areas (i.e. areas of the unit where patients were not 'allowed' such as within nursing stations), declining to provide care or meet patient needs (i.e. ignoring a patient waiting to ask a question at the nursing station), or enforcing particular patient behaviours and actions (i.e. asking patients to go to their rooms rather than sit in common spaces). The students frequently expressed both surprise and distress at nurses' disengagement

from patients, and articulated these approaches as not representative of best practices. In this way, the students' narratives framed disengagement as reflective of power relations in the practicum: nurses could choose to disengage from patients seemingly without consequence, while patients were neither afforded freedom of choice to behave as they wished on the unit, nor able to consistently have their needs (which were frequently dependent on nurses' responses) met. Further, students' recognition of disengaged nursing practices represented their resistance to such approaches, as rather than seek to emulate such practices, students articulated disengagement as morally distressing, and frequently harmful to patients.

With the exception of one student who described helpful and engaged nurses on her unit, every other participant spoke of how nurses spent little time engaging with patients and significantly more time in the nursing station; nurses were described as present in common areas only while they attended to basic tasks such as administering medications. Any interaction with patients was described as brief and often superficial. For example, one participant stated: "I found that they go see the patient, be like 'so do you feel safe?' and if the patient answered 'yes', sometimes that was kind of it." Another participant described her experience of the nurses' approach to patient care as:

> In the morning, they would do their checks as a team, and introduce themselves. And then they would go back, prepare meds, give out meds as necessary, they would do kind of a…5-minute chat, 10-minute chat with a client, and then there was no more interaction unless something went really poorly and they had to intervene, or unless the client approached them at the desk… Other than that, they kind of let the clients, you know, shower when they wanted to, and if they stayed in bed all day, then they stayed in bed all day, and it was very – it was just not what I thought was going to happen.

In addition to witnessing nurses limit patient interaction to basic tasks, many participants witnessed instances of nurses actively avoiding engaging with patients. For example, one

participant described observing patients approach the nursing station and being asked to wait up to five minutes, despite nurses not appearing to be engaged in other tasks.

While many students noted that certain nurses demonstrated care and concern and spent time engaging with patients, these nurses were described as individual exceptions to the predominant disengagement from patients at all three clinical sites. In the nursing station, participants frequently witnessed nursing staff engaging in conversations and tasks not related to patient care. Many described nurses socializing, spending time on social media, and applying for other jobs – one participant estimated that only 30% of nurses' time was spent engaged in patient care, direct or indirect. Participants characterized this disengaged approach as "laissez-faire", "us-versus-them", and "distanced", with many participants speculating that nurses may be dissatisfied with their jobs or uncaring. While participants were frequently understanding of the need for some conversation and camaraderie amongst staff, they were also surprised by the extent of disengagement with patients and expressed their ongoing distress in consistently observing the lack of interaction. One participant in telling the story of her first day on the unit, described:

> We had our report in the morning…and then I remember being so shocked – I was like "this is so different from med/surg" because this one nurse is like "ugh, do we have to?" and then they're like "let's just sit here for five minutes". And they just sat there! And I was like, "is this normal for mental health, or is this like, they're actually slacking?" I was so confused. But that was just kind of the whole day, like "do we *have* to go down the hallway and do this right now?"

In this narrative, the student contrasts nursing approaches to patient care in medical/surgical settings with those in mental health, and in doing so, frames the nurses as 'slacking' in comparison to the behaviours of staff she witnessed in other practicums. As such, this story identifies one way in which power relations played out within the mental health setting: the nurses' reluctance to engage with patients illustrated their *ability* to disengage. While this student

ultimately concluded that the approach to patient care that she witnessed on her first day was normative in the nursing attitudes and behaviours in the provision of patient care, she resisted interpreting these practices as acceptable. Rather, her continued expressions of shock and distress regarding this incident during the interview demonstrated her resistance to the nursing approach of disengagement.

An additional way in which participants identified power relations as operating through nurses' disengagement from patients was in nurses' frequent use of PRN medications to 'manage' patient behaviour. Many participants described observing what they perceived as nurses utilizing PRN medications in place of interacting with patients, such as in situations in which a patient was becoming distressed or agitated – an approach which students consistently articulated as an inappropriate nursing intervention for the situation. One individual, in describing the frequency of this approach, herself utilized the expression "ten and two" in describing the use of PRN medications as a "primary nursing intervention". 'Ten and two' refers to the commonly administered doses of antipsychotic and benzodiazepine medications – 10mg of loxapine and 2mg of lorazepam – with the short-hand itself suggesting the regularity of this particular pharmaceutical intervention within the clinical setting and the frequency of this student's exposure to this terminology. While many students described their surprise at the immediacy of PRN medications being administered as a nursing intervention in incidents of patient distress, one student also described a situation in which a patient was given more medication than he believed was necessary or appropriate:

> She started having a breakdown a bit and got really agitated. And they were like "okay, give her all her PRNs right now". Like everything – Ativan, lox, just everything that she had PRN, they just gave it to her all at once. And half hour later, just pfff, conked out… And you're like, "oh, we'll just put her into bed and we'll watch her vitals every so often"… Rather than talking to her, maybe calming her down, or working with [her],

you're like "nope, here, take a bunch of medications." And that's what I frequently felt was happening. It was just like "problem? PRN."

This participants' story suggests that mechanisms of micro-power in the clinical setting included not only nurses' withdrawal or refusal of contact, but also enforced disengagement, in which a patient could be controlled medically to – in this student's view – avoid the prolonged engagement of working through her distress in conversation. Through this story, this participant resisted the common practice of PRN medications as an appropriate first intervention, and endorsed the alternate perspective that nurses' engagement with patients could serve to prevent or reduce the use of PRN medications. The administration of PRN medications as an immediate response to a range of patient behaviours was viewed consistently by participants as indicative of the dominant approach of disengagement in nursing care, and provides an example of the ways in which, through addressing their concerns regarding this intervention in their narratives within interviews, students recognized power relations between nurses and patients in this setting.

Unsafe and Unethical Practices

In addition to describing a pervasive approach of disengagement with patients, most participants described witnessing particular instances of unsafe and unethical nursing practice, which were characterized by participants as events in patient care provision that were disrespectful, harmful, and/or distressing to patients. In their narratives, the students consistently articulated these practices as representative of inappropriate and non-therapeutic care, and in doing so recognized these practices as serving to uphold nurses power over patients, rather than to provide respectful and compassionate care. As discussed in Chapter Two, the provision of "safe, compassionate, competent, and ethical care" is both a professional value and ethical responsibility at the national level (Canadian Nurses Association [CNA], 2008), and a professional standard at the provincial level (College of Registered Nurses of British Columbia,

2013). The inclusion of classroom content on professional standards is an essential component of

nursing education programs in Canada (Canadian Association of Schools of Nursing, 2015c),

and participants were therefore likely familiar with this value as it is framed in regulatory

documents. This value therefore likely also informed their narratives and their interpretations of

the nursing practices that they observed in the setting. Narratives of witnessing nurses' unsafe

and unethical practice frame these events in care provision as representative of everyday

mechanisms of micro-power, through which nurses asserted their control over patients and

reaffirmed their position of power.

In describing unsafe and unethical practices witnessed in the clinical setting, many

students described hearing nurses, either in the nursing station or during nursing report, describe

and label patients as "annoying", "aggressive", or "intrusive". In retelling these instances,

participants resisted these characterizations through their narratives, instead interpreting patient

behaviour as symptomatic of their mental health challenges, or related to legitimate concerns and

attempting to approach nurses to have their needs met. Participants described patients frequently

being turned away from the nursing station, with nurses often using an "antagonizing" tone of

voice, or in some instances, "yelling". In telling stories of these incidents, participants frequently

highlighted the negative impact of these events on their patients' well-being and experiences of

treatment in the clinical setting. One participant explained, "I would go and talk to clients and

they would say 'oh, I feel dismissed' [and] 'they don't care about me anyways'. And it made

them not want to be there even more." In retelling a story in which one patient was caught using

drugs on the unit and subsequently "strip search[ed]" in the unit's isolation room, the participant

who had worked with this individual described her observation that the impact of the

"authoritative" nursing approaches to patients "always procured [sic] feelings of shame".

Another participant shared a story of working with a First Nations patient who she stated became "very upset" after nursing staff arranged for a pastor to come to the unit to meet with her without her prior knowledge or consent. This participant further recounted her own reaction as dismayed that "no one put the dots together on that one, that that might be so triggering for somebody who has intergenerational trauma, right?" As in this story, participants frequently centered patient perspectives in interpreting and making meaning out of the events they observed in the clinical setting, and expressed distress in witnessing insensitive or harmful nursing practices. One participant recounted a story in which she approached a nurse for assistance after encountering her patient masturbating in the unit's common space. When the nurse "had a laugh" with other staff in the nursing station after approaching the patient but leaving without addressing him directly, this participant recounted: "He was *so* embarrassed…I was devastated".

Students' stories of unsafe, unethical practices implicitly made power visible through the act of retelling these stories, and their framing nurses' actions as representative of their control over patients. Further, some of the students described how during their practicums, they explicitly interpreted particular events and practices as indicative of a nursing approach characterized by power over patients. One participant described a conversation amongst her group of clinical students in which they debriefed multiple experiences that "seemed like almost abusive, like an abuse of power over the patients". While some students characterized the nursing practice of making rounds in the morning to check in on each patient as either benign or positive, one participant read the morning check as "authoritative" – representative of nursing control over patients and suggestive of the mental health nursing role as "like a guard". Another participant recounted a story that illustrated nurses' maintenance of control through what he

believed to be a trivial matter of the volume of a radio in the unit's sensory modulation room near the nursing station:

> The volume would [with] some patients be a little bit higher, just a little bit, not an annoyingly high level… but for them [the nurses] it was "turn it down! Turn it down! You can't do that! You can't keep it that high!", in the sense they needed to try to keep order on the unit, like correctional officers in a sense, right? Like, you gotta maintain order, you gotta keep the volume– but we [students] would look at and be just like, yeah, it's listening to music, I mean, there's worse things they could be doing. It's not disruptively loud…it was more to try to keep order, right? Because if you give them that inch, right? If you let them turn up the volume to 8 instead of 7, well then who knows where it can go from here…

This participant's comparison of nurses to correctional officers was echoed in the narratives of other participants, who described the units feeling like prisons, and the power wielded by nurses as reminiscent of guards. Such comparisons explicitly framed nurses as enacting power over patients in this setting.

Students frequently resisted integrating the practices described above into their own patient care. Yet, as a result of identifying the practices they were witnessing as behaviours they did not want to emulate, the students were frequently unable to draw on experiences within the clinical setting to alternatively inform their learning. In the absence of observing nursing practices that students *did* want to emulate, participants articulated that they "saw what not to do – not so much what to do", which one individual described as "learning the gaps". While one participant identified one nurse who "took [her] under his wing", and a few others found that some unit nurses were open to answering questions, most participants described nurses as "not approachable" and reluctant to engage with students. Some students presented extreme examples of poor relationships between nurses and students on their unit: one participant's nurse on her first day "didn't want to hear my name", and another student recalled being present in the nursing station while two nurses argued about students, with one refusing to have students work

with her patients or to change her patient assignment to allow the students to continue to work with their assigned patients.

In recognizing observed nursing practices as indicative of power relationships between nurses and patients, and themselves experiencing fraught relationships with nurses, participants experienced a complex relationship to power within the clinical setting. Their identification of witnessing "what not to do", and identifying gaps in their learning as a result, demonstrated their resistance to the dominant nursing approaches on the units through their recognition and rejection of common practices. However, students also expressed concern regarding their own lack of competence in working with patients effectively, suggesting reflection in their own power over patients. In the absence of identifying practices which they did want to emulate and therefore feeling insufficiently knowledgeable or prepared to provide patient care, some participant narratives reflected a concern that they may also be complicit in power relations as enacted through the provision of nursing practices that undermine safe, competent, and ethical care. One student in working with her first patient recalled wondering "am I doing this right?", while other participants described working in pairs to attempt to address their perceived lack of competence. In addressing the lack of oversight for her own patient care, one student questioned, "how do you know that I'm not causing more harm than good?" Yet while students described a lack of confidence and competence in their care provision, they continued to differentiate their concerns about their own practices from the practices they observed from nurses, thereby situating themselves in a liminal space in relation to power within the clinical setting. This differentiation of their own practices from those of nurses is described through the students' enactment of resistance, below.

Enacting Resistance

Emergent from participant narratives of their practicums were stories of enacting resistance to the attitudes and practices that they observed in the clinical setting. Students described instances in which they took up care approaches that differed from the normative nursing practices on the unit, and as such, enacted resistance to power as operationalized through these everyday practices. In this section, three aspects of students' enactment of resistance are presented. One mechanism through which students enacted resistance was their engagement and connection with patients in contradiction to the dominant approach of nursing disengagement. Additionally, rather than emulating nursing practices observed in the clinical setting, students sought out and enacted ways of knowing that informed their own nursing practices in ways that differed from those of the nursing staff in the practicum. These ways of knowing were drawn from a variety of other sites of learning, and the students' enactment of this learning challenged dominant nursing approaches and informed their resistance to power. Lastly, to foster their enactment of resistance in a setting characterized by power relations, students frequently drew on their student role to provide explanation and justification for their actions. Within each participant story of resistance was a common narrative of identifying practices that they viewed as unprofessional and unethical (as discussed previously), and practicing differently in resistance to these practices. This narrative of enacting resistance demonstrates the ways in which students recognized and took up their ability to resist micro-power in the practicum through their refusal to align their practices with the dominant attitudes and behaviours of the setting.

Connection as Resistance

In a setting in which disengagement from patients was a dominant approach to nursing practice, connecting with patients was a form of resistance. Students connected with patients by

engaging in conversation regarding patients' mental health challenges and also on a range of topics, and by spending time socializing in common areas of the unit one-on-one or in a group – as one individual recounted, "playing games of ping pong, doing puzzles, doing the therapy colouring books, and just really trying to get to know them". Many participants described their actions of spending time with patients as specifically in contrast to the nursing behaviour they were witnessing and to nurses' expectations of students. The disengaged approach to patient care in the clinical settings contributed to one student feeling unsure whether spending time with patients on the unit was acceptable:

> Initially it took a couple of weeks maybe for me to be comfortable, to be like, okay, I'm not doing anything, I gave all their meds, did my charting, I don't need to look at my facebook for four hours during a day, nothing that exciting is happening! So yeah, why not go talk to them?

When she did begin to talk to patients in the common areas of the unit, she stated that she "felt sometimes that they [the unit nurses] thought it was weird". Another participant reflected "it just felt very not part of the culture to be out wandering the halls".

While participants consistently articulated that spending time connecting with patients in common areas was outside of nurses' usual practices, some students further encountered direct opposition to their actions. One participant told a story of having worked with a patient for five weeks before he requested to not work with students anymore following a negative experience with a student from a different nursing school. She recounted that the following week, after assigned to work with different patients: "when we saw each other on the unit, I said 'hi', and then one of the nurses saw us talk, and then she reported me to my CI [clinical instructor]." Another student was similarly reprimanded by a nurse for spending time with her patient:

> I was with this one patient the whole six weeks. And so I would go into his room, and we would be having conversations, and at one point, I came out of the room, and the nurse was like "why were you in there?" I was like "oh, we were just talking" and she's like

"it's been like 45 minutes…" And I didn't have any other patients at the time, and I was like "oh, he was just kind of telling me about his story…" – things that weren't in the chart yet… She was just so demeaning towards me for it. It was really weird.

In this participant's narrative, and many others', continuing to engage with patients despite opposition from nursing staff was a primary mechanism for resisting nurses' pervasive disengagement. However, one student's resistance took the form of directly engaging in conversation with a nurse about connecting with patient, and negotiating with him the extent to which she was permitted to talk to her patient about difficult topics:

So at times she would want to start talking about her trauma history, and I talked to my primary nurse… and his advice to me was to "shut that right down! Shut it down. Don't listen, don't acknowledge it, just redirect her." And so I explored that a bit with him, and I was sort of like "well, I'm happy to acknowledge her feelings, and provide some supportive care, and maybe suggest some things that she can use to cope right now." But really his focus was, "shut it down, redirect her, and when she's discharged, they can deal with that" – was pretty much the exact conversation. So we came to a compromise on that, because I agreed – yeah, I'm not a counsellor, it's true, but I am a nurse, and we can do therapeutic communication with people and we can provide supportive listening and acknowledge people's feelings.

As in this example, students' stories illustrated their encountering a variety of challenges to their engagement and connections with patients, including the predominance of disengagement from patients in the setting, and in some cases, nurses' overt disapproval. However, participants described continuing to seek opportunities for connection in resistance to micro-power as enacted through disengagement.

While some students framed their actions of connecting with patients as "what we're supposed to do", or enjoying being busy – "I don't like being in one spot" – many participants also reflected on the importance and impact of connecting with patients: "I think being present is essential", "I feel like it made a difference". Participants consistently described forming close, trusting therapeutic relationships with patients, which contributed to their ability to complete comprehensive assessments and work closely with their patients regarding their symptoms and

challenges. One student, in describing her relationship with her patient, stated "I think we had a good connection and he felt pretty good about telling me things", while another articulated that developing rapport with patients contributed to her ability to "unpack what's been happening with this person". Participants also described their own presence as a "therapeutic tool" for both understanding and intervention – for example, in recounting working with an individual with diagnosed bipolar disorder one student stated, "I was the first to see a manic episode coming on. I could see the changes and I could see that it was happening just from having spent the afternoon with him." Another participant described receiving different responses from her patient than what she witnessed in his behaviour with nursing staff: "He would raise the volume of his voice sometimes… But with me he was never like that. I was joking with him…treating him like a person – that there's not that secured door between us."

As well as forming relationships that contributed to positive outcomes in patient care and implicit resistance to disengagement through practicing differently, stories also demonstrated the ways in which participants drew on connection with patients to explicitly resist power in the clinical setting. Students' connection with patients served to increase their knowledge and insight into patients' lives, personalities, and experiences, and led to students disagreeing with the negative characterizations of patients that students consistently encountered from nurses. For example, one student describes how learning about his patient's history provided him with an understanding of his patient that contradicted the nurses' characterization:

> They said he was always being sarcastic. But when I would go with a friend and we'd just chat with him…he was actually I thought, very calm, kind of nice guy! He wasn't super sarcastic. And it was just interesting that some nurses would, they would label him sarcastic. But when we looked at his chart, we found out that he had been raped as a kid…So you begin to understand why they might have trauma and lingering mental health concerns because of what they've experienced. And so those kind of things just really help you to develop a sense of empathy and more relational practice, an interpersonal understanding of what's going on.

Another participant told a similar story in which nurses' attitudes toward a patient were incongruent with her own:

> She was there for the whole time that I was there, so I just felt this sense of investment in her well-being…She had befriended another woman who…had gone off unit and taken what she thought were T3s but then it had fentanyl in it, and ended up having to go [to another unit] because she was too [medically] unstable… And [the patient] that I'd worked with, she was *super* upset about that, and it felt like [with] the nurses, simply because she had befriended this other woman, she was tainted in a sense… It was weird because like I felt like I had this soft spot for her, but then by the end of it, it was like the nurses were kind of casting doubt on whether all that empathy that I felt was deserved.

As in this story, participants frequently spoke to the challenges of disagreeing with the labelling of patients as "uppity", "intrusive", or unable to achieve their goals. Students consistently illustrated that through conversations and time spent with patients, they gained knowledge and understanding that contradicted these characterizations, and expressed the view that the absence of connection between nurses and patients perpetuated these negative portrayals. In this way, students demonstrated resistance not only to nurses' disengagement but also to the judgment and stigma toward patients that was reflected in the power relations in the setting.

Enacting Ways of Knowing

Participants consistently framed many of the care approaches they witnessed in their practicums as contrary to best practice, and resisted the notion that they should emulate such practices in their own care. While some students were able to observe individual nurses practicing in ways that were in contradiction to the dominant nursing approaches of unsafe and unethical care, many students drew on other ways of knowing and ways of understanding the nursing role to inform their own provision of nursing care. The students aimed to translate theoretical knowledge from the classroom into practice, sought guidance and support for nursing practice from clinical instructors, and drew on personal and professional values to inform their

nursing care approaches in resistance to normative practices of disengagement and unsafe and unethical care, and the power relations these practices perpetuated.

Theoretical Knowledge: Students frequently positioned theoretical knowledge from the classroom in direct contradiction to observed nursing practices. Students integrated this theoretical learning to enact resistance through taking up approaches to caring for their patients that challenged dominant normative practices. One individual attributed her awareness of the importance of connecting with patients to her theoretical knowledge gained in the nursing program: "And that's the thing we learn in school – therapeutic relationship, you really want to gain trust… Sometimes people just need to talk, you know? I feel like that is a nursing skill, to be able to connect with people." She described this understanding of building therapeutic relationships as directly informing her own nursing practice and that of her peers: she recalled spending time and engaging in conversation with patients, despite her observation that the students "were the only ones we saw doing that". Other participants similarly resisted nursing disengagement on the unit by drawing on the concept of relational practice to inform their approaches to mental health practice. Relational practice as discussed in Chapter 3, is described by Doane and Varcoe (2007) as the ways in which nurses "engage with, and respond to, specific patients in particular situations" (p. 195). The concept of relational practices is grounded in nurses' "contextual understanding" of each patient as an individual and involves interaction and connection to support this understanding (Doane & Varcoe, 2007). 'Relational Practice' is the title of a series of courses in the UBC BSN program, and as such, participants in this study received extensive education on this concept and thus, on the importance of spending time getting to know patients. In one students' narrative of developing her own approaches to patient care, she reflected:

I think it's [relational practice] something that's very ingrained in us, and I know for sure [our mental health course instructor] taught us that too. So I think I went into it knowing that I should interact more with my patient and I like to anyways, so it wasn't forced. I just feel like that's the best way to care for them and I didn't see that from the other nurses that were already there.

Participant narratives consistently referenced additional nursing concepts learned in the classroom context, including patient-centered care, trauma-informed care, and strengths-based approaches to care, and the students utilized these terms in differentiating the care approaches they drew on in their practicums from the nursing practices they observed in the clinical setting. For example, one participant who wrote a class paper on trauma-informed nursing practices recounted an interaction with her patient that demonstrates her integration of this concept in the context of conducting a mental status exam (MSE), a standardized nursing assessment:

As students, we're asking a lot of questions and trying to do an in-depth MSE… I didn't ask direct questions about things I had read in her trauma history – but just sort of asking her to elaborate on some things. She did feel comfortable to say, "you know what, I've already talked about this and I don't want to talk about it". And I was like "good! That's totally in your power".

This student's narrative demonstrates how she, drawing on theoretical nursing concepts, provided care in a manner that aimed to create space for her patient to hold agency and power in the interaction. In doing so, she resisted nursing approaches to assessment that are reflective of mechanisms of micro-power, such as asking invasive questions or insisting patients talk about uncomfortable topics. As in this example, participants' stories of drawing on theoretical knowledge to inform their practices demonstrated the students' ability to transform theoretical perspectives into interventions and approaches to patient care in the clinical setting, and spoke to their enactment of resistance to nursing practices that they identified as inconsistent with these perspectives. As one student summarized:

We need more of that critical lens on things, so that when we go into these environments where that's not necessarily the perspective, we cannot assimilate that – we can choose our own practice and kind of shape our own mindset.

Theoretical nursing knowledge provided participants with perspectives on nursing care that differed fundamentally from the those underlying the nursing practices they observed in the clinical setting. Students demonstrated their ability to enact concepts such as relational practice and trauma-informed care in everyday interactions with clients, and in their taking up of this knowledge in their own practices, the students enacted resistance to the dominant nursing practices that were illustrative of power and control as opposed to engagement and respect.

Clinical Instructors: While theoretical knowledge informed many of the students' strategies for enacting resistance to power, other participant narratives spoke to the difficulty of enacting classroom concepts in a practical setting. Students frequently drew on the knowledge, perspectives, and support of their clinical instructors to bridge the gap between theory and practice, provide guidance for their care approaches, and navigate challenges in enacting resistance. Participants frequently framed clinical instructors as a source of emotional support following distressing events, and described clinical instructors being "a person to talk through things with" and supporting students with "discussions and debriefs". In many instances, clinical instructors provided students with advice and direction from the beginning of the practicum, which contributed to students' development of mental health nursing knowledge and informed ways of providing care that resisted dominant practices. For example, one participant explained her clinical instructor's request that students wear regular clothes, though nurses working on the unit wore scrubs:

> Her rationale was, "we don't want to be different than them, we don't want to be separate, like, we're not better than them… We're here to kind of help people navigate their mental health journeys", which I really identified with… Just because I'm another human being that doesn't experience that [mental health challenges] doesn't mean that I should be looking down on you for it, you know? So that really struck me.

In this way, this student identified wearing scrubs as a mechanism of micro-power, and through

wearing regular clothes, visibly enacted resistance to the power that scrubs signified within this

environment. Clinical instructors were frequently described as supporting students in resisting an

us-versus-them attitude toward patient care, and as in this example, offered practical suggestions

for care approaches that resisted micro-power.

Further, students' took up theoretical perspectives presented by their clinical instructors,

which contributed to their development of practices that centered patient respect and autonomy.

In one example, a participant recounted a story in which a patient approached a nurse to request a

PRN medication, and the nurse subsequently administered the PRN without consulting the

medication record, stating "we just give them PRN medications here… They're just going to go

somewhere else and find the drugs". He further endorsed the opinion that "harm reduction does

nothing". This student described initially being unsure whether this nurse's perspective on harm

reduction was "common" and approached her clinical instructor for guidance. As well as "hating

that he said that", her clinical instructor offered this student an alternative perspective on PRN

medication and harm reduction to counter the nurse's. This participant recounted her clinical

instructor advising her:

> Ask them why they need the PRN medications, do your assessments… Harm reduction's
> kind of like a negotiation where maybe they do need the [PRN] drug, and maybe you
> should give them the drug, but you need to at least figure out what's going on in their
> head, how you can help them.

Framing care as a negotiation re-centered power in the nurse-patient relationship: for this

student, her clinical instructor's care approach encouraged nurses' engagement and

communication with patients, as opposed to nurses' decision-making based on their own beliefs

or priorities. She articulated that her clinical instructor's perspective, unlike the nurse's,

resonated with her, and she drew on these concepts in her own nursing practice. This student's

story demonstrates the ways in which clinical instructors' perspectives on mental health care informed students' approaches to patient care and provided a theoretical and practical foundation for students' enactment of resistance to observed dominant practices. Many students described utilizing their clinical instructors' perspectives to provide guidance for how – or how not – to practice. In daily clinical group conferences, one participant shared stories of the care he was seeing on the unit, and frequently received a response from his clinical instructor of "that's not how it's supposed to happen…don't do that, don't do that, don't do that." In drawing on clinical instructors' reframing of the unsafe and unethical practices that they were witnessing in the clinical setting, students were able to practice in ways that resisted the dominant practices of nursing care on the units.

Personal and Professional Values: Many participants described their approaches to care as their inherent ways of being, reflecting that elements of their practice "just came naturally". However, their narratives suggested that underlying their articulated natural approach to nursing care were ways of knowing and understanding drawn from their personal histories and experiences in other classes and practicums. For example, one participant described her family background as influencing her approaches to mental health care that resisted dominant practices:

> I feel very privileged that I grew up healthy, and my family is healthy… I feel like people who didn't have those privileges, sometimes they had it rougher… I just feel like they're so stigmatized outside. I just felt like I could help, and would love to help.

Another student likewise identified her personal background as informing her understanding of patient engagement as central to mental health nursing practice. She described that having a close family member who worked in mental health care contributed to her holding fewer stigmatizing attitudes toward this population and to her sense of the importance of building

therapeutic relationships. In keeping with her family perspectives on mental health, she described her own approach to practice as:

> Why am I gonna sit in a room with nothing to do, and kind of twiddle my thumbs when these two people are my patients and I could be sitting with them, talking to them, getting to know them. To me it was kind of a no-brainer, I feel like that's what you do. That's why you're there.

Other students similarly described developing nursing practices in their practicums based on their inherent sense of what was 'right'. One individual spoke to the importance of "hold[ing] onto what you know in your gut is the right thing". Another student recounted a story in which he was asked by a nurse to give all of his patient's available PRN medications in the early evening – he described the implication of this request as, "don't give PRNs, like as *they* need, but like, so we don't have to deal with him tonight". He states he felt "not comfortable" with this request and didn't administer the medications, stating "if I get in trouble, I'll say 'all right'". In this story, he, like many other students, drew on his own sense of best practice and appropriate nursing care to enact resistance to dominant nursing care approaches. In their narratives, students were not always able to articulate the ways in which their values and previous experiences both outside of and within the nursing program may have shaped their experiences and actions. Yet their narratives of taking a "natural" approach to patient care demonstrated the ways in which their personal and professional values inherently informed their practices. Framing their resistance to power as 'natural' positioned the nursing practices they observed as un-natural, further illustrating the students' identification of nurses' attitudes and behaviours as representative of micro-power and contrary to nursing values and best practices.

Student Role and Possibilities for Resistance

An additional strategy that participants frequently utilized for enacting resistance to power in the practicum was justifying their actions of resistance by framing them as

consequences of their student role. For many students, this involved referencing their smaller patient load as compared to unit nurses, and utilizing the narrative of having more time than nurses, while also rejecting the validity of this narrative for justifying nurses' disengagement from patients. For example, one student in describing the importance of conversing with patients about "something that's not medical" stated: "to have the time as a student to do that was probably helpful, whereas the nurses might not have had the same amount of time – although, they probably did!" Another student described an instance in which the narrative of students having more time was utilized by the unit nurses to explain her frequent engagement with patients: "They were like… 'oh, that's nice of you, that's great – it's so good to have students who have the time to do that…' But I was thinking 'yeah, you have the time too!'" In this situation, nurses drew on this justification to frame why they may not be spending as much time with patients as this student, while their justification also permitted her to continue with this practice unquestioned. A student who completed her practicum at a different clinical site experienced a similar response from nurses of, "'oh, they're students and they're going to talk [to patients]'", but she likewise resisted the narrative of having more time as explanatory for her care approach:

> I can't believe this is happening, like why am I the student who– really I had two or three patients at some point, and the nurses only have two more, and they're quite experienced… And I had more than enough time to play cards with my patient, right?

Students additionally drew their obligation to conform to best practices as explanation for actions that they took in resistance to unit norms. One participant described that, on his unit, "basic nursing standards were not being used" – specifically, nurses frequently pre-poured medications and saved half-tablets of restricted medications for later administration, rather than discarding ('wasting') them according to policy. He stated that to avoid following these dominant practices, he informed the nurses, "no, we're not allowed to, we have to waste it, that's

the rule". Another participant described how being a student was in itself enough of a rationale, without further explanation, for many forms of resistance. She recounted saying to nurses, "'oh, you know, I'm a nursing student, so I'm just going to do it this way…'" She described this approach as utilizing a "veil of academia" but stated, "whereas really in my mind, I'm trying to be a bit more critical, and I'm…weaving through what I'd like to adopt into my practice and what I will leave out." Despite the power differential between nurses and students and the inherent challenges of opposing pervasive practices, participants recognized that drawing on their role as students provided a rationale for their adherence to best practices and nursing competencies, and reduced scrutiny of or opposition to their approaches of resistance.

Narratives of Disempowerment

Though participant narratives spoke to multiple aspects of their resistance to power within the practicum, in reflecting on their experiences in the interview, of most of the students did not identify as having enacted resistance. Though the student role created opportunities for resistance to power, as discussed above, participants more often conceptualized the student role as one of disempowerment, and described numerous ways in which power relations in the clinical setting precluded their ability to resist dominant practices and speak up in instances of oppression. As such, the students' narratives of disempowerment demonstrate that despite opportunities for enacting resistance, this resistance was bound up in a complex interplay of empowerment and disempowerment. As resistance was frequently subtle and only at times direct or explicit, participants' narratives of disempowerment demonstrated that the students' actions and behaviours in the clinical setting were also, though differently than patients', situated within and influenced by power relations. Participants further articulated the predominance of particular approaches to nursing care as a threat to opportunities for resistance, and in reflecting on their

future nursing practice after graduation, anticipated ongoing challenges were they to seek employment in inpatient mental health settings. The participants shared that in working in these settings, they risked both adopting dominant nursing practices into their own care approaches, and experiencing further disempowerment.

Disempowerment in the Student Role

Students frequently described feeling disempowered as a student in the clinical environment, demonstrating that power and disempowerment intersected in complex and challenging ways in the practicum. For example, one student recounted a distressing comment made by a psychiatrist in a team meeting that this student's patient was likely "exaggerating" or "over-reacting" to a recent sexual assault. She states:

> And no one says anything. Everyone's just continuing to write little notes and whatever – including myself. I didn't say anything, 'cause I'm just this disempowered nursing student… I didn't feel super empowered to be like, "um, excuse me, Mr. Doctor Man, like what do you mean by that?"

In this story, this participant articulated her position as a student in the clinical setting as disempowered. However, as described previously in a separate story, she directly engaged a nurse in navigating the degree to which she could work with her patient regarding her trauma history, demonstrating the ways in which disempowerment and resistance may co-exist and intersect. Similarly, another participant who frequently resisted dominant nursing practices through connecting with patients, recounted a story in which she felt unable to enact resistance to power as played out in an interaction between a nurse and her patient. She described working for five weeks with a patient who, partway through his hospital stay, had begun engaging romantically with another patient, contrary to unit policy. One day, this student walked into her patient's room to find the two engaged in sexual contact. After notifying the nurses, she

attempted to approach her patient in the hallway of the unit to inform him that the nurses were aware of what she had seen. She then told:

> As I'm approaching the patients, my primary nurse comes up and she said…something like "you guys can't be doing that…if you do it again we're going to put you in the isolation room" – not only implicating me in it…but also that's not what the isolation room is for… I just felt like that was just a horrible way to use your power as a nurse.

In this narrative, this student described feeling implicated in power relations as played out through the nurse's threat of an inappropriate punishment, and having little recourse as a student to resist in the moment or afterwards. Though she attempted to rebuild therapeutic relationships following this incident, she characterized this situation as "not only ruining his experience, but ruining the student experience, and creating this rift forever". However, even within her articulated disempowerment in this narrative, she continued to resist disengagement as normative, describing the 'rift' between her and her patient as a concern, needing to be addressed and worked through. Other participants likewise articulated subtle ways in which the unit dynamics precluded their advocating for patients, asking questions, or stating their opinions and sharing information during team meetings. One participant described her sense of the student role in the practicum as: "you don't want to impose, you don't want to draw attention to yourself…you're here to learn, but don't cause waves". Participant narratives of disempowerment demonstrated their understanding of the student role as a liminal space in which resistance to power intersected with ways in which their actions were, though differently than patients, constrained by micro-power within the clinical setting.

Disempowerment in Future Nursing Practice

Although participants described genuinely enjoying many aspects of their practicums, most notably engaging with patients, their narratives illustrated that resistance to power in these settings was bound up with disempowerment. In addition to reflecting on their perceptions of

their own disempowerment within the student role, the students also identified disempowerment

as a detractor from pursuing inpatient mental health nursing after graduation from their program.

Though participant narratives illustrated the students' enactment of resistance to power within

their practicums, their narratives also suggested that this resistance could not be maintained

while in the role of a staff nurse – the role through which they observed power being enacted.

For example, the individual who described feeling "implicated" in a nurse's threat of the

isolation room after her patient engaged in sexual contact later reflected of that story:

> I wanted to make sure I brought that up, because I feel that really speaks to how much I
> did not look forward to being in that position of authority… That's when I was like "I
> can't go into mental health".

Describing the role of the nurse as a "position of authority" reflected many participants'

perceptions of nurses as inherently holding power over patients within the setting. One

participant stated of the nursing approach to patient care: "it bothered me so much that I decided

that I didn't want to go into acute mental health". Another participant articulated the differences

he observed between his own student role and the nursing role he observed during his practicum

as a primary contributor to his concerns about continuing to work in the field of mental health in

the inpatient hospital setting:

> If I was to look at what the actual staff was doing, they had responsibilities that we did
> not…i.e. the passes, that's a real big part of it – that was control, right? "No, you can't go
> out" or "oh, you did this? Okay, we gotta tell the psychiatrist now and they'll change the
> orders around your passes" But I think as a student I didn't have to necessarily worry
> about that – I could focus more on just the care aspect… You have to walk that line
> between being both a caregiver and sort of a person who maintains control – so you're a
> caregiver and guard at the same time, and I would find walking that line to be distressing.

As in this narrative, the students frequently described the clinical environment as morally

distressing and emotionally challenging, and anticipated similar challenges in pursuing inpatient

mental health work: "I think I would still feel the same – worry that I'm gonna feel morally distressed".

Participants additionally articulated concerns of integrating into their own future nursing practice the dominant approaches to nursing care that they resisted as students. For some students, concerns about adopting problematic nursing practices overshadowed their enjoyment of working with individuals with mental health challenges, and they adamantly stated: "I would never go back to that!" and "would never, absolutely not, I would never even think about it". One participant described witnessing another student integrate aspects of the dominant nursing practices of his practicum setting, and the effect this experience had on his own intentions to pursue inpatient mental health nursing:

> There was one student that was [working there as an Employed Student Nurse], and you could tell how she quickly bought in to their style of nursing and how they did stuff. And you're like, well, if you're already changed, if you've already sort of gone this sour route or not-so-positive route so fast, then I don't really want to come work here where I'm not going to learn best practice or…making this better.

Many participants' narratives similarly reflected that it is "easy to get brought down by a negative unit culture", and to preserve their own emotional well-being and values of nursing care provision, planned to avoid working in mental health settings despite their enjoyment of working with the patient population. Some of the participants interviewed for this study had pursued opportunities within the nursing program to complete additional mental health practicums (in advanced consolidation courses and preceptorships) and did plan to pursue inpatient mental health nursing work after graduation. However, students building careers in these settings shared similar concerns regarding integrating dominant nursing practices into their own care approaches. In describing the field of adult inpatient psychiatry, one participant stated:

> I think it can be a positive culture or a negative culture… I think unit culture really influences how things go and how nurses inform their practice as well. Not that it *should* influence how you practice, but it does.

This individual stated that for her, working in an inpatient setting with a positive culture would be "ideal"; however, she stated that in a negative culture, "I don't think I'd last very long… I know it takes one person to make a change, but it can be tough."

As a result of anticipating their inability to enact resistance to power in a nursing role in inpatient mental health settings, and in relation to concerns regarding adopting problematic practices, most of the participants in this study stated that they would not pursue work in this field. However, participants frequently endorsed the notion that "mental health is everywhere" and described attempting to preserve opportunities for mental health nursing work by selecting environments in which they could continue to provide patient care in accordance with the positive practices they defined in their practicums. For some, this included pursuing mental health nursing work in community settings. Although students did not have clinical experiences in community mental health through their practicums, they anticipated that mental health nursing outside of hospital settings would differ in the nature of the work and the environment, while preserving aspects of mental health nursing that students valued. For example, one student who demonstrated an interest in working with individuals with mental health challenges outside of inpatient settings speculated that in community mental health nursing,

> you have a more personal connection with your clients, and you're able to build that rapport over a long time with someone, and it's your responsibility to care for that client as opposed to just passing it off to the next person, or someone else will handle that…like, "oh, the night staff will deal with that".

This individual also suggested, "I would work in general emerg, where I saw some mental health clients – I think that I would definitely do that, but I couldn't work in acute mental health."

Another student chose to focus her career predominantly on pediatric mental health, where she

found the nursing culture to be more patient-centered and therapeutic than in adult settings. While many sought alternate opportunities within their nursing careers for working with patients with mental health challenges, most participants articulated concerns of integrating unsafe and unethical practices into their own ways of nursing and reflected on the emotional burden of ongoing attempts to resist dominant practices; as a result, most participants stated that they would not pursue employment opportunities in inpatient mental health settings.

Summary

Participant narratives of their mental health practicums illustrate the ways in which their experiences were shaped by micro-power, as conceptualized by Foucault as everyday mechanisms that reinforce control and dominance of one group (in this case, nursing staff) over another (patients). Participants' stories demonstrated that students viewed the practicum as fundamentally different from others within their nursing program, and illustrated the strategies they drew on to prepare for experiences and challenges encountered in the practicum. The students built capacity for resistance in advance of the practicum through developing strategies for managing their own well-being throughout the experience, and resisting damaging stereotypes regarding individuals with mental health challenges through critical reflection. Within the clinical setting, students drew on similar critical lenses to identify micro-power as played out in nurses' disengagement from patients and approaches to care that undermined safe and ethical practice. In recognizing power as such, students resisted interpreting dominant practices as representative of best practice, and resisted integrating such practices into their own care approaches. In their enactment of resistance to power within the practicum, students sought meaningful connections with their patients and spent time engaging directly with patients on the unit in contrast to the normative nursing approach of disengagement. Additionally, students drew

on and enacted ways of knowing that resisted nursing approaches, including theoretical

knowledge, perspectives of their clinical instructors, and their personal and professional values.

Despite students' frequent enactment of resistance to dominant nursing practices, participant

stories from the practicum experience also were informed by narratives of disempowerment.

Students described the disempowerment of the student nursing role, and anticipated multiple

concerns in pursuing a career in inpatient mental health nursing, including the risk of adopting

problematic practices and the challenges of continuing to enact resistance to power. In light of

these challenges, many students planned to avoid inpatient mental health settings in their career

as nurses, yet sought opportunities to continue to work with patients with mental health

challenges in other healthcare settings.

CHAPTER FIVE: DISCUSSION

Introduction

In this chapter, I discuss the contributions of this study to understandings of students' experiences in mental health practicums. First, I summarize the key findings explored in Chapter Four, outlining the narratives of resistance emergent from participant stories of their practicums. I then present a discussion on the primary contributions from this study's findings, situating each in the literature. I then explore the study contributions to practice, education, and research, and discuss recommendations for future strategies and directions for improving students' practicum experiences and patient care. I conclude this chapter with a discussion of the study's limitations.

Summary of Key Findings

This study explored nursing students' narratives of resistance that emerged from their experiences within their mental health practicums. Analysis of participants' narratives illustrated the ways in which students' experiences of the clinical environment and observations of nursing practices within this setting were impacted by power relations as theorized in this study through Foucault's concept of micro-power; the students both grappled with power relations in nurses' attitudes and behaviours toward patients, and in nurses' responses to students within the clinical setting. Nursing students' narratives of resistance to power extended across the practicum experience, from pre-engagement with anticipated challenges, to their recognition of power in the unsafe and unethical nursing practices within this environment, to ultimately enacting resistance to power through a variety of strategies. These strategies included: connecting with patients, in contrast to a practice context in which disengagement from patients was the dominant approach of staff nurses; enacting ways of knowing gleaned from other sites of learning, including the classroom, their clinical instructors, and personal and professional values; and

drawing on their role as students to rationalize and justify actions that resisted dominant practices that perpetuated power relations. However, student narratives of resistance to power also spoke to their self-perception as disempowered within the clinical setting, and unable to enact change beyond the practicum into nursing practice in inpatient mental health settings after graduation. As such, participants consistently articulated that they did not intend to pursue inpatient mental health nursing in their careers; however, many participants described preserving opportunities for working with individuals with mental health challenges through seeking out work opportunities in other mental health settings or in areas of nursing with frequent interaction with this population.

Discussion

In this section, I discuss key contributions that this study's findings make to the literature on students' experiences of mental health practicums, mental health inpatient settings, and students' resistance in the context of empowerment and disempowerment. While specific recommendations for practice, education, and research are presented later in this chapter, this section presents a discussion of: stigmatizing nursing practices, students' resistance to power, and students' attitudes toward mental health nursing.

Stigmatizing Nursing Practices

Students' narratives in this study illustrate troubling approaches to nursing care of patients with mental health challenges in inpatient settings, as reflected in the literature (Breeze & Repper, 1998; Kontio et al., 2012; Larsen & Terkelsen, 2014; Shattell, Andes, & Thomas, 2008). While many students in this study directly identified the practices they observed as stigmatizing, the distressing events in patient care they described observing within their practicums were reflective of harmful and unethical practices, such as disrespectful comments

and ridicule toward patients. As explored in the Background to this study, individuals with mental health challenges experience stigma and discrimination across health care settings (Clarke, Usick, Sanderson, Smith, & Baker, 2014; Ross & Goldner, 2009) and nurses in mental health settings frequently hold stigmatizing beliefs regarding this population (Björkman, Angelman, & Jönsson, 2008; Linden & Kavanagh, 2012; Stevenson, Jack, O'Mara, & LeGris, 2015). Research on nursing practices in inpatient mental health environments that aims to address stigma in this setting has predominantly focused on the specific nursing practices of coercion and containment, such as seclusion use and locking unit doors (Ashmore, 2008; Bullock, McKenna, Kelly, Furness, & Tacey, 2014). While some research endorses these practices as effective and necessary for ensuring safety for patients, staff, and the public (Gerace et al., 2015; Happell & Koehn, 2010; Nijman et al., 2011), a substantial body of literature has positioned these practices as outdated, non-therapeutic, and reflective of stigmatizing attitudes toward individuals with mental health challenges such as the perception of dangerousness (Bullock, McKenna, Kelly, Furness, & Tacey, 2014; Muir-Cochrane et al., 2012; Stevenson et al., 2015).

However, the distressing events in patient care described by the students within this study rarely involved the practices of coercion and containment most frequently identified as unethical and non-therapeutic in the literature. Rather, students described nurses' disengagement and dismissal of patients, perceived over-use of PRN medication, and disrespectful comments as the primary enactments of unsafe and unethical care. As such, this study's findings extend understandings of harmful nursing practices within inpatient mental health settings as practices of coercion and containment primarily, to also include those that perpetuate micro-power through everyday interactions, such as in assessments and daily communication. This finding is

corroborated in some studies that recognize nurses' arbitrary enforcement of rules or antagonistic interactions with patients as reflective of nurses' control over patients (Breeze & Repper, 1998; Isobel, 2015; Larsen & Terkelsen, 2014). Study findings further contribute to this research by framing such behaviours and attitudes as representative of micro-power: the continuous operationalization of power and control through nurses' everyday practices.

Students' narratives illustrated that the pervasive nature of such everyday practices normalized stigmatizing and dehumanizing attitudes and behaviours toward patients, and participants described observing such practices being perpetuated by many or all nursing staff, with few role models for safe and ethical care within the practice setting. Identifying everyday practices as perpetuating micro-power within the inpatient mental health setting has important implications for mental health nursing practice and for future research, suggesting that even interventions that aim to produce systemic shifts in stigmatizing and discriminatory practices may not be effective if they target specific nursing practices – such as use of seclusion – alone (Paterson et al., 2013). In contrast, interventions that address nursing attitudes, everyday behaviours, and unit cultures may be more effective in shifting dehumanizing and harmful practices in this setting (Isobel, 2015). Specific recommendations for nursing practice and research are discussed further in their respective sections below.

Students' Resistance to Power

This study's analysis of students' recognition of power within their mental health practicums, and their ongoing resistance to power within this setting, represents a key contribution to the literature, which to date, has limitedly explored the concept of nursing students' resistance. Research has suggested that students, as learners in the practicum environment with as yet insufficient knowledge and understanding, may not be able to identify

unsafe and unethical nursing practices, let alone address these practices (Bickhoff, Levett-Jones, & Sinclair, 2016; Ion, Smith, & Dickens, 2017). Studies exploring students' responses to witnessing unsafe and unethical nursing practices that do acknowledge their ability to recognize such practices have predominantly explored students' decisions to report nurses' behaviours versus stay silent in such instances (Bellefontaine, 2009; Bickhoff, Levett-Jones, & Sinclair, 2016; Ion, Smith, Nimmo, Rice, & McMillan, 2015), or students' coping with the associated distress (Monrouxe, Rees, Endacott, & Ternan, 2014). However, understandings of students' capacity for resistance in response to challenging and distressing clinical environments has been limitedly explored in the literature (Bickhoff, Sinclair, & Levett-Jones, 2017; Jackson et al., 2011).

Despite the normalization and dominance of unsafe and unethical nursing practices in their practicums, the participants' narratives demonstrate that they not only recognized micro-power in nurses' practices, but actively responded to observing nursing practices that are non-therapeutic and harmful to patients. This response extended far beyond reporting witnessed nursing behaviours, and encompassed a range of acts of resistance implicit and explicit, including spending time with patients, and engaging in refusal or negotiation with nurses surrounding unethical practices. These findings demonstrate that students can and do recognize and enact resistance to power, and that this resistance may positively impact patient experiences of care (Gilburt, Rose, & Slade, 2008; Shattell, Starr, & Thomas, 2007). For example, students described that as a result of their connecting with patients in resistance to nurses' disengagement, they observed early emergences of symptoms, rejected and reframed nurses' negative stereotypes or interpretations of patient behaviour, and built therapeutic relationships of mutual trust and respect.

These findings thus challenge two narratives in the literature on nursing students'

practicum experiences: firstly, that students are merely learners within the practicum in

preparation for *future* nursing practice, and as such, may not have the ability, skill, or knowledge

to impact patient care (Flott & Linden, 2015; Hartigan-Rogers et al., 2007). Secondly, findings

challenge previous understandings of students' resistance as primarily a response to their own

marginalization in the health care team (Jackson et al., 2011). Though the students within this

study themselves experienced marginalization within the nursing staff, their enactment of

resistance directly contributed to safe, ethical, and compassionate patient care in response to their

observations of unsafe and unethical practices that were harmful and distressing to patients. This

study's findings, which demonstrate students' ability to enact resistance in challenging

environments, contribute to a reconceptualization of the role of the student in practicum

environments, and to the need for supporting both students and nurses to further enact resistance

to dominant practices of disengagement and unethical practices in mental health care

environments. Specific strategies for supporting students in challenging practicum environments

and for shifting practices within mental health nursing care are discussed in depth in the

Recommendations section below.

This study further suggests that students' resistance to power may occur even within a

context of perceived disempowerment. Within the literature on students' experiences in mental

health practicums, empowerment and disempowerment are frequently conceptualized as two

fixed and distinct states, which inform students' voice versus silence, and action versus inaction

(Ahn & Choi, 2015; Bradbury-Jones, Sambrook, & Irvine, 2007; Kennedy, Hardiker, &

Staniland, 2015). In contrast, this study frames student resistance within the complex interplay of

empowerment and disempowerment, challenging the notion that empowerment is a precursor for

resistance. As discussed in the theoretical framework for this study (see Chapter 3), Kincheloe and McLaren (2000), state "we are all empowered and we are all unempowered" (p. 283), and argue that within societal oppression and disempowerment lies opportunities for resistance to power. Within this study, participant narratives spoke to their disempowerment in their perceived inability to advocate or speak up in instances of observing unethical or unsafe practices, and in instances where students felt complicit in the power relations of the practicum. At the same time, their narratives demonstrated the ways in which through subverting power – through connecting with clients, and enacting nursing concepts of relational practice and trauma-informed care, for example – students were themselves empowered and aimed to empower their patients. Their resistance to power occurred in the context of this liminal space between empowerment and disempowerment – a concept that resonates with theoretical approaches to empowerment and resistance. Kuokkanen and Leino-Kilpi (2000) articulate empowerment as a process through which "power is taken over" through individual or collective action, then "given away" or shared (p. 236). Empowerment is thus conceptualized as in contrast to Foucault's (1979) articulation of power, which seeks submission of others through control and dominance. As such, students' resistance to power is in itself a form of empowerment, even if students themselves experience oppression and marginalization within the practicum setting (Bradbury-Jones et al., 2007; Jackson et al., 2011).

Students' resistance to power within their practicums not only demonstrated their empowerment as co-existing with their feelings of disempowerment, but also demonstrated their enactment of resistance as empowering their patients. For example, participants described ways in which resistance to power enabled patients to have their concerns heard and needs met, gave patients agency over their own stories and health care goals, and reframed patient behaviours

interpreted by nurses as difficult by understanding patients' needs as justified (Breeze & Repper, 1999). Connection as resistance is a strategy for subverting power that has been described by both Goffman and Foucault: Goffman (1961) describes inmates in asylums as resisting the power of total institutions through both "collective subversive action" (for example, keeping secrets from staff, or organizing strikes) and individual action, such as intentionally modifying behaviour in a manner that produces ongoing challenges for those in power (pp. 60-61). This collective and individual resistance likewise presents possibility for the subversion power despite the aims of total institutions to control all aspects of a person's behaviour and identity. Similarly, Foucault (1979) describes resistance as strategies that "establish horizontal conjunctions" and thereby disrupt the verticality, or hierarchal nature, of power (pp. 219-220). Within the context of the prison system described in "Panopticon", such strategies may include coalitions between prisoners, collective organizing, or revolts – all of which subvert power through collective resistance, even in the context of disempowerment. While not identical concepts, empowerment and resistance share the subversion of power and may both occur in the context of disempowerment (Gengler, 2016; Kincheloe & McLaren, 2000). This study demonstrates that resistance within contexts of disempowerment is possible for nursing students in mental health practicums, a finding with significant implications for shifting stigmatizing and discriminatory practices that negatively impact individuals with mental health challenges in health care settings (e.g. Larsen & Terkelsen, 2014; Loukidou, Ionnidi, & Kalokerinou-Anagnostopoulou, 2010). Within this study, students subverted the verticality of power relations – nurses' power *over* patients – through connecting with patients and supporting their agency (sharing power), even in contexts where students themselves feel disempowered.

Understandings of resistance to power as occurring within a complex context of students' empowerment and disempowerment, as explored in this study's findings, contradict previous conceptualizations of empowerment within the literature on nursing students' clinical experiences, as a distinct state from disempowerment and as a necessary precursor to acts of resistance (e.g. Bradbury-Jones, Sambrook, & Irvine, 2007; Lindh, Severinsson, & Berg, 2008; Peter et al., 2004). As such, students' resistance within disempowerment demonstrates that even in challenging practice environments, students may still subvert power through recognizing the ways in which it operates within the setting, and through small, subversive actions such as connecting with patients. Levett-Jones and Lathlean (2009) argue that "don't rock the boat" is common reaction to students' perceptions of disempowerment in practicum settings. However, this study's findings demonstrate that even in the context of disempowerment, students can be supported to enact resistance that is meaningful to both themselves and patients with or without explicitly challenging nurses' practices. Resistance through connection and through enacting ways of knowing are strategies that students and educators, as well as nurses practicing in complex practice environments, can take up in response to pervasive non-therapeutic and harmful practices.

Students' Attitudes Toward Mental Health Nursing

Current literature on students' attitudes toward mental health nursing consistently demonstrates that students are disinterested in pursuing this area of nursing in their careers (Happell & Gaskin, 2012; Hastings et al., 2017; Hoekstra, van Miejel, & van der Hooft-Leemans, 2010; Stevens, Browne, & Graham, 2013). Studies on this topic have identified correlates to disinterest in mental health nursing, such as anxiety (Happell et al., 2008b), lack of preparedness (Happell & Gough, 2007), and stigmatizing beliefs about individuals with mental

health challenges (DeKeyser Ganz, & Kahana, 2006; Hoekstra, van Meijel, & van der Hooft-Leemans, 2010). However, this study's findings provide further nuance to students' attitudes toward mental health nursing that challenge the dominant understandings in the literature. Though research suggests that students' residual stigmatizing beliefs and attitudes after their mental health practicums, may contribute to subsequent lack of interest in pursuing this area of nursing in their careers (Stevens, Browne, & Graham, 2013; Thongpriwan et al., 2015), students within this study conversely reflected on *nurses'* stigmatizing practices in the practicum setting as the primary rationale for not pursuing a career in inpatient mental health. Many of the students in this study stated they would 'never' work in mental health settings as a result of distressing experiences of observing unsafe and unethical nursing practices and nurses' disengagement from patients, rather than due to disinterest in the field of nursing. Participant narratives demonstrated that students genuinely enjoyed working with individuals with mental health challenges and sought opportunities to continue to work with patients experiencing such challenges after graduation from their nursing programs.

As such, students' articulated interest not only challenges the dominant perspective in the literature that nursing students are not interested in a career in mental health nursing due to disinterest in working with the patient population (e.g. Happell et al., 2008b; Happell, Platania-Phung, Harris, & Bradshaw, 2014; Hastings, Kroposki, & Williams, 2017), but also offers a counterpoint to the literature that suggests that students are not prepared to work with individuals with mental health challenges following their practicums (Hunter, Shattell, & Harris, 2015; Walsh, 2015). Despite completing practicums in settings that did not support their learning, students' narratives of their experiences within these settings demonstrated that they frequently provided engaged and compassionate patient care. While this study did not aim to evaluate

students' perception of their level of knowledge of mental health concepts or skills, participants' narratives demonstrated a high level of critical thinking and nursing judgment in applying theoretical concepts to patient care, despite a lack of role models to emulate in the practice setting. These students' interest in and preparedness for working with individuals with mental health challenges points to the importance of recognizing other factors that may impact students' perceptions of mental health nursing, such as distress in observing unsafe and unethical practices (Wojtowicz, Hagen, & Van Daalen-Smith, 2014). Specific strategies for supporting students through these experiences, and for shifting practice settings are discussed in detail in the Recommendations section below.

In their career planning, many of the students in this study described targeting settings that they believed would be less morally distressing than the inpatient settings they experienced in their practicums, but that would preserve opportunities for working with individuals with mental health challenges. For example, students within this study articulated an interest in community or pediatric mental health nursing, or stated that working with individuals with mental health challenges was a rationale for pursuing a career in settings such as emergency nursing or in particular hospitals serving populations with increased prevalence of mental health challenges. While some literature has explored the relative benefits of completing practicums in inpatient versus community mental health settings (Henderson, Happell, & Martin, 2007; Perese, 1996), studies on students' career preferences have not as yet addressed the nuances of students' interest in mental health nursing settings other than inpatient (Happell & Gaskin, 2012). As a result of the perception that students are not interested in mental health nursing, nursing programs may continue to under-utilize practicum opportunities in community mental health settings – a current trend in practicum selection in Canada (Smith, Corso, & Cobb, 2010; Smith,

Spadoni, & Proper, 2013). Further, nursing educators may inadvertently or actively discourage nursing students from pursuing areas of interest that are identified as specialty fields, such as community mental health nursing, in favour of establishing foundational knowledge and skills through inpatient nursing practice after graduation (Nadler-Moodie & Loucks, 2011). Findings from this study suggest that students have genuine interest in working with individuals with mental health challenges, and that this interest should be recognized and fostered by educators and explored with greater nuance in research.

Recommendations

This section presents recommendations for practice, education, and research based on the study findings. I first discuss recommendations for nurses and nursing leaders in addressing harmful nursing practices in mental health settings. I then provide recommendations for educators in supporting students in advance of and during mental health practicums, and finally, for researchers in continuing to develop understandings of the contextualized nature of students' experiences in the practicum and perspectives on future nursing care of individuals with mental health challenges.

Practice

Study findings demonstrate that nursing practices that students perceived as harmful and non-therapeutic for patients extended beyond particular nursing interventions, such as use of seclusion, which have frequently been the focus of research (Bullock et al., 2014). This study demonstrates that within mental health inpatient settings, change is needed that addresses everyday practices, such as nurses' disengagement from patients and instances of humiliation and disrespect, which are similarly distressing and harmful to patients though not consistently addressed in the literature (Isobel, 2015; Shatell et al., 2008). A key strategy to addressing these

harmful practices is connecting with patients, as discussed by the students within this study. Participants narratives demonstrated that spending time with patients in conversation or shared activities contributed to building therapeutic relationships and increasing their depth of understanding of their patients' symptoms, concerns, and needs. The students described getting to know their patients, and frequently described developing meaningful relationships over many weeks. Connecting with patients has been long established as a cornerstone of nursing care (e.g. Doane & Varcoe, 2013; Malone, 2003; Peplau, 1952/1991); however findings from this study, corroborated by research on inpatient mental health settings, indicates that nursing care of individuals with mental health challenges remains stigmatized and disengaged. This section presents specific strategies for both individual nurses and nursing managers in supporting nurses' connection with patients in this setting.

In the practice setting, individual nurses can likewise build meaningful relationships with patients by spending dedicated time with patients outside of required nursing tasks – for example, engaging in conversation on non-clinical topics, or participating in an activity such as playing cards (Blair & Moulton-Adelman, 2015; Lewis, Taylor, & Parks, 2009). Students further articulated that identifying and responding to patient concerns through conversation, rather than medication use, may reduce patient distress and instances of violence – a finding corroborated by the literature (Björkdahl, Hansebo, & Palmstierna, 2013; Kontio et al., 2012). As such, nurses can additionally aim to respond to patient concerns when they first present, through empathetic communication centred on the patients' needs; this may both contribute to the development of mutual trust and respect, and reduce patients' distress and agitation (Stenhouse, 2010; Yang, Hargreaves, & Bostrom, 2014).

However, Larsen and Terkelsen (2014) suggest that individual nurses working in inpatient mental health settings may frequently feel conflicted between perceiving control as necessary for maintaining order and boundaries, and aiming to therapeutically and relationally engage with patients as human beings, and may therefore have difficulty in independently shifting practices. Participant narratives from this study further suggest that individual nursing practices of micro-power and disengagement from patients were normalized amongst nurses, and as such not explicitly identified by staff as unsafe or unethical. As such, changes to stigmatizing and harmful nursing practices must also be initiated at a systemic level (Paterson et al., 2013). Nursing managers are situated both within the milieu of the inpatient setting and outside of the direct care role, and as such, may be ideally positioned to foster change and shift normalized practices (Horton-Deutsch & Sherwood, 2008; Märtensson, Jacobsson, & Engström, 2014). While nursing managers may not be able to directly shift nurses' attitudes, they can create opportunities for nurses to connect meaningfully with patients. For example, managers can structure opportunities for nurses to spend time outside of the nursing station, such as establishing a practice of shared meals between staff and patients or initiating regular meetings between staff and patients to collaborate on therapeutic goals (Blair & Moulton-Adelman, 2015; Bowers, 2015; Pereira & Woollaston, 2007). The Safewards Model, developed by Bowers (2015) provides further direction for unit- or hospital-level changes that aim to promote connection between nurses and patients – for example, developing a formal system such as a poster board on the unit for nurses and patients to share personal (though not private) information such as favourite movies. This sharing of information humanizes nurses and patients and provides a starting point for initiating conversations outside of health care topics (Bowers, 2015).

Connection between health care providers and patients on a personal level, through the strategies described above, has been demonstrated to improve patients' perceptions of care (McAndrew et al., 2014; Shattell et al., 2007) and can contribute to shifting the inpatient mental health environment as a setting characterized by stigmatizing and harmful practices. Recommendations for shifting practices in the inpatient mental health setting are small and specific in nature to address the ways in which micro-power is operationalized through similarly small, everyday practices. While research has often focused on occasional nursing practices such as seclusion, a renewed focus on everyday practices may contribute to shifting harmful and stigmatizing nursing practices within these settings. Individual nurses and nursing managers can implement everyday practices and unit-wide initiatives that shift currently harmful practices to nursing care that centers connection and engagement. Shifting nursing practices within inpatient mental health settings is needed not only to support safe and ethical patient care, but also to create more supportive learning environments for students to prepare for providing care for individuals with mental health challenges.

Education

Participant narratives in this study depict mental health practicums as challenging, complex, and frequently distressing experiences for students. This study speaks to the need for educators to support students both in preparing for the practicum and navigating challenges throughout the experience, as well as the need for further research in this area. To support students in navigating the challenges of the mental health practicum, educators first must develop awareness and understanding of the difficulties students experience in advance of and throughout the practicum, including emotional and moral distress, anxiety, and fear. Further, educators must directly support students in navigating these difficulties. In this section, I discuss implications of

this study for nursing education in two areas: firstly, educators' support for students in theoretical, practical, and emotional preparation for the practicum; secondly, clinical instructor's provision of practicum support.

Preparation: Study findings illustrate that participants anticipated fundamental differences between mental health practicums and other clinical practicums in nursing school, and demonstrate that students may therefore experience unique concerns in advance of the practicum including being triggered in relation to personal mental health challenges, anticipating interactions with patients on topics perceived as more personal, and fearing violence or unpredictability in patient behaviour. Although it is well-established in the literature that students experience fear and anxiety *within* mental health practicums (Fisher, 2002; Happell, Platania-Phung, Harris, & Bradshaw, 2014; Mun, 2010), there is a dearth of research on students' expectations of the practicum and the strategies they draw on to manage these expectations in advance. This study contributes to this gap by offering further understanding of students' anticipation of particular challenges within their practicums, and the strategies students drew on to manage their concerns, such as discussing anticipated challenges with others, selecting particular practicum sites they believed would best maintain their mental well-being, and engaging in critical reflection on societal stereotypes of individuals with mental health challenges. While participants anticipated encountering significant challenges to their well-being in the practicum, the students predominantly developed preparation strategies independently or with peers, suggesting a gap in effective practicum preparation from nursing educators in the classroom setting.

Educators can support students in navigating their anticipated challenges of the mental health practicum, through directly addressing student concerns in the classroom setting in

advance of the practicum. This may include classroom teaching and activities that directly address stigma toward this population and contribute to students' development of critical reflection on media portrayals and societal stereotypes (McAllister, 2008; McKie & Naysmith, 2014). As study findings suggest that students' independent critical engagement with stereotypes lessened their fear of patient violence within the practicum, educational approaches toward the same aim may facilitate the reduction of student anxiety and misconceptions about working with this population (Happell, Byrne et al., 2014; Terry, 2012). More broadly, educators can support students in their preparation for the mental health practicum by introducing theoretical nursing concepts with application to mental health nursing (Ajani & Moez, 2011; Hatlevik, 2011). For example, educators can introduce concepts of trauma-informed care and relational practice – both articulated by participants as informing their care approaches in the practicum – and articulate the relevancy of these concepts to working with patients with mental health challenges. Education on these theoretical concepts may provide students with direction for nursing care in the practicum, and may support resistance to unsafe and unethical practices.

Additionally, educators can introduce classroom content that contributes to students' comfort and familiarity in conducting mental health assessments, and offers students the ability to practice asking questions that they may view as personal and difficult to broach. Numerous studies have explored the efficacy of simulation in preparing students for interacting with individuals with mental health challenges in the clinical setting, and have demonstrated the success of this educational strategy in reducing student anxiety (Goh, Selvarajan, Chng, Ran, & Yobas, 2016; Sarikoc, Tangul Ozcan, & Elcin, 2017; Szpak & Kameg, 2013). While research supports educational strategies such as simulation for supporting students' preparation for mental health practicums, there is a dearth of research on nursing students' anticipation and preparation

for these practicums in context of their own mental health challenges. Further research is needed

that explores the perspectives and experiences of nursing students with mental health challenges

(historical or current), to support both further understandings of these students and educational

strategies for supporting students in advance of and through the practicum. Some students in this

study described approaching instructors to discuss concerns regarding their own mental health

challenges, and described the subsequent conversations as helpful and reassuring – as such,

instructors could offer to student groups the opportunity to individually discuss such concerns if

students wish.

Practicum Support: Participant narratives from this study demonstrated that the students

consistently encountered emotionally and morally distressing situations within their mental

health practicums. Participants described numerous instances of unsafe and unethical nursing

practices, which were distressing to students in their perception of the resultant harm to patients,

and in that such practices were not only unquestioned by other staff, but often normalized. In the

context of these challenges, participant narratives illustrated the numerous forms of support that

their clinical instructors provided, including debriefing challenging events and providing

perspectives that informed students' strategies in managing clinical challenges. Clinical

instructors should be prepared to debrief with students following distressing events on the unit

(Ironside, Diekelmann, & Hirschmann, 2005; O'Mara, McDonald, Gillespie, Brown, & Miles),

which may support students by reducing clinical anxiety related to challenging clinical situations

(Galvin et al., 2015). Additionally, regular debriefing opportunities through a daily clinical

conference with the instructor and student group can support students in maintaining their

emotional well-being and learning from challenging situations encountered by their peers.

Discussion within clinical conferences may further develop students' critical thinking and

nursing judgment related to real practice challenges (Megel, Nelson, Black, Vogel, & Uphoff, 2013; Potgeiter, 2012), and may also provide also provide clinical instructors with the opportunity to offer students perspectives on mental health nursing care in counterpoint to the unsafe and unethical practices they may observe in the clinical setting.

Despite the need for student support from clinical instructors, as illustrated by this study, literature suggests that clinical instructors may not be adequately prepared to provide this support. Bell-Scriber and Morton (2009) argue that clinical instructors are often hired for their clinical expertise as opposed to their teaching ability, and as such, may not have particular skills or training needed to provide students with emotional support or develop students' critical thinking. While this study's findings speak to the importance of clinical instructors' knowledge of the practice area, particularly in clinical contexts that do not adequately support student learning, a lack of teaching experience may jeopardize clinical instructor's ability to support students through challenging events. In context of this study's findings that mental health practicums may be particularly challenging and distressing environments for students, clinical instructors must be prepared with the knowledge, skills, and attitudes to support students through challenging situations (Dahlke, Baumbusch, Affleck, & Kwon, 2012). To ensure that students are supported and to promote learning and critical reflection in mental health practicums, nursing programs must ensure that adequate training and resources are available for clinical faculty in developing teaching and debriefing skills (Bell-Scriber & Morton, 2009; Reid, Hinderer, Jarosinski, Mister, & Seldomridge, 2013). Yet, research on clinical instructor support for students, particularly in mental health settings, is limited and further inquiry is needed into how clinical instructors can provide effective debriefing and learning opportunities for students, as well as how nursing programs can support clinical faculty toward these aims.

Research

   Nursing students within this study enacted resistance to power within their mental health practicums through a variety of strategies, however their narratives also demonstrated the multiple challenges they faced in doing so, including being questioned by nursing staff, experiencing disempowerment in the setting, and having few role models for how to enact best practices in providing patient care. To date, research on nursing students' experiences in mental health practicums has offered very little direction for nursing students in enacting resistance and coping with the distress of observing nursing practices reflective of micro-power. As studies demonstrate that students may frequently adopt negative coping strategies as a result of the stressors of the mental health practicum (Alzayyat & Al-Gamal, 2016; Galvin & Smith, 2015; Galvin, Suominen, Morgan, & O'Connell, 2015), further research is needed that provides direction for nursing students in effectively coping with challenging clinical environments (O'Mara, McDonald, Gillespie, Brown, & Miles, 2014). To address this gap, researchers could engage in further inquiry of students' experiences of resistance or examine nursing clinical instructors' perspectives on students' responses to witnessing unsafe and unethical practices and potential strategies to support students in challenging clinical environments (Dahlke, Baumbusch, Affleck, & Kwon, 2012).

   Further, to both support students in navigating mental health practicums, and to address the troubling practice challenges this study illustrated, further research is needed that addresses specific strategies for shifting stigmatizing practices in inpatient mental health environments. While research has explored the therapeutic relationship (Dziopa & Ahern, 2009; McAndrew et al., 2014) and trauma-informed care (Isobel, 2015; Muskett, 2014), for example, as nursing concepts that may guide changes to systemic practices, further research is needed that explores

specific everyday strategies for addressing power in the mental health care setting. Student narratives in this study suggest that connecting with patients contributes to building therapeutic relationships and rapport, yet research has limitedly explored how nurses who are not already engaging in therapeutic relationships with clients may be inspired to change their practices (Bowers et al., 2014; Yang et al., 2014). Shifting cultures and established, normative practices is a complex undertaking requiring both individual and systemic change (Paterson et al., 2013). Within the historical and current context of societal stigma, interventions that address nursing practices in inpatient mental health units must be multi-faceted and multi-level; as such, research is needed that develops and evaluates interventions that specifically address everyday practices within the critical framework of power.

As described above in the discussion of student attitudes toward mental health nursing, findings from this study challenge and provide a novel nuanced perspective to the large body of literature that demonstrate that students are disinterested in pursuing mental health nursing as a career. Study findings therefore have significant implications for future research on this topic. A potential explanation for the incongruity between the findings from this study and quantitative studies is that questionnaire-based research may not adequately capture the nuances of students' career preferences; surveys on this topic typically identify a small number of nursing specialties for participants to rank, such as 'mental health', 'pediatrics', or 'medical' (e.g. Halter, 2008; Happell & Gaskin, 2012; Stevens et al., 2013; Surgenor et al., 2005). As such, this study speaks to the need for a shift in how students' career preferences are conceptualized and explored within nursing literature. Future research to further investigate the questions raised by these findings could include quantitative survey-based studies that include sub-specialties of mental health nursing and that include measures that incorporate students' perspectives on their practicum

experiences related to staff and the environment of the practicum to differentiate interest in the population from potentially negative practicum experiences. Further, this study suggests that nursing students may be eager to work with individuals with mental health challenges in other health care settings outside of inpatient mental health, however research has not sufficiently addressed the nuanced question of how students perceive mental health nursing work beyond mental health settings. As mental health nursing is itself a stigmatized profession (Hoekstra, van Meijel, & van der Hooft-Leemans, 2010), research that acknowledges the multiple dimensions of the broad field of nursing may contribute to a more nuanced understanding of the possibilities of the profession and may inspire more nursing students to pursue their interest in working with individuals with mental health challenges across health care settings.

Limitations

While this study makes some important contributions to the literature on nursing students' experiences of mental health practicums and to strategies for nursing educators in supporting students through these experiences, it is important to note the limitations. The demographics of the sample represent a more mature population: the mean age of participants was 29, and 33% of participants (5/15) had previous Master's degrees. The participant demographics are likely a result of the advanced entry design of the nursing program from which students were sampled; for contrast, a study sampling from two nursing programs – one 2-year advanced entry and one 4-year – reflected a sample similar to the demographics represented in this study within the 2-year program, and a sample from the 4-year program in which the mean age was 24 and 70% of participants' highest level of education was high school (O'Mara et al., 2014). Partially mitigating concerns of a more mature sample in this study was the age range of participants, which spanned 21-40 years, with narratives consistent across participant

demographics including younger participants; however, the sampling for this study may affect

transferability of findings (Lincoln & Guba, 1985). A further limitation of the sample is the

imbalance of clinical sites: 66% of participants (10/15) were from Site A and only 13% (2/15)

and 20% (3/15) from sites B and C, respectively. One concern emerging from this over-

representation of participants at one site may be that students who had particularly negative

experiences at this one site may have participated in the study for the purposes of debriefing or

with the aim of effecting change. However, the participants at Site A were divided between three

inpatient mental health units located across the hospital, which shared only a limited number of

nursing staff and did not share direct nursing managers. Further, data analysis between all three

sites confirmed that narratives of participants at Sites B and C were consistent with those at Site

A.

Conclusions

Despite the limitations discussed above, this study makes several important contributions

to the literature on nursing students' experiences of mental health practicums. Students'

descriptions of nursing attitudes and behaviours within their practicums suggest that nursing

practices experienced as stigmatizing and harmful to patients extend beyond specific practices

such as seclusion and locking unit doors, and include everyday practices of micro-power. The

recognition of power in everyday practices has implications both for nursing practice, and for

future research on interventions to shift practices within mental health inpatient settings.

Participant narratives demonstrated the multiple ways in which students resisted nursing

practices that perpetuated power in the health care setting, which challenges previous

understandings of students as unable to identify or respond to unsafe and unethical practices

observed in practicums. Though students experienced disempowerment within the practicum

context in relation to their role as a student, they enacted resistance to power both reflecting their own empowerment in the setting, and contributing to empowering their of patients. Lastly, students' attitudes toward mental health nursing challenge previous understandings of students as disinterested in mental health nursing and unprepared for nursing practice with individuals with mental health challenges.

These findings, representing new contributions to the literature on students' mental health practicum experiences and nursing practices in inpatient mental health settings, speak to the need for systemic change to nursing practices, and reconceptualization of the ways in which micro-power impacts nursing care through everyday interactions. Interventions are needed at individual and organizational levels that can shift the pervasive stigmatizing and harmful practices that the participants within this study resisted, but which continue to negatively impact patient care for individuals with mental health challenges. The findings from this study also have implications for educators, demonstrating the importance of supporting nursing students through emotional, practical, and theoretical preparation for the practicum and ongoing emotional support throughout. Finally, the findings from this study point to directions for further research inquiry such as into what specific strategies may support students' resistance in mental health practicums, and thus, may support students in learning to provide safe and ethical care for individuals with mental health challenges in all settings.

References

Adams, C.G. (1993) An evaluation of four student placements in psychiatric nursing. *The Journal of the New York State Nurses' Association 24*, 19–22.

Ahn, Y.-H., & Choi, J. (2015). Factors affecting Korean nursing student empowerment in clinical practice. *Nurse Education Today, 35*, 1301-1306.

Ajani, K., & Moez, S. (2011). Gap between knowledge and practice in nursing. *Procedia Social and Behavioral Sciences, 15*, 3927-3931.

Alexander, V., Ellis, H., & Barrett, B. (2016). Medical–surgical nurses' perceptions of psychiatric patients: A review of the literature with clinical and practice applications. *Archives of Psychiatric Nursing, 30,* 262-270.

Alzayyat, A., & Al-Gamal, E. (2016). Correlates of stress and coping among Jordanian nursing students during clinical practice in psychiatric/mental health course. *Stress and Health, 32*, 304-312.

Aneshensel, C.S., Phelan, J.C., & Bierman, A. (2013). The sociology of mental health: Surveying the field. In C.S. Aneshensel, J.C. Phelan, & A. Bierman (Eds.), *Handbook of the Sociology of Mental Health, 2nd ed.* (pp. 1-19). New York, NY: Springer Netherlands

Ashmore, R. (2008). Nurses' accounts of locked ward doors: Ghosts of the asylum of acute care in the 21st century? *Journal of Psychiatric and Mental Health Nursing, 15*, 175-185.

Balen, R., Rhodes, C., & Ward, L. (2010). The power of stories: Using narrative for interdisciplinary learning in health and social care. *Social Work Education, 29*(4), 416-426.

Barrett, M.S., & Stauffer, S.L. (2012). Resonant work: Toward an ethic of narrative research. In M.S. Barrett & S.L. Stauffer (Eds.), *Narrative soundings: An anthology of narrative inquiry in music education.* Houten: Springer Netherlands.

Bartlett, M.L., Taylor, H., & Nelson, J.D. (2016). Comparison of mental health characteristics and stress between baccalaureate nursing students and non-nursing students. *Journal of Nursing Education, 55*(2), 87-90.

Beer, M.D. (2007). History of psychopathology, psychiatric treatment and the psychiatric profession. *Current Opinion in Psychiatry, 20*, 599-604.

Bell-Scriber, M.J., & Morton, A. M. (2009). Clinical instruction: Train the trainer. *Nurse Educator, 34*(2), 84-87.

Bellefontaine, N. (2009). Exploring whether student nurses report poor practice they have witnessed on placements. *Nursing Times, 105*(35), 28-31.

Bennett, J., & Stennett, R. (2015). Attitudes towards mental illness of nursing students in a Baccalaureate programme in Jamaica: A questionnaire survey. *Journal of Psychiatric and Mental Health Nursing, 22*, 599-605.

Bickhoff, L., Levett-Jones, T., & Sinclair, P.M. (2016). Rocking the boat - nursing students' stories of moral courage: A qualitative descriptive study. *Nurse Education Today, 42*, 35-40.

Bickhoff, L., Sinclair, P.M., & Levett-Jones, T. (2017). Moral courage in undergraduate nursing students: A literature review. *Collegian, 24*, 71-83.

Birks, M. (2008). Memoing in qualitative research: Probing data and processes. *Journal of Research in Nursing, 13*(1), 68-75.

Björkdahl, A., Hansebro, G., & Palmstierna, T. (2013). The influence of staff training on the violence prevention and management climate in psychiatric inpatient units. *Journal of Psychiatric and Mental Health Nursing, 20*(5), 396-404.

Björkman, T. Angelman, T. & Jönsson, M. (2008). Attitudes towards people with mental illness: A cross-sectional study among nursing staff in psychiatric and somatic care. *Scandinavian Journal of Caring Sciences, 22*, 170-177.

Blair, M., & Moulton-Adelman, F. (2015). The Engagement Model for reducing seclusion and restraint: 13 years later. *Journal of Psychosocial Nursing and Mental Health Services, 53*(3), 39-45.

Bowers, L. (2014). Safewards: A new model of conflict and containment on psychiatric wards. *Journal of Psychiatric and Mental Health Nursing, 21*(6), 499-508.

Bowers, L., Allan, T., Simpson, A., Jones, J., & van der Merwe, M. (2009). Identifying key factors associated with aggression on acute inpatient psychiatric wards. *Issues in Mental Health Nursing, 30*, 260-271.

Bowers, L., James, K., Quirk, A., Simpson, A., SUGAR, Stewart, D., & Hodsoll, J. (2015). Reducing conflict and containment rates on acute psychiatric wards: The Safewards cluster randomised controlled trial. *International Journal of Nursing Studies, 52*(9), 1412-1422.

Bradbury-Jones, C., Sambrook, S., & Irvine, F. (2007). The meaning of empowerment for nursing students: A critical incident study. *Journal of Advanced Nursing, 59*(4), 342-351.

Bradbury-Jones, C., Sambrook, S., & Irvine, F. (2008). Power and empowerment in nursing: A fourth theoretical approach. *Journal of Advanced Nursing, 62*(2), 258-266.

Bradbury-Jones, C., Sambrook, S., & Irvine, F. (2011). Nursing students and the issue of voice: A qualitative study. *Nurse Education Today, 31*, 628-632.

Breeze, J.A., & Repper, J. (1998). Struggling for control: The care experiences of 'difficult' patients in mental health services. *Journal of Advanced Nursing, 28*(6), 1301-1311.

Bruner, J. (1987). *Actual minds, possible worlds*. Cambridge: Harvard University Press.

bte Abd Malik, N.N., Kannusamy, P., & Klanin-Yobas, P. (2012). The effectiveness of mental health-related theoretical education and clinical placement in mental health settings in changing the attitudes of health care students towards mental illness: A systematic review. *JBI Database of Systematic Reviews and Implementation Reports, 10*(58), 4019-4076.

Bullock, R., McKenna, B., Kelly, T., Furness, T., & Tacey, M. (2014). When reduction strategies are put in place and mental health consumers are still secluded: An analysis of clinical and sociodemographic characteristics. *International Journal of Mental Health, 23*, 506-512.

Bvumbwe, T. (2016). Student nurses' preparation for psychiatric nursing practice: Malawian experiences. *The Journal of Mental Health Training, Education, and Practice, 11*(5), 294-304.

Canadian Association of Schools of Nursing. (2015b). *Entry-to-practice mental health and addiction competencies for undergraduate nursing education in Canada.* Retrieved from http://www.casn.ca/wp-content/uploads/2015/11/Mental-health-Competencies_EN_FINAL-3-Oct-26-2015.pdf

Canadian Association of Schools of Nursing. (2015c). *National nursing education framework.* Retrieved 12 August 2017 from http://www.casn.ca/wp-content/uploads/2014/12/Framwork-FINAL-SB-Nov-30-20151.pdf

Canadian Association of Schools of Nursing. (2015a). *Practice domain for baccalaureate nursing education: Guidelines for clinical placements and simulation.* Retrieved 12 August 2017 from http://www.casn.ca/wp-content/uploads/2015/11/Draft-clinical-sim-2015.pdf

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada. (2014). *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*. Retrieved 12 August 2017 from http://www.pre.ethics.gc.ca/pdf/eng/tcps2/TCPS_2_FINAL_Web.pdf

Canadian Medical Association (2008). 8th annual report card on health care. Retrieved 12 August 2017 from http://www.bc-psychologist.com/downloads/other/National_Report_Card_EN.pdf

Canadian Nurses Association. (2008). Code of ethics for Registered Nurses. Retrieved 12 August 2017 from http://www.nurses.ab.ca/content/dam/carna/pdfs/DocumentList/EndorsedPublications/RN_CNA_Ethics_2008.pdf

Canadian Nurses Association. (2012). *Position statement on mental health services*. Retrieved 12 August 2017 from https://www.cna-aiic.ca/~/media/cna/page-content/pdf-en/ps85_mental_health_e.pdf?la=en

Canadian Nurses Association. (2017). Education. Retrieved 12 August 2017 from https://www.cna-aiic.ca/en/becoming-an-rn/education

Centre for Addiction and Mental Health. (2016). Peaceful places: CAMH pilots global Safewards program. Retrieved 12 August 2017 from http://www.camh.ca/en/hospital/about_camh/newsroom/CAMH_in_the_headlines/stories/Pages/Peaceful-places-CAMH-pilots-global-Safewards-program.aspx

Clandinin, D.J. (2013). *Engaging in narrative inquiry.* Walnut Creek, CA: Left Coast Press.

Clandinin, D.J., & Connelly, F.M. (2000). *Narrative inquiry: Experience and story in qualitative research*. San Francisco: Jossey-Bass, Inc.

Clark, E., & McCann, T.V. (2005). Researching students: An ethical dilemma. *Nurse Researcher, 12*(3), 42-51.

Clarke, D., Usick, R., Sanderson, A., Giles-Smith, L., & Baker, J. (2014). Emergency department staff attitudes towards mental health consumers: A literature review and thematic content analysis. *International Journal of Mental Health Nursing, 23*, 273-284.

Clinton, M. & Hazelton, M. (2000). Scoping the Australian mental health nursing workforce. *Australian and New Zealand Journal of Mental Health Nursing, 9*, 56–64.

College of Registered Nurses of British Columbia. (2013). Professional standards for Registered Nurses and Nurse Practitioners. Retrieved 12 August 2017 from https://crnbc.ca/Standards/Lists/StandardResources/128ProfessionalStandards.pdf

Cornish, J. & Jones, A. (2010) Factors affecting compliance with moving and handling policy: Student nurses' views and experiences. *Nurse Education in Practice, 10*(2), 96-100.

Corrigan, P.W., Druss, B.G., & Perlick, D.A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest, 15*(2), 37-70.

Corrigan, P., & Shapiro, J. (2010). Measuring the impact of programs that challenge the public stigma of mental illness. *Clinical Psychology Review, 30*(8), 907-922.

Curtis, J. (2007). Working together: A joint initiative between academics and clinicians to prepare undergraduate nursing students to work in mental health settings. *International Journal of Mental Health Nursing, 16*, 285-293.

Dahlke, S., Baumbusch, J., Affleck, F., & Kwon, J.-Y. (2012). The clinical instructor role in nursing education: A structured literature review. *Journal of Nursing Education, 51*(12), 692-696.

Daiute, C. (2014). *Narrative inquiry: A dynamic approach.* Los Angeles: SAGE Publications, Inc.

De Santis, M., Myrick, H., Lamis, D.A., Pelic, C.P., Rhue, C., & York, J. (2015). Suicide-specific safety in the inpatient psychiatric unit. *Issues in Mental Health Nursing, 36*, 190-199.

DeKeyser Ganz, F., & Kahana, S. (2006). Perceptions of Israeli student nurses regarding clinical specialties and factors that influence these perceptions. *Journal of Advanced Nursing 56*, 88-98.

Dey, I. (1993). *Qualitative data analysis: A user-friendly guide for social scientists.* London: Routledge.

Doane, G.H., & Varcoe, C. (2007). Relational practice and nursing obligations. *Advances in Nursing Science, 30*(3), 192-205.

Doane, G.H., & Varcoe, C. (2013). *How to nurse: Relational inquiry with individuals and families in changing health and health care contexts*. Philadelphia: Lippincott Williams & Wilkins.

Dziopa, F., & Ahern, K. (2009). What makes a quality therapeutic relationship in psychiatric/mental health nursing: A review of the research literature. *Internet Journal of Advanced Nursing Practice, 10*(1).

Edward, K., Warelow, P. Hemingway, S., Hercelinskyj, G., Welch, A., McAndrew, S., & Stephenson, J. (2015). Motivations of nursing students regarding their educational preparation for mental health nursing in Australia and the United Kingdom: a survey evaluation. *BMC Nursing.* doi:10.1186/s12912-015-0084-8

Erdil, F. & Korkmaz, F. (2009). Ethical problems observed by student nurses. *Nursing Ethics, 16*(5), 589-598.

Ernst, W. (2016). Therapy and empowerment, coercion and punishment: Historical and contemporary perspectives on work, psychiatry, and society. In W. Ernst (Ed.), *Work, psychiatry, and society, c. 1750-2015* (1-30). Manchester: Manchester University Press.

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods, 5*(1), 80-92.

Ferguson, L.M., Myrick, F., & Yonge, O. (2006). Ethically involving students in faculty research. *Nurse Education Today, 26*(8), 397-403.

Finn, C. (2011). Forensic nurses' experiences of receiving child abuse disclosures. *Journal for Specialists in Pediatric Nursing, 16*, 252-262.

Fisher, J.E. (2002). Fear and learning in mental health settings. *International Journal of Mental Health Nursing, 11*, 128-134.

Flott, E.A., & Linden, L. (2015). The clinical learning environment in nursing education: A concept analysis. *Journal of Advanced Nursing, 72*(3), 501-513.

Fossen, P., & Stoeckel, P.R. (2016). Nursing students' perceptions of a hearing voices simulation and role-play: Preparation for mental health clinical practice. *Journal of Nursing Education, 55*(4), 203-208.

Foucault, M. (1978). *The history of sexuality.* New York: Pantheon Books.

Foucault, M. (1979). *Discipline and punish: The birth of the prison.* New York: Vintage Books.

Foucault, M. (1982). The subject and power. *Critical Inquiry, 8*(4), 777-795.

Galderisi, S., Heinz, A., Kastrup, M, Beezhold, J., & Sartorius, N. (2015). Toward a new definition of mental health. *World Psychiatry, 14*(2), 231-233.

Galvin, J., & Smith, A.P. (2015). Stress in U.K. mental health training: A multi-dimensional comparison study. *British Journal of Education, Society & Behavioural Science, 9*(3), 161-175.

Galvin, J. Suominen, E., Morgan, C., O'Connell, E.J. & Smith, A.P. (2015). Mental health nursing students' experiences of stress during training: A thematic analysis of qualitative interviews. *Journal of Psychiatric and Mental Health Nursing, 22*, 773-783.

Ganzer, C.A., & Zauderer, C. (2013). Structured learning and self-reflection: Strategies to decrease anxiety in the psychiatric mental health clinical nursing experience. *Nursing Education Perspectives, 34*(4), 244-247.

Gengler, A.M. (2016). Defying (dis)empowerment in a battered women's shelter: Moral rhetorics, intersectionality, and processes of control and resistance. *Social Problems, 59*(4), 501-521.

Gerace, A., Oster, C., Mosel, K., O'Kane, D., Ash, D., & Muir-Cochrane, E. (2015). Five-year review of absconding in three acute psychiatric inpatient wards in Australia. *International Journal of Mental Health Nursing, 24*, 28-37.

Gilburt, H., Rose, D., & Slade, M. (2008). The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the U.K. *BMC Health Services Research, 8*(92). doi:10.1186/1472-6963-8-92

Goffman, E. (1961). On the characteristics of total institutions. In *Asylums: Essays on the social situation of mental patients and other inmates* (1-124). New York: Anchor Books.

Goh, Y.-S., Selvarajan, S., Chng, M.-L., Tan, C.-S., & Yobas, P. (2016). Using standardized patients in enhancing undergraduate students' learning experience in mental health nursing. *Nurse Education Today, 45*, 167-175.

Gooding, P. (2016). From deinstitutionalisation to consumer empowerment: Mental health policy, neoliberal restructuring and the closure of the 'Big bins' in Victoria. *Health Sociology Review, 25*(1), 33-47.

Gough, K. & Happell, B. (2009). Undergraduate nursing students' attitude to mental health nursing: A cluster analysis approach. *Journal of Clinical Nursing, 18*, 3155-3164.

Gouthro, T.J. (2009). Recognizing and addressing the stigma associated with mental health nursing: A critical perspective. *Issues in Mental Health Nursing, 30*, 669-676.

Granados-Gámez, G., del Mar López Rodríguez, M., Corral Granados, A., & Márquez-Hernández, V.V. (2017). Attitudes and beliefs of nursing students toward mental disorder: The significance of direct experience with patients. *Perspectives in Psychiatric Care, 53*, 135-143.

Gunther, M. (2011). Empathic anger in junior nursing students. *Journal of Nursing Education, 50*(5), 242-247.

Guruge, S., Ze Yu Wang, A., Jayasuriya-Illesinghe, V., & Sidani, S. (2017). Knowing so much, yet knowing so little: a scoping review of interventions that address the stigma of mental illness in the Canadian context. *Psychology, Health & Medicine, 22*(5), 507-523.

Hanrahan, N.P., Aiken, L.H., McClaine, L., & Hanlon, A. (2010). Relationship between psychiatric nurse work environments and nurse burnout in acute care general hospitals. *Issues in Mental Health Nursing, 31*(3), 198-207.

Happell, B. (2008a). The importance of clinical experience for mental health nursing – Part 2: The importance of clinical experience for mental health nursing – Part 1: Undergraduate nursing students' attitudes, preparedness and satisfaction. *International Journal of Mental Health Nursing, 17*, 326-332.

Happell, B. (2008b). The importance of clinical experience for mental health nursing – Part 2: The importance of clinical experience for mental health nursing – Part 2: Relationships between undergraduate nursing students' attitudes, preparedness, and satisfaction. *International Journal of Mental Health Nursing, 17*, 333-340.

Happell, B., Byrne, L., Platania-Phung, C., Harris, S., & Bradshaw, J. & Davies, J. (2014). Lived-experience participation in nurse education: Reducing stigma and enhancing popularity. *International Journal of Mental Health Nursing, 23*, 427-434.

Happell, B., & Gaskin, C.J. (2012). The attitudes of undergraduate nursing students towards mental health nursing: A systematic review. *Journal of Clinical Nursing, 22*, 148-158.

Happell, B., & Gough, K. (2007). Undergraduate nursing students' attitudes towards mental health nursing: determining the influencing factors. *Contemporary Nurse, 25,* 72-81.

Happell, B., & Koehn, S. (2010). Attitudes to the use of seclusion: Has contemporary mental health policy made a difference? *Journal of Clinical Nursing, 19*, 3208-3217.

Happell, B., & McAllister, M. (2014). Perspectives of Australian nursing directors regarding educational preparation for mental health nursing practice. *Issues in Mental Health Nursing, 35*(11), 891-897.

Happell, B., & Platania-Phung, C. (2012). Mental health placements in a general health setting: No substitute for the real thing! *Journal of Clinical Nursing, 21*, 2026-2033.

Happell, B., Platania-Phung, C., Harris, S., & Bradshaw, J. (2014). It's the anxiety: Facilitators and inhibitors to nursing students' career interests in mental health nursing. *Issues in Mental Health Nursing, 35*, 50-57.

Happell, B., Welch, T., Moxham, L., & Byrne, L. (2013). Keeping the flame alight: Understanding and enhancing interest in mental health nursing as a career. *Archives of Psychiatric Nursing, 27*, 161-165.

Harrison, C.A., Hauck, Y., & Ashby, R. (2017). Breaking down the stigma of mental health nursing: Qualitative study reflecting opinions from western Australian nurses. *Journal of Psychiatric and Mental Health Nursing*. doi:10.1111/jpm.12392

Hartigan-Rogers, J.A., Cobbett, S.L., Amirault, M.A., & Muise-Davis, M.E. (2007). Nursing graduates' perceptions of their undergraduate clinical placement. *International Journal of Nursing Scholarship, 4*(1), Article 9.

Hastings, T., Kroposki, M., & Williams, G. (2017). Can completing a mental health nursing course change students' attitudes? *Issues in Mental Health Nursing, 38*(5), 449-454.

Hatlevik, I.K.R. (2012). The theory-practice relationship: Reflective skills and theoretical knowledge as key factors in bridging the gap between theory and practice in initial nursing education. *Journal of Advanced Nursing, 68*(4), 868-877.

Hatzenbuehler, M., Phelan, J., & Link, B. (2013). Stigma as a fundamental cause of population health inequalities. *American Journal of Public Health, 103*(5), 813-821.

Haydon, G., & van der Riet, P. (2014). A narrative inquiry: How do nurses respond to patients' use of humour? *Contemporary Nurse, 46*(2), 197-205.

Heller, K.J. (1996). Power, subjectification and resistance in Foucault. *SubStance, 25*(1), 78-110.

Henderson, S., Happell, B., & Martin, T. (2007). So what is so good about clinical experience? A mental health nursing perspective. *Nurse Education in Practice, 7*, 164-172.

Hermanns, M., LuAnne Lilly, M., & Crawley, B. (2011a). Behind the Door: Simulated crises implemented in psychiatric/mental health nursing education. *Journal of the American Psychiatric Nurses Association, 17*(5), 360-364.

Hermanns, M., Lilly, M. L., & Crawley, B. (2011b). Using clinical simulation to enhance psychiatric nursing training of baccalaureate students. *Clinical Simulation in Nursing, 7*(2), 41-46.

Horton-Deutsch, S., & Sherwood, G. (2008). Reflection: An educational strategy to develop emotionally-competent nurse leaders. *Journal of Nursing Management, 16*, 946-954.

Hoekstra, H.J., van Miejel, B.B., & van der Hooft-Leemans, T.G. (2010). A nursing career in mental health care: Choices and motives of nursing students. *Nurse Education Today, 30*, 4-8.

Hung, B., Huang, X., & Lin, M. (2009). The first experiences of clinical practice of psychiatric nursing students in Taiwan: A phenomenological study. *Journal of Clinical Nursing, 18*, 3126-3135.

Hunter, L., Weber, T., Shattell, M., & Harris, B.A. (2015). Nursing students' attitudes about psychiatric mental health nursing. *Issues in Mental Health Nursing, 36*, 29-34.

Ion, R., Smith, K., & Dickens, G. (2017). Nursing and midwifery students' encounters with poor clinical practice: A systematic review. *Nurse Education in Practice, 23*, 67-75.

Ion, R., Smith, K., Nimmo, S., Rice, A.M., & McMillan, L. (2015). Factors influencing student nurse decisions to report poor practice witnessed while on placement. *Nurse Education Today, 35*, 900-905.

Ironside, P., Diekelmann, N., & Hirschmann, M. (2005). Learning the practices of knowing and connecting: The voices of students. *Journal of Nursing Education, 44*(4), 153-155.

Isobel, S. (2015). 'Because that's the way it's always been done': Reviewing the nurse-initiated rules in a mental health unit as a step toward trauma-informed care. *Issues in Mental Health Nursing, 37*, 272-278.

Jackson, D., Hutchison, M., Everett, B., Mannix, J., Peters, K., Weaver, R., & Salamonson, Y. (2011). Struggling for legitimacy: Nursing students' stories of organisational aggression, resilience and resistance. *Nursing Inquiry, 18*(2), 102-110.

Jansen, R. & Venter, I. (2015). Psychiatric nursing: An unpopular choice. *Journal of Psychiatric and Mental Health Nursing, 22*, 142-148.

Johansson, I.M., Skärsäter, I., & Danielson, E. (2013). The experience of working on a locked acute psychiatric ward. *Journal of Psychiatric and Mental Health Nursing, 20*, 321-329.

Jorm, A., & Oh, E. (2009). Desire for social distance with people with mental disorders: A review. *Australian and New Zealand Journal of Psychiatry, 43*(3), 183-200.

Karimollahi, M. (2012). An investigation of nursing students' experiences in an Iranian psychiatric unit. *Journal of Psychiatric and Mental Health Nursing, 19*, 738-745.

Kelly, T., & Howie, L. (2007). Working with stories in nursing research: Procedures used in narrative analysis. *International Journal of Mental Health Nursing, 16*, 136-144.

Kennedy, S., Hardiker, N., & Staniland, K. (2015). Empowerment an essential ingredient in the clinical environment: A review of the literature. *Nurse Education Today, 35*, 487-492.

Kincheloe, J. L., & McLaren, P. L. (2000). Rethinking critical theory and qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research, 2nd ed.* (pp. 279-313). Thousand Oaks, CA: Sage.

Kirkbakk-Fjær, K., Andfossen, N.B., & Hedelin, B. (2015). Perceptors' expectations of nursing students' preparation before placement in psychiatry: Ability and will to reflect on and exercise knowledge. *Issues in Mental Health Nursing, 36*(4), 300-306.

Kontio, R., Joffre, G., Putkonen, H., Kuosmanen, L., Hane., K…. & Välimäki, M. (2012). Seclusion and restraint in psychiatry: Patients' experiences and practical suggestions on how to improve practices and use alternatives. *Perspectives in Psychiatric Care, 48,* 16-24.

Koskinen, L., Mikkonen, I., & Jokinen, P. (2011). Learning from the world of mental health care: Nursing students' narratives. *Journal of Psychiatric and Mental Health Nursing, 18*, 622-628.

Kuokkanen, L., & Leino-Kilpi, H. (2000). Power and empowerment in nursing: three theoretical approaches. *Journal of Advanced Nursing, 31*(1), 235-241.

Larsen, I.B., & Terkelsen, T.B. (2014). Coercion in a locked psychiatric ward: Perspectives of patients and staff. *Nursing Ethics, 21*(4), 426-436.

Law, G.U., Rostill-Brookes, H., & Goodman, D. (2009). Public stigma in health and non-healthcare students: Attributions, emotions and willingness to help with adolescent self-harm. *International Journal of Nursing Studies, 46*, 108-119.

Levett-Jones, T., & Lathlean, J. (2007). Belongingness: A montage of nursing students' stories of their clinical placement experiences. *Contemporary Nurse, 24*(2), 162-174.

Levett-Jones, T., & Lathlean, J. (2009). 'Don't rock the boat': Nursing students' experiences of conformity and compliance. *Nurse Education Today, 29*, 342-349.

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry.* Newbury Park, CA: Sage Publications.

Linden, M., & Kavanagh, R. (2012). Attitudes of qualified vs. student mental health nurses towards an individual diagnosed with schizophrenia. *Journal of Advanced Nursing, 68*(6), 1359-1368.

Lindh, I.-B., Severinsson, E., & Berg, A. (2008). Exploring student nurses' reflections on moral responsibility in practice. *Reflective Practice, 9*(4), 437-448.

Loh, J. (2013). Inquiry into issues of trustworthiness and quality in narrative studies: A perspective. *The Qualitative Report, 18*(33), Article 1.

Loukidou, E., Ioannidi, V., & Kalokerinou-Anagnostopoulou, A. (2010). Institutionalized nursing staff: Planning and developing a specialized educational framework that enhances psychiatric nurses' roles and promotes de-institutionalization. *Journal of Psychiatric and Mental Health Nursing, 17*, 829-837.

Madan, A., Borckardt, J.J., Grubaugh, A.L., Danielson, C.K., McLeod-Bryant, S., Cooney, H., … Frueh, B.C. (2014). Efforts to reduce seclusion and restraint use in a state psychiatric hospital: A ten-year perspective. *Psychiatric Services, 65*(10), 1273-1276.

Markström, U., Gyllensten, A.L., Bejerholm, U., Björman, T., Brunt, D., Hansson, L., Leufstadius, C., Sandlund, M., Svensson, B., Östman, M., & Eklund, M. (2009). Attitudes towards mental illness among health care students at Swedish universities: A follow-up study after completed clinical placement. *Nurse Education Today, 29*, 660-665.

Mårtensson, G., Jacobsson, J.W., & Engström, M. (2014). Mental health nursing staff's attitudes towards mental illness: An analysis of related factors. *Journal of Psychiatric and Mental Health Nursing, 21*, 782-788.

McAllister, M. (2008). Looking below the surface: developing critical literacy skills to reduce the stigma of mental disorders. *Journal of Nursing Education, 47*(9), 426-430.

McAndrew, S., Chambers, M., Nolan, F., Thomas, B., & Watts, P. (2014). Measuring the evidence: Reviewing the literature of the measurement of therapeutic engagement in acute

mental health inpatient wards. *International Journal of Mental Health Nursing, 23*(3), 212-220.

McCann, T.V., Lu, S., & Berryman, C. (2009). Mental health literacy of Australian Bachelor of Nursing students: A longitudinal study. *Journal of Psychiatric and Mental Health Nursing, 16*, 61-67.

McKie, A., & Naysmith, S. (2014). Promoting critical perspectives in mental health nursing education. *Journal of Psychiatric and Mental Health Nursing, 21*, 128-137.

Megel, M.E., Nelson, A.E., Black, J., Vogel, J., Uphoff, M. (2013). A comparison of student and faculty perceptions of clinical post-conference learning environment. *Nurse Education Today, 33*, 525-529.

Melincavage, S.M. (2011). Student nurses' experiences of anxiety in the clinical setting. *Nurse Education Today, 31*, 785-789.

Melrose, S. & Shapiro, B. (1999). Students' perceptions of their psychiatric mental health clinical nursing experience: A personal construct theory exploration. *Journal of Advanced Nursing, 30*(6), 1451-1458.

Mental Health Commission of Canada. (2012). *Changing directions, changing lives: The mental health strategy for Canada.* Retrieved 12 August 2017 from http://strategy.mentalhealthcommission.ca/pdf/strategy-images-en.pdf

Mental Health Commission of Canada. (2013). *Making the case for investing in mental health in Canada.* Retrieved 12 August 2017 from http://www.mentalhealthcommission.ca/sites/default/files/2016-06/Investing_in_Mental_Health_FINAL_Version_ENG.pdf

Monrouxe, L.V., Rees, C.E., Endacott, R., & Ternan, E. (2014). 'Even now it makes me angry': Health care students' professionalism dilemma narratives. *Medical Education, 48*, 502-517.

Moxham, L, Taylor, E., Patterson, C., Perlman, D., Brighton, R., Sumskis, S., … Heffernan, T. (2016). Can a clinical placement influence stigma? An analysis of measures of social distance. *Nurse Education Today, 44*, 170-174.

Muir-Cochrane, E., van der Merwe, M., Nijman, H., Haglund, K., Simpson, A., & Bowers, L. (2012). Investigation into the acceptability of door locking to staff, patients, and visitors on acute psychiatric wards. *International Journal of Mental Health Nursing, 21,* 41-49.

Mun, M.S. (2010). An analysis of narratives to identify critical thinking contexts in psychiatric clinical practice. *International Journal of Nursing Practice, 16*, 75-80.

Munro, S. & Baker, J.A. (2007) Surveying the attitudes of acute mental health nurses. *Journal of Psychiatric and Mental Health Nursing, 14*, 196-202.

Muralidharan, S., & Fenton, M. (2012). Containment strategies for people with serious mental illness. *The Cochrane Library, 2*, 1-15.

Muskett, C. (2013). Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing, 23*(1), 51-59.

Naber, J., Hall, J., & Schadler, C.M. (2014). Narrative thematic analysis of baccalaureate nursing students' reflections: Critical thinking in the clinical education context. *Journal of Nursing Education, 53*(9), S90-S96.

Nadler-Moodie, M., & Loucks, J., (2011). The implementation of a new-graduate nurse residency training program directly into psychiatric-mental health nursing. *Archives of Psychiatric Nursing, 25*(6), 479–484.

Nankivell, J., Happell, B., & Scott, D. (2013). Access to physical health care for people with serious mental illness: A nursing perspective and a human rights perspective – Common ground? *Issues in Mental Health Nursing, 34*, 442-450.

Nijman, H., Bowers, L., Haglund, K., Muir-Cochrane, E., Simpson, A., & Van Der Merwe, M. (2011). Door locking and exit security measures on acute psychiatric admission wards. *Journal of Psychiatric and Mental Health Nursing, 18*(7), 614-621.

Nolan, P., & Brimblecombe, N. (2007). A survey of the education of nurses working in mental health settings in 12 European countries. *International Journal of Nursing Studies, 44*, 407-414.

Novella, E. (2010). Mental health care and the politics of inclusion: A social systems account of psychiatric deinstitutionalization. *Theoretical Medicine and Bioethics, 31*, 411-427.

O'Mara, L., McDonald, J., Gillespie, M., Brown, H., & Miles, L. (2014). Challenging clinical learning environments: Experiences of undergraduate nursing students. *Nurse Education in Practice, 14*, 208-213.

Palese, A., Petean, M., & Cerne, D. (2013). Unexpected deaths in medical wards during night shifts: A narrative analysis of nursing experiences. *Journal of Clinical Nursing, 23*, 2599-2608.

Paterson, B., McIntosh, I., Wilkinson, D., McComish, S., & Smith, I. (2013). Corrupted cultures in mental health inpatient settings: Is restraint reduction the answer? *Journal of Psychiatric and Mental Health Nursing, 20*, 228-235.

Peplau, H. E. (1952/1991). *Interpersonal relations in nursing*. New York: Springer Publishing.

Perese, E.F. (1996). Undergraduates' perceptions of their psychiatric practicum: Positive and negative factors in inpatient and community experience. *Journal of Nursing Education, 35*(6), 281-285.

Perlman, D., Patterson, C., Moxham, L., Taylor, E., Brighton, R., Sumskis, S., & Heffernan, T. (2017). Preparing nursing students for mental health care: The impact of a recovery-oriented clinical placement. *Issues in Mental Health Nursing.* doi:10.1080/01612840.2017.1312650

Petty, J. (2017). Creating stories for learning about the neonatal care experience through the eyes of student nurses: An interpretive, narrative study. *Nurse Education Today, 48*, 25-32.

Pickett, B.L. (1996). Foucault and the politics of resistance. *Polity, 28*(4), 445-466.

Pijl-Zieber, E.M., Barton, S., Konkin, J., Awosoga, O., & Caine, V. (2014). Competence and competency-based nursing education: Finding our way through the issues. *Nurse Education Today, 34*, 676-678.

Polkinghorne, D. (1988). *Narrative knowing and the human sciences.* Albany: State University of New York Press.

Polkinghorne, D.E. (1995). Narrative configuration in qualitative analysis. *International Journal of Qualitative Studies in Education, 8*, 5-23.

Poreddi, V., Thimmaiah, R., Chandra, R., & BadaMath, S. (2013). Bachelor of nursing students' attitude towards people with mental illness and career choices in psychiatric nursing. An Indian perspective. *Investigación y Educación en Enfermería, 33*(1), 148-154.

Potgeiter, E. (2012). Clinical teaching: Developing critical thinking in student nurses. *Professional Nurse Today, 16*(2), 4-8.

Rao, H., Pillay, P., Abraham, A., & Luty, J. (2009). A study of stigmatised attitudes towards people with mental health problems among health professionals. *Journal of Psychiatric and Mental Health Nursing 16*, 279–284.

Rees, C.E., Monrouxe, L.V., & McDonald, L.A. (2015). 'My mentor kicked a dying woman's bed...' Analysing UK nursing students' 'most memorable' professionalism dilemmas. *Journal of Advanced Nursing, 71*(1), 169-180.

Reid, T.P., Hinderer, K.A., Jarosinski, J.M., Mister, B.J., & Seldomridge, L.A. (2013). Expert clinician to clinical teacher: Developing a faculty academy and mentoring initiative. *Nurse Education in Practice, 13*(4), 288-293.

Reissman, C.K. (2008). *Narrative methods for the human sciences.* Los Angeles: SAGE Publications, Inc.

Riley, T., & Hawe, P. (2005). Researching practice: The methodological case for narrative inquiry. *Health Education Research, 20*(2), 226-236.

Roberts, M. (2009). Service user involvement and the restrictive sense of psychiatric categories: The challenge facing mental health nurses. *Journal of Psychiatric and Mental Health Nursing, 17*(4), 289-294.

Rogers, A., & Pilgrim, D. (2014). *A Sociology of Mental Health and Illness, 5th ed*. New York: Open University Press.

Ross, C.A. & Goldner, E.M. (2009). Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: A review of the literature. *Journal of Psychiatric and Mental Health Nursing, 16*, 558-567.

Rungapadiachy, D.M., Madill, A., & Gough, B. (2004). Mental health student nurses' perception of the role of the mental health nurse. *Journal of Psychiatric and Mental Health Nursing, 11*, 714-724.

Ryles, S.M. (1999). A concept analysis of empowerment: Its relationship to mental health nursing. *Journal of Advanced Nursing, 29*(3), 600-607.

Sandelowski, M. (1994). We are the stories we tell: Narrative knowing in nursing practice. *Journal of Holistic Nursing, 12*(1), 23-33.

Sarikoc, G., Tangul Ozcan, C., & Elcin, M. (2017). The impact of using standardized patients in psychiatric cases on the levels of motivation and perceived learning of the nursing students. *Nurse Education Today, 51*, 15-22.

Schafer, T., Wood, S., & Williams, R. (2011). A survey into student nurses' attitudes toward mental illness: Implications for nurse training. *Nurse Education Today, 31*, 328-332.

Schwind, J.K. (2014). Opening the black-box of person-centered care: An arts-informed narrative inquiry into mental health education and practice. *Nurse Education Today, 34*, 1167-1171.

Sealy, P. (2012). The impact of the process of deinstitutionalization of mental health services in Canada: An increase in accessing of health professionals for mental health concerns. *Social Work in Public Health, 27*, 229-237.

Seidman, I. (2013). *Interviewing as research: A guide for researchers in education and the social sciences, 4th ed.* New York: Teachers College Press.

Shattell, M.M., Andes, M., & Thomas, S.P. (2008). How patients and nurses experience the acute care psychiatric environment. *Nursing Inquiry, 15*(3), 242-250.

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 Journal of Mental Health Nursing, 16*, 274-284.

Smith, P.M., Corso, L.N., & Cobb, N. (2010). The perennial struggle to find clinical placement opportunities: A Canadian national survey. *Nurse Education Today, 30*, 798-803.

Smith, P.M., Spadoni, M.M., & Proper, V.M. (2013). National survey of clinical placement settings across Canada for nursing and other healthcare professions – Who's using what? *Nurse Education Today, 33*, 1329-1336.

Southwick, S.M., Litz, B.T., Charney, D., & Friedman, M.J. (2011). Resilience and mental health: Challenges across the lifespan. Cambridge: Cambridge University Press.

Statistics Canada. (2013). *Canadian community health survey: Mental health, 2012*. Retrieved 12 August 2017 from http://www.statcan.gc.ca/daily-quotidien/130918/dq130918a-eng.pdf

Stenhouse, R.C. (2010). 'They all said you could come and speak to us': Patients' expectations and experiences of help on an acute psychiatric inpatient ward. *Journal of Psychiatric and Mental Health Nursing, 18*(1), 74-80.

Stevens, J., Browne, G., & Graham, I. (2013). Career in mental health still an unlikely career choice for nursing graduates: A replicated longitudinal study. *International Journal of Mental Health Nursing, 22*, 213-230.

Stevenson, K.N., Jack, S.M., O'Mara, L., & LeGris, J. (2015). Registered Nurses' experiences of patient violence on acute care psychiatric inpatient units: An interpretive descriptive study. *BMC Nursing, 14*(35), 1-13.

Stewart, D., Bowers, L., & Ross, J. (2012). Managing risk and conflict behaviours in acute psychiatry: The dual role of constant special observation. *Journal of Advanced Nursing, 68*(6), 13401-1348.

Surgenor, L.J., Dunn, J., & Horn, J. (2005) Nursing student attitudes to psychiatric nursing and psychiatric disorders in New Zealand. *International Journal of Mental Health Nursing, 14*, 103-108.

Szpak, J.L., & Kameg, K.M. (2013). Simulation decreases nursing student anxiety prior to communication with mentally ill patients. *Clinical Simulation in Nursing, 9*(1), 13-19.

Terry, J. (2012). Service user involvement in pre-registration mental health nursing education classroom settings: A review of the literature. *Journal of Psychiatric and Mental Health Nursing, 19*, 816-829.

The University of British Columbia Board of Governors. (2013). *Policy 85: Scholarly integrity*. Retrieved 12 August 2017 from http://universitycounsel.ubc.ca/files/2015/08/policy85.pdf

Thomas, S., & Bhattycharya, C. (2012). A study to assess the change in attitude and perceived stress of nursing students during their first mental health clinical placement. *International Journal of Nursing Education, 4*(1), 69-72.

Thongpriwan, V., Leuck, S.E., Powell, R.L., Young, S., Schuler, S.G., & Hughes, R.G. (2015). Undergraduate nursing students' attitudes toward mental health nursing. *Nurse Education Today, 35*, 948-953.

Timmins, F., Corroon, A.M., Byrne, G., & Mooney, B. (2011). The challenge of contemporary nurse education programmes. Perceived stressors of nursing students: Mental health and related lifestyle issues. *Journal of Psychiatric and Mental Health Nursing, 18*, 758-766.

Treloar, A., McMillan, M., & Stone, T. (2016). Nursing in an imperfect world: Storytelling as preparation for mental health nursing practice. *International Journal of Mental Health Nursing, 26*, 293-300.

Tuck, J.A. (2017). A new approach to team clinical supervision on an acute admissions unit. *Mental Health Practice, 20*(5), 24-27.

University of British Columbia. (2016-2017). Course descriptions: School of Nursing, Faculty of Applied Sciences. Retrieved 12 August 2017 from http://www.calendar.ubc.ca/vancouver/courses.cfm?code=NURS

University of British Columbia School of Nursing. (2016, May 10). 2016-2018 BSN program curriculum structure. Retrieved 12 August 2017 from https://nursing.ubc.ca/sites/nursing.ubc.ca/files/documents/2016-2018%20UBC%20SoN%20Curriculum%20Structure.pdf

University of British Columbia School of Nursing. (n.d.). Undergraduate FAQs. Retrieved 12 August 2017 from https://nursing.ubc.ca/undergraduate-program/faq?combine=&page=1

VanDerNagel, J.E.L., Tuts, K.P., Hoekstra, T., & Noorthoorn, E.O. (2009). Seclusion: The perspective of nurses. *International Journal of Law and Psychiatry, 32*, 408-412.

Vigo, D., Thornicroft, G., & Atun, R. (2016). Estimating the true global burden of mental illness. *The Lancet Psychiatry, 3*(2), 171-178.

Vruwink, F.J., Noorthorn, E.O., Nijman, H.L.I., VanDerNagel, J.E.L., Hox, J.J., & Mulder, C.L. (2012). *Archives of Psychiatric Nursing, 26*(4), 307-315.

Waite, R. (2006). The psychiatric educational experiences of advance beginner RNs. *Nurse Education Today, 26*(2), 131-138.

Walsh, A. (2015). Are new mental nurses prepared for practice? *Mental Health Review Journal, 20*(2), 119-130.

Webster, L., & Mertova, P. (2007). *Using narrative inquiry as a research method: An introduction to using critical event narrative analysis in research on learning and teaching.* New York: Routledge.

Weiss, R.S. (1994). *Learning from strangers: The art and method of qualitative interview studies.* New York: The Free Press.

Wells, K. (2011). *Narrative inquiry.* Oxford: Oxford University Press, Inc.

Whitmore, C. (2017). Evaluation of Safewards in forensic mental health: A response. *Mental Health Practice, 20*(8), 26-29.

Wilson, J.E.H., Azzopardi, W., Sager, Sh., Gould, B., Conroy, S., Deegan, P., & Archie, S. (2009). A narrative study of the experiences of student nurses who have participated in the Hearing Voices that are Distressing Simulation. *International Journal of Nursing Education Scholarship, 6*(1), Article 19.

Wojtowicz, B., Hagen, B., & Van Daalen-Smith, C. (2014). No place to turn: Nursing students' experiences of moral distress in mental health settings. *International Journal of Mental Health Nursing, 23*, 257-264.

World Health Organization. (2013). *Mental health action plan 2013-2020.* Retrieved 12 August 2017 from http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf?ua=1

World Health Organization (2014). Mental health: A state of well-being. Retrieved 12 August 2017 from http://www.who.int/features/factfiles/mental_health/en/

World Health Organization (2017). Mental disorders. Retrieved 12 August 2017 from http://www.who.int/mental_health/management/en/

Wynaden, D., Heslop, K., Al Omari, O., Nelson, D., Osmond, B., Taylor, M., & Gee, T. (2014). Identifying mental health nursing research priorities: A Delphi study. *Contemporary Nurse, 47*(1-2), 16-26.

Yang, C.-P., Hargreaves, W.A., & Bostrom, A. (2014). Association of empathy of nursing staff with reduction of seclusion and restraint in psychiatric inpatient care. *Psychiatric Services, 65*(2), 251-254.

Yeh, M.-Y., Wu, S.-M., & Che, H.-L. (2010). Cultural and hierarchical influences: Ethical issues faced by Taiwanese nursing students. *Medical Education, 44*, 475-484.

Appendix A

Interview Guide

Introduction: Thank you for taking the time to participate in this study. To get us started please tell me a little bit about your educational background.
-   What year of the program are you in?
-   Which courses have you completed?
-   What type of previous education have you had before you came to the UBC nursing program?

Question 1: Now to focus on your mental health experiences, tell me about the setting where you completed your clinical practicum part of the mental health course?

→ **What was the set-up of your clinical experience?**
-   What were your clinical shifts?
-   How was your clinical group divided amongst units at your site?
-   What was the nature of your clinical supervision/support?

→ **Can you describe the clinical site to me?**
-   What populations did this site serve?
-   How was nursing care of this population organized?
-   Can you describe the interdisciplinary team?
-   What was your impression of the environment?
-   Walk me through the unit, describe what you see? What do you think of the _____ *i.e. nursing station, client rooms, common areas, etc.*?

→ **When you first learned you were placed at this site, what were your reactions?**
-   Did you choose this site? Why/why not?
-   What had you heard about this site?
-   Tell me about any information or expectations you had about this particular site.

Question 2: Tell me about getting ready for this upcoming clinical placement – what kinds of things were you thinking about beforehand?
Probing Questions:
-   What did you expect for the practicum?
-   Did you discuss the upcoming practicum with anyone else in your life before you began? What did you talk about with this person?
-   Was there anything in particular you were looking forward to?
-   Did you have any fears or concerns?

→ What were your general thoughts about working as a nursing student in a mental health setting?
-   Had you worked with individuals with mental illness in other practicums? Tell me about those experiences. How did you think that working with individuals with mental illness in this setting (mental health site) might be similar or different?
-   Why did you think working with individuals with mental illness might be _____ *(based on participant responses)*?
-   What have you heard from others in your life regarding mental illness or individuals with mental illness?
-   What have you heard from other nursing students about working with clients with mental illness?

→ How prepared did you feel beginning this clinical practicum?
-   At what point in time in your nursing degree did you complete this practicum?
-   What do you think contributed to your feeling prepared/not prepared for this practicum?
-   What is your perspective on the timing of your practicum within your degree as a whole?

Question 3: Tell me about the first day.
-   What was it like when you first came onto the unit?
-   Tell me about meeting your first client.
-   What experiences or situations stood out to you in the first few days of your clinical practicum?
-   Did anything surprise you?

→ What was it like working with your first client(s)?
-   *Based on participant responses:* What was _____ (i.e. challenging, interesting, etc.) about it?
-   Can you tell me about one instance in which working with a client was _____?
-   Did you have any experiences with clients that were the opposite (*expand based on participant responses)*? What was this experience like?

Question 4: What stands out for you when you think back on your practicum?

→ Are there any clients or client interactions from this practicum that stand out in your memory? Tell me about this person.
-   What about this person do you remember? Are there particular conversations or events that stand out?
-   What was it like interacting with this individual?
-   What was it like providing nursing care to this individual?
-   Why do you think this person/situation stands out to you?

→ Tell me about some of the challenges that you encountered in your clinical placement.
-   Did any situations or events occur that upset you? What happened?

- Did you encounter any difficult or challenging clients or client situations? Tell me about your experiences in working with this client. What happened?
- Did you experience any challenges in providing nursing care to a client or client population? Tell me about those challenges.

Question 5: During your clinical practicum, did you talk to anyone in your life about your experiences within the placement? What were these conversations like?
- What stories or types of stories did you tell?
- What was this person's reactions?
- *If participant spoke to classmate:* How do you think your experience compares with others' in your class?
- *If participant spoke to a non-nurse/nursing student:* What was it like for you talking to someone outside of the nursing profession about the practicum/individuals with mental illness?

Question 6: Since this clinical practicum ended, have you worked with any clients with mental illness in other settings? Tell me about those experiences.
- Tell me about this client.
- What was it like providing nursing care for this client?
- Were there any challenges that arose in providing care? What happened?
- What do you think it might be like providing nursing care for clients with mental illness in future clinical placements? In your preferred area of practice for your career?

→ After completing the mental health clinical practicum, is there anything that worries or concerns you about providing nursing care to individuals with mental illness?
- Why does that concern you?
- Have you had any experiences in your practicums that have caused you to worry about this?

Question 7: What are your impressions of mental health nursing? What do you think it would be like to work as a mental health nurse?
- What do you think you would like about working as a mental health nurse? Or dislike?
- Would you choose to work in mental health nursing? Why/why not?

Question 8: If a new nursing student wanted to know about working with clients with mental illness and asked you to give them an example, which client would you talk about? Tell me about that person.
- Why did you choose this person?
- What do you think this person's story tells us about mental illness?
- How do you think this story would benefit a new nursing student?

Question 9: What recommendations would you have for students in this practicum going forward?

➔ **What were some of the take-aways for you from the course?**

Wrap-Up Demographic Questions
- Age
- Gender identity
- Race/ethnicity
- Educational background (degree? previous studies?)

CONSENT FORM
Nursing students' experiences in mental health practicums: A narrative inquiry

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Co-Investigators

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This research is being conducted by Allie Slemon for the thesis component of the Master of Science in Nursing (MSN) program at UBC. The resulting thesis will be public document.

STUDY PURPOSE

The purpose of this study is to explore the experiences of UBC undergraduate nursing students in their mental health clinical placements.

You are being invited to take part in this research study because you have completed the UBC Bachelor of Science in Nursing (BSN) program's N335 Mental Health course, including the corresponding clinical placement, within the last 12 months.

STUDY PROCEDURES

If you decide to take part in this study, you will be asked to participate in one in-person interview conducted by Allie Slemon. This interview is expected to take between 60 and 90 minutes and will take place in person at a mutually agreed upon time and location. With your permission, the interview will be audio recorded.

STUDY RESULTS

The results of this study will be reported in a graduate thesis, which will be a publicly available document. Additionally, results may also be published in academic journal articles. As a study participant, you may also choose to receive a summary report of the research findings.

POTENTIAL RISKS

Some of the questions asked by the researcher in this study may be sensitive in nature and may elicit feelings of distress or remind you of difficult experiences. You are able to decline to answer any question at any time. Additionally, you may pause the interview (including the audio recording) at any time, and may withdraw from the study during or after the interview. If you choose to withdraw the audio recording will be permanently deleted and none of your information will be used in data analysis or in writing up the results. Your participation in this

study will not impact or influence your educational progression, grading, or class standing in any way. If you become distressed following the interview, I encourage you to seek support. On-campus student services include UBC Counselling Services (604-604-822-3811). Contact information and additional services can be found at https://students.ubc.ca/health-wellness/mental-health-support-counselling-services.

POTENTIAL BENEFITS
Your participation in this study will offer you an opportunity to discuss your experiences in the BSN mental health clinical placement in a safe, confidential space. The data collected in this study will provide information about student experiences in this setting, and may benefit future nursing students through the development of educational strategies for teaching mental health content and supporting students through mental health clinical placements.

CONFIDENTIALITY
To ensure confidentiality, you will be asked to provide a pseudonym which will be used to identify you throughout the study documents including publications.

All documents including audio files and transcriptions will be identified only by your pseudonym. Electronic files will be password-protected and kept on secure servers, and hard copy documents will be kept in a locked filing cabinet. Only myself and the investigative team will have access to the original files, identified only by your pseudonym. Information that discloses your identity will not be released without your consent unless required by law. All consent forms, audio recordings, and transcriptions will be destroyed after 5 years.

CONTACT INFORMATION
If you have any questions or concerns about the study purpose or procedures, please contact any member of the research team. Names and contact information are listed at the top of this document. Additionally, you may contact Allie Slemon at ubc.mhnursingstudy@gmail.com.

CONTACT FOR COMPLAINTS
If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598.

PARTICIPANT CONSENT
Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact on your class standing.

Consent for participation in this study will be verbal and will be established at the beginning of the interview. You will not be required to sign your name to indicate consent and your full name will therefore not be kept on file. You will also be asked to verbally confirm that you have received a copy of this consent form for your own records.

☐ I wish to receive a summary report of research findings once the project has been completed.

This document may be sent to:

Email Address: _____

Mailing Address: _____

                              _____

(Signature not required.)