

II. Nurses' Training in Mental Health Aspects of Public Health Field Work

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✿ It is difficult to define the role of the public health nurse in the mental health field, because it involves many different functions and touches upon areas as divergent as the understanding of possibly unconscious motivation in vomiting during pregnancy and community education for water fluoridation. Considering the wide variety of problems with which the public health nurse may have to deal, the difficulties in formulating educational goals to be achieved through undergraduate and graduate training programs become all too apparent.

However, in all phases of her work the nurse interacts with people, and such interaction always has mental health implications. We may consider the mental health of the individual as a balanced state of homeodynamic and interpersonal processes producing a general sense of well-being and personal gratification while the person engages productively and harmoniously in a social role. Consequently, I propose to discuss certain facets of the entire nursing career in terms of different roles and interpersonal situations, because this, I believe, is "mental health" in operation. Moreover, in public health practice effective technics and skills must be mastered by a large number of personnel so that we need not concern ourselves here with the education of the relatively small number of specialists—important as that may be in itself.

In any professional career we can distinguish two general facets in the learning process. One is the teaching program which we might call the content of a course or courses, usually made

explicit in catalogues and detailed schedules. The second, but not secondary, aspect of the training experience is intangible and is rarely made explicit and then only in very general terms, such as the lofty ideals of a profession. This facet concerns the learning of a role through barely conscious copying of or identifying with one's preceptors. Thus the student nurse becomes a nurse not only by acquiring a vast amount of knowledge and proficiency in many technical skills, but also by learning the many formal and informal details that constitute the "role" of the nurse—her characteristic interaction with patients, peers, and other health personnel. Thus, the first proposition in nurses' education is that of "becoming" a nurse and thereby a member of the health team.

Second, the nurse functions as the eyes and ears of all health services. This is obvious in the hospital where she is the close observer of symptoms and of clinical events which she interprets and reports appropriately. However, the hospital nurse reports to a member of the same agency while the public health nurse carries out this function in a setting where in addition to reporting to her own agency, she may also have to communicate effectively with other community services about the same problem.

Third, the nurse learns skills in relating to patients, and to people generally, beyond the technical aspects of her job, and beyond the "role learning" to which we alluded above. There should be explicit instruction and acquisition of competence in the dynamics of interpersonal processes.

Fourth, the nurse and especially the public health nurse has to operate skillfully with groups, especially families, which often requires a different approach from relating to a single person. Moreover, to function effectively as educators, nurses also have to master group techniques not related in any strict sense to technical maneuvers of nursing.

A fifth role for the nurse in the mental health field should be mentioned briefly. Here, nurses may be in a strategic position to collect epidemiologic data and to identify relevant factors or help eliminate irrelevant ones. This role is largely hypothetical at this time in view of the rarity of well planned research in community mental health, but as it grows, this function will assume increasing importance for public health nurses.

Last, there is the psychiatric specialist in nursing who functions in mental hospitals providing service and education, as educator in nursing schools or as consultant in agency training programs.

Preparation—As is well known, professional education for nurses is merely 120 years old, and it is noteworthy how completely we have come to accept the process of nurses' training as inseparable from the hospital setting. However, nursing as an activity has been known at least throughout the Christian era. These forerunners of our nurses functioned freely in the community and only in the 17th century were they encouraged by St. Vincent de Paul to extend their activities from homes to institutional settings. At a time when hospitals were unknown and two centuries before the innovation at Kaiserswerth became the model for modern nursing schools, the sisters were urged to go into the poorhouses, orphanages, and similar institutions of the sick, disabled, and unfortunate. Thus the modern public health nurse is more in line with her "non-professional" forerunners than is the

institutional nurse. However, as the basic education of the nurse is bound to the hospital at present, we cannot limit ourselves to the particular preparation of the public health nurse in considering her function in mental health work. We have to think of all nurses and all their preparation, basic and advanced. In this connection we can benefit from observation and understanding of the nurses' roles in the past, just as we benefit from a thorough understanding of the role of the "old fashioned family physician" whose departure is so often regretted and lamented. I do not propose that either profession return to the training and mode of operation of past centuries, but rather stress that we possess today a body of knowledge which permits us to inculcate these attributes of our predecessors effectively and efficiently in addition to all other advances in the medical and nursing sciences.

To be a nurse requires not only the successful completion of a three- or four-year school curriculum, but a decision on the part of the individual nurse concerning the role of nursing in which she wants to spend her life. The choice of field has important implications on the kind of life the nurse will lead during and after working hours, regardless of what motivation underlies her nursing career. There are generally two interpersonal areas in her work career in which the nurse can seek for satisfaction and from which she may derive necessary security. One source is the nurse-patient relationship, be it an individual patient, groups of patients, or the family as is often the case for the public health nurse. The other

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area is that of her peers, her teammates, or her students. While these areas for personal investment are not mutually exclusive, it is clear that the first is dominant in private case nursing, whereas the second might be dominant for a nurse consultant in the field. There are many other roles open, that of administrator, professional educator in the nursing school, the nursing specialist for a particular disease or disease group, the nurse as lay educator, and the public health nurse. I have already mentioned that for her the entire community may be on the team, especially if she is concerned with educational projects in the community, which almost always happens if one is actively engaged in the promotion of mental health. Thus, community-wide or county-wide assignment offers a great variety of interpersonal experiences for the public health nurse, but if she cannot gain satisfaction from these it can also lead to isolation and loneliness. In order to function effectively from the mental health standpoint the nurse must enjoy a reasonable degree of mental health herself, professional education aside.

Whether nursing schools should give more time and consideration to the preparation for public health work is a question worth debating, but we must survey mental health aspects of existent school curriculums regardless of the student's ultimate goal. In this consideration I shall not include the usual time allotted to psychiatric nursing which ranged from 150 to over 300 hours in a sampling of seven schools. This education in mental illness proper is designed to acquaint the student nurse with the character of mentally disturbed patients and with their particular symptoms, important to permit her to function as the eyes and ears for health services. For public health nurses this experience is especially important today when an increasing number of psy-

chiatric patients on drug therapy may live in the community instead of being isolated in hospitals. However, a case of typhoid fever or rheumatic fever seen in and nursed in the hospital teaches us nothing about the conditions through which this illness arose: the same is true of mental illness. Only here it is vastly more difficult and complex to discern conditions that breed or contribute to mental ill-health than is the case with, say, sanitary defects which may cause dysentery.

I shall indicate only a few conditions of epidemiologic significance, such as the relationship between the incidence of psychosis, especially schizophrenia, and social class, or between the same factors and the adjustment difficulties of the aged. On the other extreme of life we find nursing and rearing technics in the neonatal and infant period, the impact of school policies, and relationships in the family among the many complex phenomena concerning which nurses can make valuable observations. It is more important that we focus upon technics for the detection of such relationships which the nurse can utilize, and it is here where we run into a deficiency in current nursing school practices.

This leads to our second proposition, namely, how to be the eyes and ears in the mental health field, especially with regard to case finding. The detection of early or incipient maladjustment which may indicate the potential development of severe mental illness, either in a particular patient or in a member of the family, requires what I shall term "interpersonal process skills." We hear a great deal about the "use of self in nursing" as an important skill in all nursing. Instead of defining these skills, it may be more meaningful to give an illustration. The nurse who lives with a family through a prolonged illness has opportunities to observe the patient and the entire family. She will

become wise in the ways of this family and revise her approach and technics of handling situations and people. If she did not, either the nurse or the family would probably find the situation so uncomfortable that she could not last at it very long.

Depending on her capacity to observe and understand her own reactions and the family's, she will accomplish the job intuitively or more designedly, thinking it through and adopting certain roles and technics. She may make decisions about attempting modification or clarification of attitudes and behavior which she considers disturbing to the patient or to others. For example, it would be relatively easy for her to discover after some weeks that the patient's husband is a peculiar person, perhaps neurotic or psychotic, or just a member of a particular sect well adjusted in this subgroup, but that the subgroup is somewhat deviant in the entire community. It would be easy for her to report such findings—if they seemed pertinent or significant—to the appropriate agencies or agents, the family physician for instance. In contrast, the public health nurse has to gather and evaluate such information in a very short period of time incident to the performance of her nursing tasks. Thus, clearly, she cannot just let time work for her, but requires experience and facility in making reliable deductions from relatively few observations during brief contacts. To accomplish this there must be effective communication between the nurse and the family and the nurse and her "team."

The following example will illustrate some of the problems in communication. An unmarried girl pregnant for five months reported to her caseworker that she had no idea that she was pregnant, but that the putative father knew it right away, because he told her he had morning sickness immediately following the night of conception. The un-

educated youngster saw nothing strange or impossible in her account. She accepted being pregnant only on the basis of the father's insistence instead of correctly interpreting her menstrual irregularity. Denial of pregnancy under such circumstances is common and occurs for conscious and unconscious reasons which are quite similar for many of these girls. The caseworker apparently was not familiar with such youngster's propensity to disregard the obvious, and she heard and thought only of the incorrectness of the client's statement and tried to convince her that men do not suffer morning sickness. An experienced interviewer would have understood that the girl had some need to deny or "not see" the pregnancy, and that this indicated the presence of emotional conflicts which had to be dealt with as such. If one pays attention only to the intellectual aspects of the statement one gets into a fruitless argument, the antithesis of promoting a confidential relationship. Obviously, from any health standpoint, the girl needs help with her pregnancy and the related emotional problem, and not a lecture.

Without giving a complete account of interviewing skills, I wish to stress that they, like any other, can only be learned in doing. No physician or nurse finds the stethoscope useful until she has heard what to listen for with the help of a demonstrator or tutor. Teaching interviewing or how to listen with the third ear, as it has been epitomized, is an art best developed by social workers. Medical schools have included a great deal of social work experience and technics in the courses concerned with the examination of the patient, and students continue to refine their skills in the clinical years with the help of psychiatrists and social workers. The same cannot be reported about nurses' education. The supervisory system developed by schools of social work and by community agencies, copied to a

minor extent by medical schools, is almost unknown in nursing schools. I refer here only to the official curriculums, not to the actual bedside teaching and supervision, because many supervisors are no doubt every bit as helpful as is the casework supervisor in daily work with students. But this is done, one might say, outside, despite, or behind the curriculum, rather than as part of it. The supervisor system as practiced in social work fulfills two functions. It imparts technical skills pertaining to the interviewing process through suggestions and examples, but, equally important, it provides an opportunity for dealing with the students' feelings and reactions to the many traumatic and emotionally disturbing situations to which any student in the health field is exposed. Unfortunately, student nurses instead of being given opportunity to discuss their own feelings and reactions, such as to the first experience of seeing a patient die, are often informed by their superiors that they might as well get used to this and they will get another moribund patient as soon as one is available. In view of this kind of approach to the sensitivities of the student nurse it is not surprising that a recent survey of attitudes of medical students and nurses found that both become less responsive to emotional difficulties in their patients and less aware of what has been called the human factor in medicine as their education progresses.

Preparation for public health work is hampered by the hospital setting in which most education occurs. In seven schools the programs devoted an average of almost 1,000 hours to classroom teaching, 1,700 hours to hospital bedside nursing, and only a little over 200 hours, mostly theoretical, to such matters as public health, community agencies, and mental health principles (personality development, family hygiene, etc.). Thus on the average less than 10 per

cent of training time is devoted to the setting in which public health nurses will operate, and a good deal of this 10 per cent is also taught inside the hospital. Only a fraction of it, in some schools, is actually spent in community agencies in close association with a tutor or supervising person.

Aside from the obvious desirability of gaining active experience in a particular setting, the hospital experience carries with it some traditional handicaps for the nurse as a person. It has been said that the nurse does not know how to function on a team, and we stressed earlier how significant team integration can be for the nurse's own adjustment. Of course, the nurse is on a team, whether hospital or health department, but to be on a team implies participation. For the sake of emphasis and brevity I may overstate the case somewhat. On the hospital team the nurse often occupies a dependent and relatively silent role. Traditionally she takes orders and when she dares ask questions can easily earn epithets such as "aggressive" or "insubordinate." We doctors know from experience how we react resentfully to the nurse who "knows better," particularly when we are just out of medical school, and also how we resent it when the nurse who does know better fails to tell us so. On the other hand, I can report from personal experience that to remodel the hospital situation in such a way as to facilitate a participant role for the nurses is a task of considerable magnitude, because nurses are reticent to express opinions, let alone feelings, in mixed staff groups. I have been told by health officers that it is also a difficult task to elicit more than a formal report from freshly graduated staff nurses in department meetings.

Again, when we think of the nurse operating in relationship to the entire family, we see that the average program does little to prepare her for such ac-

tivity. In this country families do not move into the hospital with the patient, and such relatives as may be regular visitors or even partake to some extent in the nursing of the patient have very little contact with nurses or student nurses. Knowledge of family relationships and family dynamics are not easily acquired from books, in fact, few books are available concerning this topic. In this connection, the dearth of family data is one of the major deficiencies in our current figures on the heredity of mental illness for they are based solely on hospital records and hence on such information as can be given by the patient himself or by immediate members of the family that are available. It means that unless mental illness reaches a hospitalizable stage, it is not recorded, and better statistics will have to come from trained personnel who have access to the family for one reason or another. There is no other health discipline with 46,000 field agents educated and wont to enter homes, as are the public health nurses. Furthermore, identification of potentially pathogenic foci in the family, in the classroom, or in industry is essential to the prevention of further disability for the patient and of maladjustment of those closely associated with him. The public health nurse can participate effectively in this work only if prepared to recognize pertinent problems and if she has learned how to deal with them in a professional manner.

Recommendations—This discussion must not be construed as an evaluation of current nursing school programs, but only as an enumeration of certain problems in nurses' education for mental health work. I am not competent to advise or judge to what degree nursing school curriculums should be revised, and in particular I cannot assess the strengths and merits of the current programs. I am aware that much thought has gone into these programs

already and that the nursing profession is not standing still and is currently exploring and probing alternate methods and goals of training, some having to do with mental health considerations. In general the college program is geared toward broader educational objectives and therewith offers more from the mental health standpoint than do the programs run by hospitals.

It may be justified, however, to recommend that consideration of future educational programs include the points raised here. In particular, the merits of greater emphasis on educational experience in community agencies other than the hospital should be examined critically.

Proficiency in interpersonal operations with disturbed people, commensurate with current knowledge, must be achieved through practical experience under close supervision. This is admittedly a difficult task in view of the shortage of nursing personnel in all fields, nursing school faculties included.

The deficiencies pertaining to mental health in undergraduate training must be overcome in the field. It is also clear that program revisions deriving from these points, if they were to be considered valid by those in charge of training programs, could be implemented only gradually. Thus, for some time to come health departments and community agencies will have to supplement basic education with inservice training. These programs provide an educational atmosphere desirable in any agency. However, inservice programs have their own difficulties—which cannot be considered here. Personnel of varying backgrounds and skills may be available for these programs, but their success depends much less on the particular discipline or educational experience of the person involved than on the personality and adaptability to the particular agency to which he or she is assigned. The postgraduate psychiatric

training programs provide us with mental health consultants for health departments and other agencies. Though community agencies may use psychiatrists as consultants to good advantage, the typical psychiatrist does not function with the same effectiveness in the health department. While psychiatrists help with lectures and with case conferences, it must be said that the nurse does not as readily identify with the doctor or the psychiatrist as does the social worker who has a particular affinity to psychiatrists and the psychiatric way of proceeding. However, the social worker also learns more readily from a case-work supervisor, just as the nurse learns best from a nurse.

Each profession develops its own informal ways of identification and communication and both these psychological processes are prime requisites for effective teaching and learning. Experience has shown that an expert in one field cannot necessarily teach as effectively the students of another discipline as can the teacher of the same discipline who by comparison may have only a smattering of knowledge in the other subject. Besides, familiarity with the setting and structure in which students have to work is as important as theoretical expertness, and this is particu-

larly true when the work involves emotional reactions. In the field of mental health one's own emotional reactions are of great importance—"use of self"—and we carry with us not only our cultural heritage but also our cultural prejudices. Thus to become a skillful worker in this field entails awareness of at least some of one's own blind spots and prejudices as well as some ability and an opportunity to overcome them or to disregard them where indicated. The public health nurse and every nurse must be so prepared for her job—by nurses.

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