The opening of a school of nursing at McLean Hospital in Boston in 1882 is generally accepted as the beginning of the specialty of psychiatric nursing. This was the first school of nursing in a psychiatric setting. In 1920, Macmillan Company published the first psychiatric nursing textbook, Harriet Bailey’s *Nursing Mental Diseases* (Bailey, 1920). This first textbook focused on the physical care of the mentally ill rather than on the psychosocial aspects of patient care.

It took national legislative action finally to commit nursing education firmly to the development of psychiatric nursing theory and concepts of psychiatric nursing intervention. The National Mental Health Act of 1946 provided this initial impetus. Authorizing the establishment of the National Institute of Mental Health, it provided federal training funds to undergraduate programs of nursing to integrate mental health concepts throughout the curriculum and the establishment of graduate programs in psychiatric nursing. Most of the leaders in psychiatric nursing today were recipients of stipends available to nurses under the Mental Health Act.

In 1952, Hildegard Peplau’s *Interpersonal Relations in Nursing* was published (Peplau, 1952). This textbook presented the first theoretical model of psychiatric nursing practice. It focused on the therapeutic role of the nurse in a one-to-one relationship with mentally ill patients. Peplau and some of her early students travelled throughout the country educating nurses in formal and informal settings as to the benefits to the patient of clear and appropriate nursing interventions—especially working with those nurses practicing in large public institutions.

The advent of psychotropic drugs in the mid 1950s permitted greater access to more disturbed patients. Control of patients by physical restraints and seclusion gave way to discussion of situational problems of patients with nurses.

By 1963, there were two nursing journals focusing on psychiatric nursing, *The Journal of Psychiatric Nursing* (now *The Journal of Psychosocial Nursing and Mental Health Services*), and *Perspectives in Psychiatric Care*. These journals provided psychiatric nurses the opportunity to share scholarly endeavors, to provide descriptions of creative and innovative intervention techniques, and to begin to document psychiatric nursing’s development.

**Riding High**

Through the 1960s and into the early 1970s, psychiatric nursing seemed to be riding high. Bright, dedicated nurses were entering the field.
Psychosocial nursing has developed from a menial, custodial-type role toward a viable, scientifically-directed practice.

It took national legislative action finally to commit nursing education to the development of psychiatric nursing theory and concepts of psychiatric nursing intervention.

and Mental Health Nursing Practice of the American Nurses’ Association published the Statement on Psychiatric Nursing Practice. Changing trends and complex developments in the mental health field gave rise to a revision of this statement in 1976. In this document, psychiatric nursing is defined as a “specialized area of nursing practice employing theories of human behavior as its science and purposeful use of self as its art. It is directed toward both preventive and corrective impacts upon mental disorders and their sequelae and is concerned with the promotion of optimal mental health for society, the community, and those individuals who live within it” (ANA, 1976).

Psychiatric nurses derive this definition from a generic base in theory and practice of nursing and from specific philosophical beliefs related to psychiatric nursing practice. These include nursing’s commitment to holistic care, a primary focus on assisting individuals to attain their highest level of health possible, an understanding of the relationship and integration of biophysical and social systems theories in nursing practice, and the use of the nursing process to guide the problem-solving method.

Psychiatric nurses developed colleague relationships with professional peers in psychiatry, psychology, and social work. Nurses were appointed to governmental advisory panels and were named as one of the four core mental health disciplines in the report of President Carter’s Commission on Mental Health (The President’s Commission on Mental Health, 1978).

Significant psychiatric nursing contributions were identified thus within the nursing profession, in nursing educational systems, in interprofessional activities, and in the governmental political systems. Though it is impossible to separate these aspects into mutually exclusive discreet units, it will help to elucidate how changes in each aspect have worked to dilute the influence of the nurse-patient relationship in psychiatric nursing. A multitude of political, psychiatric, nursing, and educational changes have changed the picture for psychiatric nursing in 1986. The psychiatric nurse-patient relationship seems out of focus.

Deinstitutionalization

Legal judgments in the early 1970s changed the professional, institutional, and community landscapes of psychiatry. These judgments set forth a patient’s right to treatment, minimum standards of care, and the right to the least restrictive conditions necessary to achieve the plan of care. These mental health laws, spelling out increased patient rights, have had the effect of decreasing the power of the professional and non-professional staff to medicate, dictate treatment, and commit patients for long periods of time.

These laws in concert with other political movements paved the way for the massive deinstitutionalization of mental patients to community systems unable to absorb them. Untreated and underserved mental patients, stigmatized and victimized, hopeless and often homeless, seem to be ever-present, visible evidence of the failure of the professional psychiatric community. Treatment programs in the past were probably not more effective than today’s programs, but institutionalized patients were much less visible to the public.

A parallel governmental process was severe cutting of clinical training monies for psychiatric nurses and the other mental health disciplines. There were increased funds available for research related to psychopharmacology, diagnosis by lasers, CAT scanners, PET scanners, and for other biological treatments (at NIMH, such programs are dubbed “star-wars medicine”). It does not seem farfetched to predict a resurgence of interest in psychosurgery in the near future.

This biomedical interest at the national level has had a profound effect on medicine and nursing. The American Psychiatric Association has released reports related to the
"remedicalization of psychiatry," in which psychiatrists should act more like real doctors and less like social workers. Psychotherapy—though still a tolerated activity—would no longer be seen as the heart of psychiatric medicine.

In a recent report on medicine in America, Derek Bok (1984), the president of Harvard University, discussed what it means to think like a doctor:

At the heart of this conception is a view of human disease as a scientific phenomenon consisting of deviations from a biomedical norm. Such deviations are thought to result from a determinate cause or set of causes that are somatic or biochemical in nature. It is the physician's job to ascertain these causes by powers of observation supplemented increasingly by diagnostic tests and other technological aids, and then to cure the ailment or at least alleviate its effects through surgery, medication, or some other course of action . . .

The view of mental illness as a discrete somatic or biochemical problem affects the nurse-patient relationship significantly. The advent of the phenothiazines in the late 1950s and early 1960s was an exciting event. These medications would make patients more amenable to the real work of psychiatric nursing—psychotherapy and psychotherapeutic use of the milieu.

In this new conceptualization, reliance on psychopharmacology and biomedical theories of mental illness, there is increasing reliance on medication as the primary treatment. Less attention is focused on understanding patient behavior and learning psychotherapeutic intervention skills. There seems to be decreased tolerance for deviant behavior; medication is used to bring it into line. Similarly, curiosity about human behavior seems to be waning.

The psychiatric nursing role is diminished by a primary focus on monitoring medications and their side effects. Interdisciplinary team meetings focus on drug levels—polypharmaceutical interventions and reports of behavior changes resulting from biomedical interventions. The therapeutic milieu is utilized to attain medication and behavior compliance and is not often utilized as a primary mechanism for patients to learn more about themselves and their interactive coping behaviors.

Therapeutic Environment

The practice of psychiatric nursing in the milieu should be characterized by those aspects of nursing practice that involve interpersonal relationships with patients in present-oriented, here-and-now activities. In this regard, a major focus becomes the establishment and maintenance of a therapeutic environment that is attractive, comfortable, and humanistic. Interaction within the milieu presents opportunities for nursing intervention to alter maladaptive behavior patterns. Since nurses spend more time with patients than do other mental health professionals, they are in a unique position to assist in developing more effective role relationships and experimenting with more effective styles of communicating.

Because of a generic nursing background, the nurse has the knowledge and skill to assess and care for physical health problems including the many and complex responses to psychotropic medications, medical treatment regimes, and other somatic treatments. The nurse is able to assist patients and their families through health teaching in relation to physical and emotional concerns. Nurses instruct the patient and family about psychiatric treatment, drug responses, nutrition, stress, and other related health questions.

Many severely regressed patients require assistance with such activities of daily living as eating, bathing, dressing, and toileting. In helping patients to gain greater independence in these areas the nurse accepts and utilizes a surrogate parent role. In this care, given skillfully and humanely, the nurse promotes a growth-producing experience that can be carried by the patient into other aspects of behavior.

The nurse also engages individual patients or groups of patients in brief counseling focused on the present concerns expressed or demonstrated. A problem-solving approach is used to assist in the identification and specification of the problem and in an effort to assist the patient in finding more effective solutions. In this role the nurse is a model of clear and articulate communication. The nurse gains expertise in this important role through supervision of nurse-patient relationships with a clinical specialist in psychiatric nursing.

Nursing education programs at both the undergraduate and graduate levels have also changed dramatically over the years. Some of the changes are in response to the political and medical issues raised above—others have to do with intraprofessional goals.

Colleges of nursing have become more autonomous entities with curriculum plans built around conceptual frameworks of nursing theories. Nursing models of health promotion and illness prevention have replaced medical models of the diagnosis and cure of deviations from health.

Undergraduate nursing programs are based on integrated theoretical frameworks in which psychiatric nursing experiences are extremely limited and in some programs not identifiable. There is a general lack of understanding about the differences between psychosocial aspects of patient care and psychiatric nursing experiences with mentally ill patients. Because all nurses need a focus in psychosocial nursing interventions, all faculty believe they are qualified to teach these skills. In many programs, therefore, faculty teaching the psychosocial/psychiatric nursing component may not be psychiatric nurse specialists. In fact, in many integrated undergraduate programs,
faculty are seen as generalists and as interchangeable in the varied clinical experiences.

**New Nursing Myth**

Since psychiatric nursing experience is limited, if at all available, student nurses do not have the time and supervisory support necessary to look at their own fears, anxieties, and stigmas about mental illness. More attention is given to the biological theories of mental illness and the role of psychoactive medications. Less attention is focused on the nurse-patient relationship, which requires close preceptorship, introspection, and analysis of interpersonal data. Since clinical experience in all areas of practice has been shortened in baccalaureate programs, students feel anxious, unprepared, and incompetent around all the tubes, bottles, and machines. Faculty underline these natural concerns with the development of a new nursing myth: in order to be a "real nurse" the new graduate should work for at least a year on a medical-surgical unit. Psychiatrically sensitive, introspective young nurses may be lost to the field of psychiatric nursing.

In fact, the numbers of nurses choosing psychiatric nursing as a specialty area has declined dramatically in the past few years. This is probably a multifaceted problem grounded in decreasing federal funds for advanced clinical training, inadequate undergraduate psychiatric nursing experiences, lack of well-prepared, articulate faculty role models, and other specialty areas in nursing being identified as areas for more autonomous roles in the health care arena.

Psychiatric nursing curriculum in undergraduate programs should include theoretical material on psychiatric nursing phenomena and psychodynamics of behavior as well as specific supervised clinical experience with mentally ill patients. A seminar designed to enhance self-awareness and curiosity about human behavior in the student nurse is also most meaningful. Psychiatric nursing faculty members should be knowledgeable, competent, and articulate spokespersons for excellent psychiatric nursing practice. A broad understanding of the political, medical, and nursing issues as they relate to psychiatric nursing practice is essential.

Clinical specialization in psychiatric nursing is attained through formal education at the master's level. Most programs currently require three or four semesters of full-time study. Many require the student to design and complete a research project or thesis. The intense theoretical and clinical aspects of the program provide depth and breadth in psychiatric nursing knowledge and skill. Most of the programs prepare psychiatric nurses to work with a variety of psychiatric patients in a variety of settings including institutions, clinics, homes, and community mental health centers. Some, however, specify developmental age groups for specialization, ie, children, adults, geriatrics.

The theoretical base for psychiatric nursing practice has been traditionally derived from the social, biological, and behavioral sciences and psychiatric medical theories. Recently, there is more evidence of the development and utilization of nursing theory in the formulation of models of psychiatric nursing practice.

Just as undergraduate nursing programs have changed, so too have the graduate programs for advanced preparation of psychiatric nursing specialists. Decreasing federal funds not only cut off the stream of students seeking graduate education, but also reduce program budgets generally. Clinical practice and supervision, the pride of psychiatric nursing leaders, is the most expensive part of a good training program. Often utilizing a curriculum reorganization around unifying nursing theories or conceptual frameworks as justification, programs decrease specialized content and close supervisory preceptorships in favor of generic or core nursing content to be taught in more cost-effective lecture halls to all graduate students. In some, formerly excellent clinical programs in psychiatric nursing, specialized content can no longer be identified. Whereas in the past psychiatric nurse specialists were seen as the nurses able to carve out unique and autonomous nursing opportunities, more recently nurse practitioners and nurse midwives receive these accolades.

**Solutions and Challenges**

Solutions to these problems will require a concerted effort by nurse educators and nurse administrators. Psychiatric nursing educational experiences need to be improved at both the undergraduate and graduate levels. Barriers to full utilization of psychiatric nursing potential need to be removed.

There are many challenges for the future. Psychiatric nurses must further develop theoretical constructs or models to increase the understanding of psychiatric nursing phenomena. The development of a taxonomy of nursing diagnoses is presently being undertaken. Some psychiatric nurses will use this taxonomy in conjunction with DSM-III. Theory building is based on sound research findings. Research activities for psychiatric nurses will include development and refinement of knowledge, experimentation with creative approaches to practice, development of instruments for the measurement of nursing phenomena, the nurse's action, and the patient outcomes. More doctoral programs that focus on psychiatric nursing clinical practice and research are needed to provide the theoreticians and researchers to work on these tasks.

Documented evidence of thousands of mental patients unserved, underserved, or inappropriately served...
requires innovative nursing approaches to these populations at risk. Several traditional nursing functions, including ability to assess illness, knowledge of somatic therapy, crisis management, family-oriented treatment, and utilization of the milieu favor psychiatric nurses taking a lead-

Monitoring and analyzing issues in educational, political, and interdisciplinary systems must be continued for psychiatric nursing to overcome the barriers to full practice and to meet the challenges of the future.

ership role in the holistic management and care of these stigmatized populations. Increasing interest in mentally-disturbed children and youth, psychogeriatrics, and the chronically and severely mentally ill should give impetus to demonstration projects for creative nursing management.

Nurses who have sought to practice in an autonomous manner in most cases have been denied access to and authority within health care institutions and in reimbursement mechanisms. Psychiatric nurse specialists now take their place as psychotherapists next to their interdiscipli-

nary colleagues. There is hardly any controversy about this as a psychiatric nursing role for those appropriately prepared and certified. The competition becomes evident in the financing arena. There was no particular concern as long as nurses cared for the poor, indigent, or chronically ill elderly patients. Only as psychiatric nurse specialists in private practice have made advances with middle class clientele have their requests for autonomy and

appropriate reimbursement mechanisms been questioned and in many cases prevented by the medical community.

Should psychiatric nursing focus on the care and treatment of the mentally ill or the worried well or both? Are different clinical training programs required depending on the focus? In thinking about this challenge, we should begin to evaluate the place of role-blurring in defining our practice area. Defining precisely how our psychotherapy practices differ from our interdisciplinary colleagues is difficult. Theoretical material and inter-

vention approaches are similar. In the private practice model we compete for similar kinds of clients.

In institutions for the care of acutely or chronically mentally ill patients we have turned over many of our nursing activities—including individual and group counseling—to non-professional personnel. As we continue to blur up and down the psychiatric ladder, will we become unidentifiable and/or unnecessary in the field?

There are two additional trends in the field that we will need to monitor closely. They are too new to determine what effects they may have on patients and professionals. I believe they each have the potential for motivating some major imbalances in the present system of care. These two trends are the increase in private, for-profit psychiatric hospitals and the varied systems of prospective payment mechanisms being implemented.

In its first century, psychiatric nursing developed from a menial, custodial-type role toward a viable, scientifically-directed, meaningful practice. Much progress has been made. Monitoring and analyzing issues in educational, political, and interdiscipli-

nary systems must be continued for psychiatric nursing to overcome the barriers to full practice and to meet the challenges of the future.

References


**Psychiatric Nursing: 1986**

**KEY POINTS**


1. Significant psychiatric nursing contributions can be identified within the nursing profession, in nursing educational systems, in interprofessional activities, and in the governmental political systems.

2. Focus on psychopharmacology and biomedical interventions as the primary treatment for mental and emotional problems has had a profound effect on nursing education and nursing practice environments.

3. A decreased emphasis on specific psychiatric nursing theory and practice in undergraduate nursing programs and loss of federal funds for advanced clinical training in psychiatric nursing has diminished nursing student interest in psychiatric nursing as a career choice.