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**Nursing Interventions for Psychosis and Other Mental Health Crises: A
Hermeneutical Phenomenological Study of Nurses' Experiences**

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B.S. Nursing, University of Missouri-St. Louis, 2017

A Dissertation submitted to the Graduate School at the University of Missouri-St. Louis
in partial fulfillment of the requirements for the degree
Doctor of Philosophy in Nursing

May 2024

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Dedication

This dissertation is dedicated to nurses everywhere who constantly put the needs of the patients they care for over their own needs. The people of this profession time and again make the choice to go into harm's way, are sometimes harmed, and then willingly go back into harm's way. All for the sake of keeping the population healthy.

ACKNOWLEDGMENTS

There is a well-known saying that it takes a village to raise a child. I think the same concept can be applied to a PhD Student. The journey from the first semester to submitting a dissertation is not a singular accomplishment achieved on the efforts of just one person. With this in mind, I would like to acknowledge and thank the people who have aided and supported me on this quest.

First, I would like to recognize all of the people who will not be named in this section. These are the professionals who help out in large and small ways as students progress through their academic programs. This group includes but is not limited to professors and instructors, advisers, administrative assistants, librarians, registrars, IT personnel, and even peers. None of this is possible without your efforts.

Next, I would like to acknowledge and give thanks to the members of my dissertation committee. In addition to assisting with this project, I had the pleasure of taking at least one core course with each one of these professors. Through them I have learned one or more components of the research process that I have attempted to put together in this dissertation. So, in no particular order, I acknowledge them.

Dr. Wilma Calvert. Thank you for teaching me that details matter, and to always look to the next steps that you will be taking. I also learned much related to quantitative methods through your teachings. These will not be front and center in this work but this knowledge will serve me well in the future.

Dr. Anne Fish. I would like to sincerely thank you for the 30 plus times you handed me back work to revise during the three classes you taught me. Any shortcomings

I still possess in the area of grammar and composition cannot be laid at your feet. I am a better scholar because of my time under your tutelage.

Dr. Julie Bertram. You have my deepest appreciation for all of the guidance and support you have given me on this project. Through your mentorship I have learned that it is ok to be happy with your work and still look to improve on this at the same time. My time spent with you during this project has also reinforced my belief in the value of teamwork.

Dr. Roxanne Vandermause. It is difficult for me to describe the debt of gratitude that I feel for all of the assistance and guidance you have given me throughout my time as a PhD student. I simply do not think I would have made it to this point without your support. Your belief in me made a world of difference. All that I know related to the hermeneutic methodology I have learned through you. Much of the future research I plan will be done using this dynamic and vibrant approach.

Thank you all.

Abstract

The nursing profession experiences caring for patients suffering psychosis and managing crises events in a way that is unique to all other healthcare providers. A gap in research and literature exists related to this phenomenon. The purpose of this study was to examine the lived experiences of nurses caring for patients experiencing psychosis or some other severe mental health issue. By analyzing the common expressions and behaviors of nurses in situations involving care of psychosis, the meaning of the care giving experience and thus, an understanding of the interactions involved with caregivers in psychosis was revealed. Participants provided experiential, firsthand data on the interventive process as it shows itself in everyday practice. This research was undertaken to address the following questions:

1. How do nurses experience psychotic manifestations of confusion, aggression, and violence in patients they encounter?
2. How do nurses express their experiences and preparation when they must intervene with patients manifesting psychosis or other severe mental health issue?

A Heideggerian hermeneutic phenomenological approach was utilized to answer these questions. Ten nurses of varying ages and years of clinical experience at the bedside were interviewed. Their narratives gave experience rich accounts to the dataset and contributed to three major patterns and eight sub-themes that were identified from analysis.

The three patterns were Being in an Environment of Sudden Chaos, Guiding the Intervention for Security, and Needing to Prepare for the Unexpected. The eight subthemes were: Facing the Crisis, Deciding the Course, Bearing the Weight, Ensuring Safety, Communicating Therapeutically, Getting Invasive, Beginning Unequipped, and Gaining Experience.

Results from analysis found that educational institutions and employers are doing an inadequate job of preparing nurses to intervene in mental health emergencies. Clinical experience and years in direct patient care made nurses better equipped. Along with better education and training, the processes of adapting interventions for psychosis and other severe mental health conditions needs greater methodological research, rigor, and clarity. Employers and healthcare institutions must do their part to ensure nurses feel supported and safe while they develop the nursing skills necessary to effectively manage these crises events.

Prologue

Locating the Researcher

One of the elemental and core components that Heideggerian hermeneutic phenomenology is constructed upon is that the investigator comes to research with some prior knowledge of the phenomenon; also known as pre-understanding. This cannot be set aside to allow for complete objectivity during the study. This paper will go on to further explain this concept in detail. Pre-understanding effects all phases of the research process, including question development, data collection, data analysis, and literature dissemination.

It is incumbent on the researcher to identify and acknowledge this pre-understanding, and in the case of this methodological approach, use it to add further depth and meaning to the results and interpretations of the data. The following narrative is my first experience as a nurse with the phenomenon of caring for, and needing to intervene with, a patient manifesting symptoms of psychosis. This episode had a profound long-reaching effect on me and is the genesis of the research to follow.

Psychosis Through the Eyes of a New Nurse

This was my first true experience with psychosis.

I had been a licensed nurse for less than one year. I was working in a long-term care facility on a dementia ward. This was a 24-bed unit and the staff consisted of me and two Certified Nursing Assistants (CNA); we always kept pretty busy. Up to this point in my short tenure as a nurse I had dealt with some mental health issues, but had not had a real close-up look at psychosis or other severe mental health event leading to a crisis. However, this was about to change.

I had done the admission on this patient two days earlier on a Friday, and he had been exhibiting some mild agitation since arriving. These had not been serious episodes, and we had been able to redirect him effectively up to that point, but now these occurrences were getting more serious, and it was becoming increasingly difficult to keep him de-escalated. We were two days removed from his admission and this was Sunday. Sunday in any healthcare facility is scarce on managers, physicians, and other staff in leadership positions, and in long term care units these people are virtually nonexistent. I was pretty much on my own at this moment, inexperienced and unsure of my abilities as a nurse.

Somewhere around the evening time, the agitation became continuous and was accompanied by some nonsensical speech and a flight of ideas. I know now this was the beginning stages of psychosis, but did not recognize these signs at the time. I did recognize the agitation and looked in the medication administration record (MAR) to see if I had the option of a pharmacological intervention; and yes, there stood an order: **Ativan 1mg intramuscular (IM) for severe agitation.** Bingo! Modern chemistry to the rescue. I signed out the medication, drew up the prescribed amount of Ativan, administered as directed, and waited for the results.

The results of this intervention were what I would describe as less than anticipated, or desired. In fact, I had unwittingly thrown gasoline on a fire. Much to my bewilderment, the symptoms now manifesting before me looked something like this; severe agitation with aggression, pushed nonsensical speech with loose idea association, incoherent yelling, and finally, he fell to the floor and began to do somersaults, while continuing to yell.

I now had an acutely psychotic patient on my hands and a full-blown crisis. What I did not know at the time but do now is that what I was probably witnessing was a paradoxical reaction to the Ativan. This is a rare occurrence in which the medication has the opposite effect of that desired. This can, as it did in this case, take a mild mental health condition/event, make it significantly worse, turn it into acute psychosis, and compromise environmental safety.

My ward was in crisis mode now, and it was time for a nursing intervention to restore safety and order. It would have been nice to fall back on all the training and education I had received, and resources at hand to light the way and guide me down the path to safety and avoid disaster. Alas, this was not the case, and I was wholly and hopelessly ill-equipped for this moment. The one thought that crystalized in my brain was I had not been clinically or emotionally prepared for this event. This thought was fleeting however because as I looked around for help all eyes were looking back at me waiting on a decision to choose a course of action to put out the fire and end the crisis. These eyes included the other patients, staff, and various family members (visitors). I had never felt more isolated in my entire life.

My fight or flight system had kicked into overdrive and was screaming at me to choose the latter of these two options. I literally wanted to be any place on the Earth other than right there, right then. I also realized being a nurse (the sole nurse), the decision was up to me and nobody else. There would be no cavalry coming to the rescue.

Frightened and apprehensive as I was, I managed to ultimately collect my thoughts and decide on a course of action. I cleared the area, did all I could to contain and protect the patient with one staff member (CNA), and had the other staff member call for

help. This help included an ambulance accompanied by police to transport the patient to an acute care psych ward. All turned out well for the most part as no one was hurt including the patients, staff, and family members; the patient experiencing psychosis was safely transported to an acute care hospital. Still, my nerves were a little worse for wear and it took a long while for me to process this episode. I still carry some residual anxiety and trauma from this experience to this day.

The emotional distress caused by this event alone made me seriously consider leaving the nursing profession as I did not think I would be able to deal with this level of stress continuously. I did not quit nursing, and in the intervening 17 plus years since this incident, I have gained valuable clinical experience and knowledge working in direct patient care, and am able to draw on this to better navigate occurrences such as this. In my time as a nurse, I have worked with, and talked with nurses of all levels of experience employed in direct patient care, and almost all of them have a similar anecdote to relate.

This was my takeaway from this incident. I was inadequately prepared, clinically, and emotionally for this event. By either my school or my employer. A psychotic patient, or other mental health crisis situation is something almost all nurses will face at some point in their professional career (this even includes nurses who do not work on mental health or psychiatric units) and too little is done for them in preparation for these moments. In nursing school, we usually get some lectures and theory in the classroom with maybe a pseudo scenario to reinforce the teaching, but nothing like a real-life episode. Employers often do even less to prepare their staff for these unavoidable events, and this is where the irony and frustration kicks in; they are unavoidable, they are going to happen.

Once fully licensed, nurses are thrown onto the floor and these episodes go from pseudo to real in the blink of an eye. Quite often it is solely up to the nurse to decide what is to be done to restore safety and avert catastrophe. The choices must be made without delay, as much resides on timely and effective intervention. These events put an inordinate amount of emotional strain on the nurse, and this can often lead to emotional trauma that for some remains unresolved.

Two questions have stuck with me since this incident.

1. Do all nurses have a similar experience(s) to this?
2. If so, why do we not prepare our nurses adequately for this unavoidable phenomenon?

Chapter One

Background

Psychosis is one of the most serious of mental health conditions (American Psychiatric Association Diagnostic and Statistical Manual [APA, *DSM-5*, 2013]). This is a severe mental disorder which impairs thoughts and emotions and causes a loss of contact with reality (APA, *DSM-5*, 2013). In the United States of America, approximately 100,000 people experience at least one episode of psychosis each year, and 3 in 100 people will have an episode at some point in their lives (National Alliance on Mental Illness [NAMI, 2021]). The World Health Organization (WHO, 2019) reports 24 million people worldwide experience at least one episode of psychosis every year.

Psychosis is a severe mental health disorder in which a person's cognitive functioning and emotions become so impaired they lose connection with reality. The American Psychiatric Association (2013) reports that the qualifying factors for psychosis are a gross impairment in reality testing, with diminished or vacant ego boundaries, which result in a failure to meet the ordinary demands and functions of life (APA, *DSM-5*, 2013). The symptoms can include anxiety, paranoia, suspicions, hallucinations, delusions, disorganized speech, and difficulty concentrating. This can lead to confusion, cognitive dysfunction, grossly erratic/disorganized behavior, verbal aggression, and physical violence (APA, *DSM-5*, 2013).

Psychosis is just one of several serious mental health conditions that can cause a crisis in the healthcare environment and compromise the security of all. Other severe mental health issues can also be present, and the patient experiencing these can become unpredictable, disruptive, and/or violent causing an emergent situation the nurse must

address with speed and urgency. In addition to the other symptoms listed in the descriptions to follow below, each one of these other illnesses can also cause psychosis.

Schizophrenia is a disorder characterized by an inability to distinguish what is real from what is not. Many people believe that schizophrenia and psychosis are interchangeable terms/illnesses, but they are not. Schizophrenia can be one of the causes, but psychosis can be triggered by several mental health conditions (APA, *DSM-5*, 2013). Symptoms of schizophrenia fall within two major categories: positive and negative. Positive symptoms include hallucinations, delusions, disorganized thinking or speech, abnormal behavior, paranoia, and distorted perceptions (APA *DSM-5*, 2013). Negative symptoms include decreased ability to speak, engage in everyday events, find pleasure in life, or initiate plans, and a decreased or flat affect (APA, *DSM-5*, 2013).

Bipolar mood disorder is a mental illness that causes abnormal changes in a person's mood and emotional state (APA *DSM-5*, 2013). Patients can pendulum between mania and depression. Manic symptoms include high energy level, decreased sleep, reckless behavior, uncontrollable racing thoughts and actions, increased/faster speech, and distractibility with quickly changing thoughts and behaviors (APA *DSM-5*, 2013). Bipolar depression symptoms include profound and intense sadness and/or despair, fatigue, suicidal ideation, feelings of worthlessness, loss of interest in activities, and increased or decreased sleep and appetite (APA *DSM-5*, 2013).

Post-traumatic stress disorder (PTSD) is caused by being subjected to a life-threatening event, severe injury or harm, sexual violence, or other serious traumatic event (APA *DSM-5*, 2013). This can trigger the person to exhibit hypervigilance with

exaggerated responses. This can result in angry violent outbursts with little to no warning, along with physical aggression to people or objects (APA *DSM-5*, 2013).

The American Psychiatric Association Diagnostic and Statistical Manual (APA *DMS-5*, 2013) recognizes 10 distinct personality disorders. These include but are not limited to antisocial, borderline, histrionic, narcissistic, and paranoid personality disorders (APA *DSM-5*, 2013). A person can be diagnosed with one or more (cluster) of these disorders (APA *DSM-5*, 2013). These can cause a whole range of symptoms resulting in crisis events, including acts of extreme impulsivity, inappropriate and severe anger, exaggerated and rapidly shifting emotions and actions, and repeated acts of self-harm and suicide attempts (APA *DSM-5*, 2013).

At times people experiencing psychosis or other severe mental health issues are under the care of a nurse. The International Counsel of Nurses (ICN, 2022) defines a nurse as a person who has completed an educational program of basic generalized nursing, and is authorized by the proper regulatory authority to practice healthcare nursing in his/her country. The profession of nursing internationally encompasses the act of individually or collaboratively caring for individuals of all ages in wellness and sickness, promoting health, preventing illness, promoting a safe environment, and assisting with development of healthcare policy (ICN, 2022).

Most commonly, nurses care for patients experiencing mental health issues and/or psychosis on mental health or psychiatric units, and patients with psychotic disorders account for most admissions in these settings (Jacobsen et al., 2018). However, psychosis and other severe mental health disorders are not limited to these areas, and this phenomenon can be present across healthcare settings. Nurses must prepare themselves to

care for these patients regardless of where they practice. The rate of emergency departments (ED) patients presenting with psychosis has increased, and this has accounted for a higher percentage of admissions (Perez-Jones et al., 2019). Delirium, a form of acute psychosis, is a common, yet poorly assessed condition in hospital intensive care units (ICU) (Hickin et al., 2017). Lack of nursing knowledge of assessing and caring for those suffering delirium has been attributed to an increase of mortality and morbidity (Hickin et al., 2017).

Nurses constitute the largest demographic of the workforce caring for mental health patients and make vital contributions to their care, treatment, and safety (Dusseldorp et al., 2011). Nursing interventions for a patient experiencing psychosis must be quick, effective, and safe. This is for the welfare of the patient and all others in the environment of care (Dusseldorp et al., 2011). Nursing judgment and decision making have the potential to more efficiently allocate health resources, promote health, benefit patients, and prevent harm or injury (Thompson et al., 2013). Over half of all adverse events in patient care have some decision-making error at their center (Thompson et al., 2013).

In a scoping systematic review of research, Jacobsen et al. (2018) stated that before 2018 no systematic reviews or meta-analyses focusing solely on psychological interventions for psychosis within in-patient settings had been either published or registered. They further noted that evaluating therapies such as medication effects, or nursing care with inpatient therapy is difficult if not impossible, and issues persist with evaluating and accounting for the natural recovery after mental health crises such as

psychosis. The processes of adapting interventions for psychosis within in-patient settings needs greater methodological research, rigor, and clarity (Jacobsen et al., 2018).

Significance

Mental health crises are emergency events that greatly compromise the wellbeing of all with the environment of care. Nursing decisions on interventions for psychosis or other serious mental health issues must be made quickly, and this can be vital to maintaining safety and preventing injury. Jacobson et al. (2018) reported that there is no clear indication of what constitutes evidenced-based psychiatric interventions within in-patient settings. Therefore, it is necessary to focus more closely on this phenomenon, and how it affects the profession of nursing to gain understanding and clarity.

Problem Statement

Nurses are the frontline staff caring for patients experiencing psychosis or other serious mental health issue in healthcare settings, and constitute the largest population of the workforce caring for mental health patients (Dusseldorp et al., 2011). They make vital contributions to their care, treatment, and safety. However, research programs and treatment guidelines present little information for the nursing care of patients with severe mental health issues, and how to intervene without adverse outcomes for patients and staff (Dusseldorp et al., 2011).

The nursing profession experiences caring for patients suffering psychosis and managing crises events in a way that is unique to all other healthcare providers. They are the key and central figures during these episodes, and act as a prism through which these incidents flow. Often a nurse is the sole person directing the crisis intervention, and must

quickly assess the patient, environment, and situation, and then direct actions to restore safety and prevent injury.

Odeyemi et al. (2019) observed that nurses caring for patients find that evidence-based practice helps inform nursing decisions and interventions to effect safer environments for all and better clinical outcomes. However, there is no clear indication of what constitutes evidence-based nursing interventions for psychosis within in-patient settings to assist nurses (Jacobson et al., 2018). Using a Heideggerian hermenutic approach to examine the lived experience of nurses as they care for and intervene with patients suffering psychosis could assist in understanding the dynamics of actual nurse patient interactions during these episodes, and of what is required in direct care settings. Hermenutic research in this area will also identify patterns of care and other issues missing from extant research and literature. This is because its objective is to reveal common but often missed, ignored, or neglected aspects of experience, through an elicitive analytical process that seeks meaning (Dibley et al., 2020).

Purpose

The purpose of this study is to examine the lived experiences of nurses caring for patients experiencing psychosis or some other severe mental health issue. The research interviews will seek answers as to which interventions nurses utilize to best care for a patient manifesting psychosis or other serious mental illness and maintain safety in the environment, and how they are prepared for this phenomenon. By analyzing the common expressions and behaviors of nurses in situations involving care of psychosis, the meaning of the care giving experience and thus, an understanding of the interactions involved with caregivers in psychosis may be revealed. Thus, nursing experience itself

will provide experiential, firsthand data on the interventive process as it shows itself in everyday practice.

Research Questions

This research will address the following questions:

1. How do nurses experience psychotic manifestations of confusion, aggression, and violence in patients they encounter?
2. How do nurses express their experiences and preparation when they must intervene with patients manifesting psychosis or other severe mental health issue?

Aim

This proposed research will add to the existing literature and body of knowledge to assist nurses in all areas of direct patient care how to best care for and intervene with patients experiencing psychosis. The specific aim is to reveal the expressions and behaviors of nurses who have direct care knowledge of caring for patients undergoing psychosis. The expected outcomes for this study are to understand how nurses care for and intervene with a patient suffering from psychosis by interpreting the expressions and stories they describe. It will also provide information on whether and how they are prepared, as well as how these events affect their perceptions, clinically and emotionally.

Methodology

Hermeneutic Phenomenology

This study will be conducted using a Heideggerian hermeneutic phenomenological approach. This methodology is conducted to interpret and describe the phenomenon of interest, and gain a broader more profound knowledge of the research

foci to provide meaning to the lived experience (Dibley et al., 2020). Alsaigh and Conye (2021) reported that Hans-George Gadamer's philosophy on hermeneutics focuses on the human experience as it is lived. Gadamer opined hermeneutics is not only a vehicle used to develop understanding, but can be used as a means to illuminate the environment and conditions in which understanding, perception, experiences, and attainment of knowledge take place (Alsaigh & Conye, 2021). Hermeneutics will allow for the collective consciousness of nurses to be expressed to unveil that part of this phenomenon which to this point has remained hidden. This possible revelation has the potential to assist nurses, patients, and all other people psychosis touches in healthcare settings.

This methodological approach is about exploring the lived experience of people with knowledge of the phenomenon. This is accomplished through the stories of the participants. This method is used to create an open space to bring forth the lived experiences of the interviewee so that the nature of the phenomenon may be revealed in the narrative (Dibley et al., 2020). Martin Heidegger (1972) in his writing *Being and Time* postulated language and stories are vital to Dasein (existence; experience of being) and those who seek understanding of its "there." Face to face conversations are a common data collection technique in hermeneutic phenomenology to extract experiential narratives of the participants in order to gain an understanding of the phenomenon (Chang & Horrocks, 2008).

The purpose of hermeneutic phenomenological research is to give full meaning and depth to the lived experience of participants through the sharing and interpretation of their stories. The researcher is the mechanism by which the phenomenon may be

understood, but the collected data are also pivotal to gaining understanding and meaning of the lived experience (Dibley et al., 2020).

Chapter Two

Review of Literature

Literature reviews serve the primary purpose of demonstrating why the proposed research is necessary. This review should include all relevant literature and information, including traditional along with the applicable extant data. All evidence informing the phenomenon should be considered for the review. Material from multiple perspectives, disciplines, and sources, while considering all contexts and complexities, should be woven into the results. This is vital to gaining insight and understanding of human experience (Valentine et al., 2021). Material for the literature review should not just be gathered from core databases or limited to scientific and/or peer reviewed articles. The end goal is to not only expose the gap in knowledge, but to also combine the researchers pre-understanding of the phenomenon with existing literature to co-create a new understanding (Dibley et al., 2020).

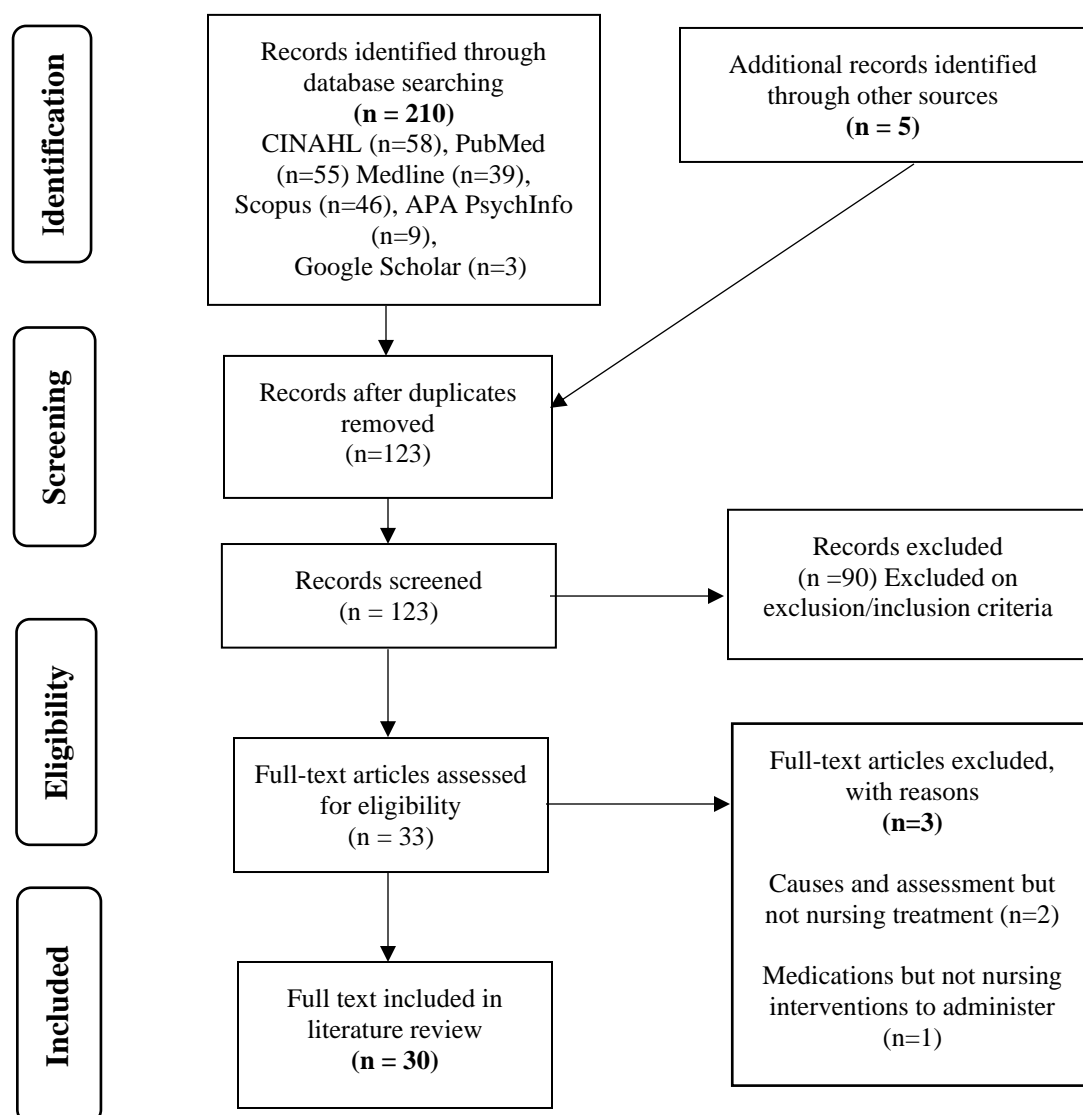
The PI comes to this research with a strong familiarity of the phenomenon; this has created a deep-rooted pre-understanding. This familiarity includes 17 plus years working as a clinical nurse, almost all in mental health. This clinical experience and at the bedside care have required interventions with patients experiencing psychosis and/or other severe mental health episodes on numerous occasions.

Research reports for this integrated literature review (n=215) were identified by an electronic search of the following databases: CINAHL (58), PubMed (55), Medline (39), Scopus (46), APA PsychInfo (9), Google Scholar (3), and additional sources (5). The search terms included Nurse* (Nurse, Nurses, Nursing) Psychiatric, Psychosis* (psychosis, or schizophrenia, or psychotic disorder), mental health crises, training,

education, interventions, actions, care, quantitative and qualitative; these were used in various combinations. Once duplicate research reports were removed, 123 were screened. Thirty-three reports fit the inclusion criteria. Two reports dealt with the cause/trigger, and assessment, but not treatment of psychosis by nurses, and one report examined the efficacy of medications used to treat severe mental illness but not the nursing intervention to administer these. This left a final total of 30 research reports included in the review (see Figure 1 for PRISMA diagram).

Figure 1:

PRISMA Diagram



Inclusion/Exclusion Criteria

Inclusion criteria comprised reports containing qualitative and quantitative data and findings. Studies on registered nurses (RN) caring for patients experiencing manifestations of psychosis and issues related to this phenomenon across all healthcare settings were included. Also reports including nursing assessment and training/education related to recognizing signs and symptoms of psychosis, other mental health crisis, and de-escalation techniques were included. Research reports without these criteria, or which included patients experiencing psychosis, but did not cover nursing or nursing care, were excluded (see Table 1 for inclusion and exclusion criteria).

Table 1*Inclusion and Exclusion Criteria*

Included	Excluded
Research reports including qualitative and quantitative findings.	Research reports which included patients experiencing psychosis, but did not cover nursing or nursing care to address this.
Reports on registered nurses caring for patients experiencing.	Reports which included nursing interventions but not those for psychosis or mental health crises.
Reports including nursing assessment or recognition of signs and symptoms of psychosis or severe mental health episode.	
Reports discussing training or education of nurses for psychosis or mental health crises.	
No time parameter for reports.	

Quality Appraisal

Research reports for this integrated literature review were assessed for quality using the Critical Appraisal Skills Programme (CASP, 2022). Using this appraisal tool, the studies were evaluated in three major areas (validity, results, and local application). The CASP asks 10 questions across these categories to determine quality and validity. All studies included in his review provided data and reports consistent with their methods, purpose, research questions, and objectives. Each of the 30 studies met an acceptable level of validity and local application, and could be applied to nursing practice in multiple healthcare environments.

Historically, mental health nursing is an under-researched area. No single report identified during the search looked at nursing interventions for a patient experiencing psychosis as a sole or primary topic. This literature review attempts to integrate data on this phenomenon from multiple research reports, looking at various viewpoints of the researchers to give a comprehensive examination of the topic.

Theoretical Backgrounds

Two theoretical frameworks and theories are used to guide and inform the search for literature relevant to nursing interventions for psychosis and other mental health crises. These include cognitive theory (mental health theory) and decision making (middle range theory). These theories are relevant because this phenomenon compels the nurse to transition into decision making mode, and psychosis and other severe mental health issues affect the cognitive process. Hermeneutic research is not dependent or necessarily built on theoretical frameworks, but these theories can assist the researcher as he/she works to develop the research questions and analyze the data.

Cognitive Theory

Cognitive theories postulate that thoughts, perception, and emotions lead to humanistic behaviors and actions. A disruption in the cognitive process can lead to misperceptions, false thinking, and a detachment from reality. This subsequently can lead to negative behaviors and action; this is the process which occurs in psychosis and other severe mental health phenomena. Moritz et al. (2016) used cognitive theory to determine that psychosis is in part caused by a lowered decision threshold than would be assessed on a person of normal mental health. This leads to an acceptance and belief in the delusions, hallucinations, and false perceptions they are experiencing in conditions such as psychosis. Social cognitive theory has proven to be effective in explaining certain human behaviors, and how these are acquired and sustained throughout the life cycle (Eslami et al., 2018). Gaining a deeper knowledge of cognitive and social cognitive theory will assist in gaining a better understanding about how these contribute to the phenomenon of psychosis and other severe mental health conditions. This new gained information will assist with informing how nurses can best care for these patients.

Decision Making Theory

Decision making is a primary and vital component to nursing practice and patient care. Decision making theory is essential to informing current and future nursing practice across all environments and disciplines in healthcare (Watkins, 2020). Nursing judgment and decision making have the potential to more efficiently allocate health resources, promote health, benefit patients, and prevent harm (Thompson et al., 2013). These authors further report that over half of all adverse events in patient care settings have some decision-making error as a contributing factor. The decision-making process on

nursing interventions for psychosis needs to be informed by best practice, timely, and if possible free of error to avoid harm or injury to all in the environment.

Assessment and Education

Before looking at nursing interventions for a patient experiencing psychosis or other mental health crises, it is important to look at interventions or nursing care of a patient before the occurrence of this phenomenon. This would include assessment to recognize and identify signs, symptoms, and behaviors of psychosis, or other severe mental health condition. A related aspect of this would include any training or education nurses might have, or could receive to assist with this. Other aspects would include any therapy the nurse might use or de-escalation techniques to prevent this from becoming a crisis.

Nursing Assessment

Nurses make up the majority of bedside care givers and are the most present discipline in healthcare (Dusseldorp et al., 2011). This includes almost all environments found in patient care. However, nurses in non-mental health settings often are given inadequate training to recognize or address psychosis and other mental health crises (Pestka et al., 2012). This deficiency in training/education often results in a lack of ability and confidence to recognize and address psychosis and/or other severe behavioral mental health issues before they move into crises. This results in nurses and other staff at being at an increased risk for job related violence and assault (Pestka et al., 2012).

Psychosis is like any other medical condition regarding effective treatment. The earlier it is detected (assessed) by the nurse, the sooner interventions can begin. Early detection is particularly important with this condition due to how quickly it can move into

crisis (Pestka et al., 2012). This is also true with other mental health conditions. The diagnosis of psychosis or other severe mental health disorders is a predictor of violence, and these situations can accelerate quickly resulting in a dangerous environment for patients, nurses, and staff (Jensen & Clough, 2016; Pestka et al., 2012). Early intervention is vital to reducing the distress and anxiety often present in a patient with psychotic symptoms, and this will reduce the risk to the environment (Reed, 2008).

The nursing process begins with assessment, and this is true of patients with mental health conditions such as psychosis. The nurse should assess symptoms, characteristics, and the psychological condition of the patient in addition to the psychosocial state (Keks, & Blashki, 2006). Nurses are also responsible to assess the patient for the risk to harm themselves and other people in the environment. This includes potential for suicide, and risk to others. Nurses should also provide interventions to reduce psychotic symptoms, and subsequently the risk of violent or aggressive behavior (O'Toole et al., 2004). This should all be included during the planning stages of the assessment (O'Toole et al., 2004).

Education

Nurses need to learn the skills to successfully recognize, assess, and intervene with a patient experiencing psychosis or other severe mental health conditions. These skills do not come naturally, and without them, these events can quickly turn into a crisis resulting in compromised safety and injury to someone (Jensen & Clough, 2016).

Education for nurses can happen through multiple processes.

Simulations

While no learning experience can compare to authentic bedside clinical experience, simulation has been shown to have major benefits. Evans et al. (2015) found nursing students knowledge and perception of psychosis and of patients experiencing audio and visual hallucinations increased with simulations following lectures. This combination better prepared them for placement in an environment caring for mental health patients, with students reporting an increased confidence in their skill and empathy for the patients (Evans et al., 2015).

Role play simulation in which volunteers or nurse education faculty demonstrate symptoms and manifestations of psychosis for students and then had them assess and intervene has proven beneficial (Huggins et al., 2019). These methods helped students gain knowledge and insight on how to care for a psychotic patient and helped students overcome some anxieties related to caring for these patients (Huggins et al., 2019)

Communication

Communicating calmly and therapeutically is a core element to nursing practice regardless of the healthcare environment, but this is of paramount importance when working with mental health patients. Timely and effective nursing interventions are vital when caring for a psychotic patient. Caregivers need to regulate self-emotions and communicate calmly and effectively when interacting with these patients (Eweida et al., 2022). However, many new or novice nurses feel they have not been trained or educated to communicate effectively with a patient experiencing psychosis. This is especially true if the patient is demonstrating aggressive or unsafe behaviors (Eweida et al., 2022). Undergraduate and newly licensed nurses often feel they have had limited training or

clinical experience, and are unprepared to communicate effectively with a patient experiencing psychosis or other severe mental health episodes (McCloughan et al., 2020).

Evidence Based Practice

One of the most effective ways for nurses to address any health issue including psychosis is to use clinical approaches that have been proven to work over the course of time and documented. These approaches are often referred to as evidence-based practices. Evidence-based practice is promoted in most healthcare settings because this encourages critical thinking, assists with reducing the research practice gap for nurses, and contributes to a larger percentage of positive clinical outcomes (Stanley & Dougherty, 2010). Nurses should construct their care for psychosis and other mental health issues using the array of evidence-based practice psychotherapeutic interventions currently available (Jung & Newton, 2009). However, this issue is not as clear cut as it might seem on the surface. For decades, researchers and nurse educators have struggled to define, quantify, and teach EBP and critical thinking (Gonzalez et al., 2022). Up to 40% of decisions and interventions by nurses affecting patients experiencing psychosis are not informed by evidence-based practices (Gonzalez et al., 2022; Jung & Newton, 2009).

Nurses perform a primary function in ensuring safety in the environment for all. They are also responsible to identify a psychotic patient with manifestations of aggression (Jensen, 2003). It is up to nurses and other healthcare professionals to incorporate evidence-based practice, and their own clinical knowledge into therapeutic interventions when caring for patients experiencing psychosis, so that the individual patient needs are met (Jung & Newton, 2009).

Crisis Prevention

The initial primary goal (desired outcome) of a nurse caring for a patient experiencing psychosis is to keep the episode from becoming a crisis. A crisis situation signifies safety in the environment has become severely compromised, and the patient and others are at risk for harm and/or injury. Patient (mental health) aggression toward nurses and other staff is a common occurrence with substantial evidence pointing to the fact that nurses are more likely to be physically threatened, assaulted, and/or abused verbally than any other discipline in the healthcare profession (Lim, 2010; Pestka et al., 2012). Nurses must first learn to recognize the signs of an impending crisis to prevent one from happening.

As with almost all aspects with patient care, the sooner the better, and this is certainly true of crisis prevention. Crisis prevention begins on admission with the nurse collecting information on patient history (Lewis et al., 2009). Nurses should use the opportunity to identify if the patient has a history of violence or aggression, if so, this indicates an increased risk for this activity in the present (Lewis et al., 2009). The admission diagnosis should also be assessed and any current symptoms and behavioral presentation should be noted and continually assessed by nursing staff (Lewis et al., 2009).

Clinical Decision Making

All nursing interventions begin with a basic and primary step, deciding on a course of action (decision-making). Decisions on what actions/interventions to take on a patient experiencing psychosis or other mental health emergency need to be quick,

assertive, and effective. Much is dependent on the outcome of these interventions and nurses need to be prepared to make these decisions before the crisis develops if possible.

When presented with a mental health crisis, some nurses use a form of decision-making method known as hypothetico-deductivist, a type of trial-and-error process in which the person reflects on the actions as they are happening (Crook, 2001). Research has also found that clinical decisionmaking often works best when nurses are able to incorporate experience into the process, and this is a vital component to a successful intervention. Alternatively, some nurses' report, when faced with a mental health crisis, they experience a phenomenon called familiarity in which they recognize body language which alerts them of potential aggressive behavior, and in turn informs the decision on the course of action and intervention (Crook, 2001).

Nursing Interventions

Regardless of how effectively the preceding issues have been addressed, most nurses will find themselves caring for a patient experiencing psychosis, psychotic disorder, or other severe mental health issues at some point. These conditions and episodes are not limited to mental health or psychiatric units, but can be present across multiple healthcare environments. Nurses need to be prepared to care for these patients and intervene when the crisis moment arrives before they happen. Each year 1 in 25 adults in the United States experience at least one severe mental health episode; this is 4% of the population. Sixty percent of these people are not diagnosed or treated for this illness (NAMI, 2021).

After a literature search and analysis, 5 themes developed from the results.

1. **Safety:** Nurses felt that maintaining and/or restoring safety was the number one priority to providing care to patients experiencing psychosis or other severe mental health episodes.
2. **Education and Training:** A need exists for initial education for nurses related to crisis interventions, and ongoing training on how to intervene with a patient experiencing a severe mental health crisis.
3. **Internal Conflict:** Nurses often feel conflicted when having to use the more invasive interventions of pharmacotherapy and restraints.
4. **Therapeutic Communication First:** Nurses felt therapeutic communication (verbal de-escalation) should be the first intervention attempted before moving to more invasive and restrictive interventions.
5. **Necessity of Pharmacotherapy and Restraint Interventions:** While most nurses do not like using the more invasive and restrictive interventions, they felt these were at times necessary in order to secure and maintain a safe environment for the patient and all others.

Themes from Literature Review

Safety

When making decisions on interventions for patients experiencing psychosis, the primary predication for nurses was maintaining safety. Providing a safe environment was vital to nursing practice, and a safe environment was the top priority (Muir-Cochrane et al., 2014). Nurses felt they carried the weight of responsibility for the safety of patients, themselves, and all other staff members (Power et al., 2020).

Safety also factored into the decision of using more invasive interventions such as pharmacotherapy and restraints. Invasive interventions were at times necessary to maintain safety in the environment (Power et al., 2020; Wong & Bressington, 2022). Nurses were willing to use all interventions to maintain safety; these included therapeutic communication and pharmacotherapy (Danda, 2022; Power et al., 2020). At times the need to maintain safety was also seen as a barrier to nursing practice change and improvement. The duty to keep all within the environment safe created a complexity that could be perceived as a barrier to a change in nursing practice (Power et al., 2020; Wong & Bressington, 2022).

Need for Education and Training

Nurses across research studies felt that initial education and training were vital to obtain clinical knowledge on how to intervene with patients experiencing psychosis. Nurses were uncertain they were making the best decision related to interventions due to a lack of education and formal guidance for best practice (Danda, 2022). Nurses identified gaps in clinical knowledge that were filled through informal training by more experienced nurses (Bigwood & Crowe, 2008). Research related to initial education and ongoing training was identified as a need. A lack of recognition of firsthand knowledge of any research, literature, formal education, or training supporting trends in nursing practice were identified (Danda, 2022; Jensen & Clough, 2016).

Internal Conflict

When having to necessitate the more restrictive interventions of pharmacotherapy and/or restraints, nurses and other clinical staff felt conflicted at times. An internal conflict existed with nurses associated with restrictive practices (Power et al., 2020).

Nurse's decisions to use more restrictive interventions were challenging and difficult to implement, and they frequently felt conflicted concerning their involvement later (Muir-Cochrane et al., 2014). Other clinical staff felt conflicted at times concerning their involvement with restrictive interventions (Power et al., 2020).

Even when coercive and invasive interventions were initiated that were safe and ethical to alleviate patient distress and prevent injury or harm, these still had the potential to cause great moral distress to nurses (Danda, 2022). Support clinical staff felt distressed, angry, let-down, and sometimes traumatized because of taking part in restrictive practices at the guidance of nurses (Danda, 2022; Power et al., 2020).

Therapeutic Communication First

Nurses across reports expressed that the initial intervention when caring for a patient experiencing psychosis should be therapeutic communication (verbal-de-escalation). Therapeutic communication was vital to nursing practice and central to the relationship between nurses and patients (Bigwood & Crowe, 2008; Felton et al., 2018). This intervention is the first in a hierarchy, which also includes pharmacotherapy and restraints, and should be maintained throughout the interaction with the patient experiencing psychosis or other severe mental health episode (Danda, 2022; Felton et al., 2018; Power et al., 2020).

In an attempt to avoid the more restrictive interventions, nurses will ensure other strategies (including therapeutic communication) are tried first. Nurses attempt to avoid more restrictive interventions, if possible, by utilizing de-escalation (communication) skills, and identified this as the most important skill for nurses to use (Bigwood & Crowe; 2008; Power et al., 2020).

Necessity of Pharmacotherapy and Restraint Interventions

While most nurses would rather avoid pharmacotherapy and restraint interventions, these were identified as integral and a necessary component to nursing practice when caring for patients experiencing psychosis and other mental health crisis (Bigwood & Crow, 2008; Danda 2022; Pérez-Toribio et al., 2022). The decision by nurses to use pharmacotherapy when necessary was not taken lightly, but was commonplace when patients were demonstrating a cognitive struggle and behavioral issues (Bigwood & Crow, 2008; Danda, 2022). Nurses perceived the more restrictive interventions such as restraints as “part of the job”, essential, and unavoidable in acute care mental health nursing practice (Bigwood & Crow, 2008; Pérez-Toribio et al., 2022). Nurses would be greatly concerned if restrictive interventions were not available, because without these there would be chaos, people would get hurt, and some would leave the profession (Muir-Cochrane et al., 2015).

Most nurses will attempt to intervene using therapeutic communication (verbal de-escalation techniques) with patients experiencing psychotic episodes before attempting more invasive interventions like pharmacotherapy and restraints (Pérez-Toribio et al., 2022). Korkelia et al (2016) reported that 62% of nurses in their study thought that alternative less invasive interventions should be attempted before implementing restraint interventions. However, Pérez-Toribio et al. (2022) noted that nurses used verbal de-escalation to a lesser extent with patients who had just recently been admitted or had previously been restrained on their current admission. Most of the time invasive nursing interventions such as restraints were commonly applied to assure safety to the patients

and all others in the environment of care (Pérez-Toribio et al., 2022; Wong & Bressington, 2022).

When therapeutic communication on its own is ineffective at de-escalating a patient experiencing psychosis or severe mental health episode, nurses will move to the more invasive intervention of pharmacotherapy (Danda, 2022). However, most nurses do not take this step lightly and describe medication interventions as both potentially harmful and beneficial (Danda, 2022). Most nurses struggle with the competing forces of doing what is best for the patient and ensuring a safe environment for all (Danda, 2022). The majority of nurses (> 80%) in the 2022 study by Pérez-Toribio et al. used pharmacotherapy interventions in an attempt to avoid using the most invasive intervention of restraints. Their study research found that many nurses failed to attempt to use the intervention of therapeutic communication before moving on to more invasive interventions.

Most of the findings in the literature show that using the most invasive nursing interventions of restraint was done in an attempt to restore safety and to keep the patient and others in the environment from injury or harm (Korkelia et al., 2016; Muir-Cochrane et al., 2015; Pérez-Toribio et al., 2022; Wong & Bressington, 2022) Korkelia et al. (2016) found that 87% of nurses thought restraint interventions were a necessary part of their job. Pérez-Toribio et al. (2022) found not using restraints when they were necessary put patients and staff at risk. Nonetheless, nurses would be greatly concerned if restraint interventions were not available (Muir-Cochrane et al., 2015).

Some nurses reported factors other than patients leading to the more restrictive and invasive interventions of restraints and pharmacotherapy (Danda, 2022; Pérez-

Toribio et al., 2022). Nurses reported that at times a noisy or crowded environment caused an escalation in patient aggression, and this led to restraint interventions (Muir-Cochrane et al., 2015). Staffing ratios factor into more invasive interventions, with nurses reporting sufficient staff being vital to reducing restraint episodes (Muir-Cochrane et al., 2015).

Safety is the number one consideration for a nurse when caring for a patient experiencing psychosis, and interventions are predicated on this. A hierarchy exists with these interventions and nurses should begin with the least invasive intervention of therapeutic communication (verbal-de-escalation) before moving to the more restrictive practices of pharmacotherapy and restraints. Nurses feel conflicted at times when having to use these interventions but feel they are necessary to restore safety when nothing short of these will succeed (Bigwood & Crow, 2008; Danda, 2022; Pérez-Toribio et al., 2022; Power et al., 2020). A need for more research, literature, initial education, and ongoing training exists so that evidence based practices can inform, guide, and shape these interventions.

Literature Review Summary

This literature search and integration sought to explore the experiences and perceptions of nurses as they care for, and intervene with, patients experiencing psychosis and other severe mental health issues. Studies comprising over 125 nurses working in direct patient care provided data for the search and analysis. The findings across reports highlighted the seriousness of psychosis and the safety risk this issue introduces into the environment. Safety was the dominant theme and nurses based much of their care and

interventions on this issue (Bigwood & Crowe, 2008; Danda, 2022; Felton et al., 2018; Muir-Cochrane et al., 2014; Power et al., 2020,).

Nurses make up the majority of bedside caregivers (Dusseldorp et al., 2010), and it is important to provide nurses with the skills and training to recognize the signs of psychosis, and if possible, intervene early to prevent a crisis from occurring. This starts with developing the assessment skills necessary to identify signs and symptoms of psychosis as early as possible to begin caring for, and intervening with, the patient and ensuring safety for all people in the environment (Pestka et al., 2012).

Nurses should do all they can to prevent crisis and maintain safety, and this starts with assessing the patients background and history for previous events related to aggression and violent behaviors. In the case of psychosis, psychotic disorder, or other severe mental health conditions, a history of violent episodes often predicts an increased risk of this happening again (Lewis et al., 2009; Lim, 2010). These patients require ongoing and constant assessment. Once the crisis does occur, the nurse needs to decide on a course of action without delay (Crook, 2001; Thompson et al., 2013; Watkins et al., 2020).

The decision on nursing interventions for a patient experiencing psychosis or other severe mental health issue must be quick, effective, and as therapeutic as possible (Crook, 2001; Thompson et al., 2013; Watkins et al., 2020). These interventions work best when they are informed by evidence based practice (Gonzalez et al., 2022; Jung & Newton, 2009; Stanley & Dougherty, 2010).

Nurses are responsible for all within the environment of care. Psychosis or other severe mental health episode presents a potential crisis and the decision to intervene, and

types of interventions have many factors (Dusseldorp et al., 2011; Felton et al.; 2018; Thompson et al., 2013). Education and training play a big part in the success or failure of these interventions, and nurses feel this has been lacking in many instances (Bigwood & Crowe, 2008; Danda, 2022; Jacobsen et al., 2018). New research is needed to inform education and training to develop action plans for best nursing practice (Danda, 2022; Jacobsen et al., 2018).

Literature analysis provides evidence that nursing interventions for psychosis should happen in a hierarchical order from least to most invasive (Danda, 2022; Felton et al., 2018). This review points out the fact that therapeutic communication is a vital and integral nursing skill all nurses should possess on day one of caring for patients at the bedside. This is the case most of the time, and the first intervention on this list is therapeutic communication (Felton et al., 2018). Often this intervention is effective alone, and no other interventions are required to restore safety (Felton et al., 2018). These findings also suggested most nurses chose to maintain this therapeutic intervention as long as possible in an effort to avoid the more restrictive and invasive interventions of pharmacotherapy and restraints (Bigwood & Crowe, 2008; Danda, 2022; Power et al., 2020).

Findings in this integrated literature review support the need to retain the more restrictive and invasive interventions of pharmacotherapy and restraints, as these are sometimes needed to maintain and restore safety (Bigwood & Crowe, 2008; Danda, 2022; Muir-Cochrane et al., 2015; Power et al., 2020). Results show that when therapeutic communication is not effective by itself, nurses will move to the second least invasive intervention of pharmacotherapy to maintain and restore safety (Danda, 2022).

The findings again highlighted a lack of education and training needed for nurses to accompany and inform this intervention (Danda, 2022; Jacobsen et al., 2018).

Only when all else fails and nurses have no other choice will the most invasive and restrictive intervention of restraint be used. The analysis of data shows most nurses feel this is an integral part of nursing when caring for patients experiencing psychosis or other severe mental health episodes (Bigwood & Crowe, 2008; Muir-Cochrane et al., 2014; Power et al., 2020). Nurses feel this is the intervention of last resort, and can have a negative effect on the therapeutic relationship between nurse and patient, but see no way to eliminate this from the available selection of interventions (Bigwood & Crowe, 2008; Muir-Cochrane et al.; 2015 Power et al. 2020).

The results showed at times more issues factored into the choice to use restraint intervention than just the behavior of the patient. On some occasions the environment and clinical staff can be an influencing component in these restrictive practices (Muir-Cochrane et al., 2015). Nurses reported a noisy and/or crowded environment can contribute negatively to a patient experiencing psychosis, can further compromise safety, and be the catalyst to restraint interventions (Muir-Cochrane et al., 2015). Conversely, having experienced and competent staff on hand to help care for these patients and respond to a crisis can at times be a factor in preventing the more restrictive interventions (Muir-Cochrane et al., 2015). These results underscore a need for more research on all factors leading into restraints.

The analysis of literature call attention to how nurses often feel they have failed in their duty to do no harm to the patient (non-maleficence) when they have to use the more restrictive and invasive interventions of pharmacotherapy and restraints (Danda, 2022;

Muir-Cochrane et al., 2015; Power et al., 2020). Often, these interventions cause nurses to feel an internal conflict, and this can influence decisions related to future interventions (Bigwood & Crowe, 2008; Danda, 2022; Muir-Cochrane et al., 2015).

No research report found in the search for literature focused solely or even primarily on the entirety of nursing interventions for psychosis or other mental health crises. Given that nurses make up the majority of bedside caregivers (Dusseldorp et al., 2011) and need to make quick effective decisions when caring for a psychotic patient (Crook, 2001; Thompson et al., 2013; Watkins et al., 2020), this phenomenon needs to be addressed from a nursing centric point of view.

Finally, the current literature also points to a need for future and more comprehensive research to further explore nurses' experiences and perceptions on caring for patients suffering from psychosis or other severe mental health issues (Danda, 2022; Jacobsen et al., 2018). The purpose of this future research should be to supply nurses with clinical and emotional resources such as training education and evidence based plans of action to assist them in caring for these patients. This is imperative to increase job satisfaction for nurses, ensure and maintain a safe environment for the patient and all others, and affect a higher percentage of positive clinical outcomes.

Chapter Three

Methodology & Methods

Research Methodology and Questions

The purpose of this research was to examine the lived experiences of nurses across healthcare settings as they cared for and intervened with patients suffering from psychosis or some other severe mental health issue. It was also done to explore how nurses prepared for this phenomenon. The chosen approach for this study was hermeneutic phenomenology. Two research questions were identified that the collected data attempted to address.

1. How do nurses experience psychotic manifestations of confusion, aggression, and violence in patients they encounter?
2. How do nurses express their experiences and preparation when they must intervene with patients manifesting psychosis, or other severe mental health issue?

Phenomenology

Phenomenology is used in research design to seek out meaning. Interpretive phenomenology is intended to find meaning through lived experience. This methodology is particularly appropriate to search for meaning for those phenomena that have been overlooked, understudied, misunderstood, and have historically remained in the shadows unnoticed. Phenomenology can provide the light that reveals what has remained hidden, and thus helps us to begin our journey to understanding and enlightenment.

The research approach chosen for this study is Heideggerian hermeneutic phenomenology, which is a subcategory of phenomenology; this is of the interpretive

branch of this research approach. This was chosen in part because the phenomenon of nurses caring for and intervening with patients experiencing psychosis or other severe mental health events has been under researched and largely ignored to this point in time. In hermeneutics, the focus is on bringing to light what has been hidden. This approach is used to question lived experiences of those who have encountered the phenomenon and to seek meaning across those experiences (Dibley et al., 2020). To better understand hermeneutics and its attributes, it is best to first understand the larger category of phenomenology and its origins in research.

In phenomenology the focuses is on understanding lived experience. There are two divisions of phenomenological research: descriptive and interpretive. Descriptive phenomenology is done to interpret the meaning of the phenomenon by describing its characteristics rather than individual experiences (Tuohy et al., 2013). This study utilized the second category of interpretive phenomenology. This approach uses the lived experiences of individuals who have encountered the phenomenon to help to interpret its meaning (Tuohy et al., 2013).

History of Phenomenology

Descriptive phenomenology, also referred to as transcendental phenomenology, was first developed by Edmund Husserl (1859-1938) around the turn of the 20th century. He established this as a philosophical way to identify authentic meaning by piercing deep into the veil of reality (Sloan & Bowe, 2014). Husserl's focus was on the relationship between consciousness and "objects of knowledge," with prominence placed on the object. Husserl referred to this as "the thing itself" (Sloan & Bowe, 2014).

Edmund Husserl is credited for developing descriptive phenomenology, but the development of interpretive phenomenology is credited to someone else. Husserl was a professor at Freiburg University in Germany and had a student and academic assistant who mentored under him for several years by the name of Martin Heidegger (Sloan & Bowe, 2014). It was Heidegger who took the lessons he learned from Husserl and pioneered/developed the interpretive phenomenology research approach, also known as existential phenomenology, also known as hermeneutic phenomenology (Sloan & Bowe, 2014).

Opinions and terminology do differ across researchers, scholars, and philosophers. Vandermause (2008) offers phenomenology was redefined by Heidegger and this changed the evolutionary course of hermeneutics. This transformation is referred to as the “hermeneutic turn” and is an adaptation and expansion of Husserlian philosophy (Thompson, 1990; Vandermause, 2008). Many scholars would opine that the similarities amongst Husserl and Heidegger and their philosophies were much greater than their differences (Dahlberg, 2002; Vandermause, 2008).

Martin Heidegger

Heidegger (1889-1976) is considered by many researchers to be the father of hermeneutic phenomenology, and many modern-day scholars and researchers use his concepts and constructs faithfully when conducting this type of research. One of the central pillars which forms the foundation of this methodology is Heidegger’s belief that an observer who has experience or “pre-knowledge” with the phenomenon cannot remove themselves from its essence and remain completely detached or neutral; it is not possible to wall oneself off and remain wholly objective (Sloan & Bowe, 2014).

Heidegger rejected the possibility that people must, or could, terminate previous knowledge or understanding. Rather it was through reflection of previous experience and knowledge that the phenomenon could be better understood. This was a departure from Husserl's belief that the observer could transcend the phenomenon and remain completely objective (Sloan & Bowe, 2014).

Heidegger believed that humans gain understanding of phenomena through lived experience. People have an interconnectedness with the world and environment surrounding them. This connection gives meaning and shapes their perception, understanding, and decision making (Dibley et al., 2020). The term he used for this was "Dasein," which translates into "being there" in the world and is often described as a space or draft of living that humans inhabit (Heidegger, 1972).

Heideggerian Concepts

Dasein

Dasein can be represented as an idea known as situatedness, or being intertwined/interconnected with the phenomenon on an environmental, social, and/or emotional level. This shapes our perception of the phenomenon and cannot be set aside. The concept of Dasein is a Being, an opening or space where human experience happens (Dibley et al., 2020). This is the core concept for hermeneutic phenomenology and forms the basis for data collection and analysis when using this methodological approach.

Thrownness

Heidegger believed we are "thrown" into the world at the time of our birth. We are unable to choose our environment or life circumstances at this time of our lives, and this shapes our perceptions and understanding going forward (Cowes, 2017). Thrownness

explains the ready-made circumstances of human experience. Humans are thrown into a life situation, in which they engage (Dibley et al., 2020).

Time

Heidegger believed that the concept of time can only be fully understood if a person had the viewpoint of eternity (Alweiss, 2002). Humans being mortal creatures with a finite amount of time are denied this viewpoint (Alweiss, 2002). Instead of looking at time as a chronological concept, Heidegger viewed time as a prominent and substantial entity that interrelated and interconnected all things (Dibley et al., 2020). In hermeneutic philosophy, this concept of time underpins all aspects of the research process including data collection and analysis.

Authenticity

Authenticity is a fundamental concept to Heidegger and his philosophical approach, and is present throughout his works. He described this as a way of thinking that moved beyond conventional, or established approaches. In his work *Being and Time* (1972), Heidegger philosophized being authentic was to be aware of what it means to exist. He also explained authenticity included claiming self though personal direction as opposed to the directions of others (Heidegger, 1972). It was his belief that without authenticity, understanding will be elusive “*Unless we have an existential understanding, all analysis of existentiality will remain groundless*” (Heidegger, 1972, p. 313).

Hans-Georg Gadamer

As Heidegger had mentored with, and then followed Husserl, Gadamer (1900-2002) learned from, followed, and built on the teachings of Heidegger. Gadamer was a student and then later a colleague of Heidegger and is credited with developing a

diverging branch of this methodology referred to as Gadamerian Hermeneutics (Sloan & Bowe, 2014). His ontological viewpoints were consistent with Heidegger's concerning pre-knowledge and prejudice; understanding must involve humans and their experiences, and their interaction in the world. This is the main character (humans) who does the interpreting. This is a core tenant of hermeneutic research (Austgard, 2012). Gadamer postulated that language and linguistics were the way to achieve understanding and reveal what it was to be in the world (Sloan & Bowe, 2013).

Gadamer hypothesized that language and linguistics were the way to achieve understanding and reveal what it was to be in the world; this was a divergence of Heidegger's philosophy (Sloan & Bowe, 2014). He believed primarily that our pre-understandings were derived from pieces of our linguistic experiences, and this is what makes comprehension manifest (Alsaigh & Coyne, 2021). He also assumed that those who can effectively express themselves and are able to be understood, are connected by human consciousness, and this is what makes understanding possible (Alsaigh & Coyne, 2021). Gadamer did not think of hermeneutics as a way to develop comprehension, but as a tool that could shine light on and reveal the circumstances in which awareness, understating, and knowing itself can take place (Alsaigh & Coyne, 2021).

Contemporary Hermeneutics

Historically interpretive phenomenology has been used by nursing researchers as an approach for inquiry to seek knowledge and answer research questions. The hermeneutic branch of phenomenology began to gain prominence in nursing research in the early 1980s with studies such as Benner (1984) who sought answers to how nurses go from novice to gaining expertise in their profession (Benner, 1984; Draucker, 1999). In

1989, Diekelmann et al. advanced and further solidified this methodology with their study describing a process to analyze narrative texts (Diekelmann et al., 1989; Draucker, 1999).

Hermeneutics in recent nursing research has contributed greatly to informing and improving nursing practice. This methodology has contributed greatly to the development of evidence based practice and patient care through inquiry into the lived experiences of nurses and the patients they care for. Hermeneutic phenomenology is a viable and vibrant qualitative research approach that is utilized by nurse researchers in multiple studies to seek answers and to improve all aspects of nursing and patient care including education, practice, and administration (Abu Ali & Abushaikha, 2019).

Components and Philosophy of Heideggerian Hermeneutic Phenomenology

Heidegger believed that hermeneutic phenomenology was derived from our perceptions of everyday experiences with phenomena. To achieve a deeper understanding of the whole, one must also consider its parts concurrently (Dibley et al., 2020). The ultimate objective is to gain a greater understanding of the meaning of how humans experience the events in their lives and how these shape their perceptions (Draucker, 1999). To gain a better understanding of how hermeneutic phenomenology as a whole helps us achieve a better understanding, one must also simultaneously consider the individual parts that comprise this methodological approach.

Hermeneutic Phenomenology Components

This process begins with identifying a phenomenon of interest and one in which the researcher desires to gain a deeper understanding. The starting point is to identify a deficit in evidence and understanding and then decide on a course of action to decrease

this deficit. These steps are not isolated, but interconnected, and form a relationship between the researcher and existing information (Dibley et al., 2020). One of the first decisions that will be made is the methodological approach for the ensuing research; for the sake of this paper the approach of choice is Heideggerian hermeneutic phenomenology.

Research Question(s)

Deciding on a research question(s) is a paramount part of the research process. The question(s) should relate back to the phenomenon and the identified gap in literature and/or knowledge. Fleming et al. (2003) observed that the area of interest should correspond with the aims and purpose of interpretive hermeneutics. When considering the philosophical approach to hermeneutics, how the question(s) are posed in relation to the phenomenon will affect how new questions and new understandings are produced for, and following, the subsequent research (Vandermause, 2008). This is so that the data collected, and the conclusions rendered will fit with the methodological approach, will be beneficial, and add to the existing body of knowledge (Fleming et al., 2003).

Pre-Understanding

Hermeneutic phenomenology is built around the concept of pre-understanding. As Heidegger observed, the researcher comes into the process with some level of knowledge/knowing of the phenomenon and is unable to set this aside and remain completely objective (Sloan & Bowe, 2014). The investigator can perceive this pre-understanding through multiple processes and varying beliefs, including the opinions of other researchers, exemplars, colleagues, past experiences, social and historical perspectives, or through literature or traditional texts (Fleming et al., 2003; Gadamer,

1990). It is of paramount importance that the researcher read, reflect, give thought, and question their current perspectives and knowledge to better understand and appreciate his/her horizon of understanding (Dibley et al., 2020).

Population and Sampling

Hermeneutic research is about exploring the lived experience of people with knowledge of the phenomenon. The researcher who applies hermeneutic phenomenology uses a purposeful sampling method where the participants need to have experienced the phenomenon firsthand. It is not the goal of this hermeneutic phenomenology research study to gather a representative sample of participants who would mirror or align with the entire population. Instead, the goal is to gain understanding and meaning of the phenomena of interest. Therefore, purposeful sampling, defined as seeking information-rich persons who can provide detailed information about their lived experience, is the appropriate sampling strategy. Dibley et al. (2020) state that researchers performing hermeneutic studies use this type of sampling to deliberately seek out those who have experienced the phenomenon, can answer the research question, and provide relevant data.

Literature Review

Literature reviews scrutinize and assess the existing body of knowledge. This process creates an underpinning to recognize weaknesses or inadequately understood aspects of the phenomenon of interest (Boell & Cecez-Kecmanovic, 2014). The review should include all relevant literature and information, including traditional along with the applicable extant data. All evidence informing the phenomenon should be considered for the review. Material from multiple perspectives, disciplines, and sources, considering all

contexts and complexities should be woven into the results. When utilizing a hermeneutic approach, the investigator(s) need to identify their pre-understanding and unite this with the existing literature to reduce the gap in knowledge and begin to create a new understanding of the phenomenon (Dibley et al., 2020)

Data Collection

Hermeneutic research is about finding meaning in the lived experience. Martin Heidegger (1972) in his analysis *Being and Time* wrote that language and stories are vital to Dasein (existence; experience of being) and those who seek understanding of its “there”.

In-person face-to-face conversations (interviews) are a viable data collection technique to this methodological approach. This allows the participant(s) the space to narrate and share their experiences and aids the researcher in their quest to gain a new understanding of the phenomenon (Chang & Horrocks, 2008). With these considerations, the participants need to be people who have experienced the phenomenon first-hand in order to allow for the deepest exploration. The person being interviewed is considered to be the exemplar, and the interviewer is considered to be the novice (Dangal & Joshi, 2020).

Data Analysis

The purpose for using a hermeneutic approach is to use the collected data to focus awareness on numerous implications connected to and within the phenomenon in an effort to gain a new understanding (Crowther et al., 2017). This is carried out through sharing the experiences of participants and interpretation of their stories. Vandermause (2008) offers that it is the hermeneutic analytic philosophy that will enable a responsive

evaluation, and this will open up new possibilities. She also postulates that it is important to remain receptive to the question(s) developed through this approach and that, by doing this, so we are returned to the idea of question and answer that pervades conventional history and the assessment process (Vandermause, 2008).

Data analysis in hermeneutic methodology is best accomplished within a team dynamic. Crist and Tanner (2003) reported that hermeneutic analysis works best through team involvement by way of debate, brainstorming, and discussion, although not required; this adds depth and insight to the interpretations. This is referred to as searching for shared meaning, and this further gives insight and scope to developing a new understanding of the phenomenon (Crist & Tanner, 2003).

Hermeneutic Circle

Utilizing the concept of the hermeneutic circle is an integral component to data analysis, and informs this research approach. This speaks to the belief that to understand the whole, a person must consider and understand the parts. Grondin (2015) elaborated that the hermeneutic circle is one of the most basic principles to hermeneutic inquiry. In its most elemental form, it teaches us that always, we can only understand or deduce a portion of the data's suppositions, but never the whole. To understand all of it we must consider its elements over and over (Grondin, 2015). For this reason, the investigator must dwell in the text reading and re-reading, considering, and re-considering, to determine what will rise to the surface of understanding/comprehension. Dibley et al. (2020) offer that this is a reflexive, circular approach to analysis that encourages themes to emerge from the data through multiple readings and returning to the text time and again.

Dissemination and Reporting

Evaluation of the data in hermeneutic phenomenology is an iterative process utilizing interview narratives, field notes, and input from the research team to consider if the question(s) and gap in knowledge have been addressed (Fleming et al., 2003). Once the data have been analyzed and themes and patterns have been identified across the interview transcripts, it is time to organize the findings for presentation. This organization normally takes written form to create literature for other scholars and stakeholders to peruse and consider. Dibley et al. (2020) stated that findings in a hermeneutic study are the answers to the identified research question(s). They further suggest that, the material presented should be done in a way that is understandable to a general audience. Also, it is the responsibility of the researcher(s) to describe the meanings derived from the data analysis and present them in a manner that resonates with the reader using language that signifies the intended meaning (Dibley et al., 2020). Vandermause (2008) intimates the conclusions are an amalgamation of the phenomena that develops, which includes the participants', the investigator's influence, and the background material that underpins the study.

Methods**Methodological Approach**

Hermeneutic phenomenology was chosen as the methodological approach for this study for multiple reasons. First the study's purpose was to examine the phenomenon of nurses caring for, and intervening with, patients experiencing psychosis or other severe mental health issues from the perspective of professional nurses. Hermeneutic phenomenology is a suitable approach to accomplish this. Vandermause and Fleming

(2011) reported that hermeneutic phenomenology is a philosophical approach and an intellectual tradition which advances research inquiry. As an academic convention, it has been used in research practices as a guide for the conception of meaning and the understanding of experience, increasing the existing extant knowledge and generating new questions about phenomena (Vandermause & Fleming, 2011).

Second, the principal investigator is a registered nurse (RN) with first-hand familiarity (pre-understanding) with this phenomenon. This methodological approach acknowledges that researchers come to study a phenomenon with some former knowledge of the phenomenon, and cannot set this aside and remain completely objective; not all methodologies will allow for this.

Heidegger opined that the observer could not detach themselves and remove pre-knowledge of the phenomenon and its fundamental identification. He/ she would be compelled to keep this in mind during the phenomenological process (Smith et al., 2009) The ability to reflect on our pre-understandings allows the researcher to move beyond these to better understand the phenomenon (Fleming, 2003).

Population and Sampling

Hermeneutic phenomenology uses a purposeful sampling method where the participants need to have experienced the phenomenon. It was not the goal of this hermeneutic phenomenology research study to gather a representative sample of participants who would mirror or align with the entire population of nurses. Instead, the goal was to gain understanding and meaning of the phenomena of interest. Therefore, purposeful sampling, defined as seeking information-rich persons who can provide detailed information about their lived experience, was the appropriate sampling strategy.

Dibley et al. (2020) stated that researchers performing hermeneutic studies use this type of sampling to deliberately seek out those who have experienced the phenomenon, can answer the research question, and provide relevant data.

The population interested in this study was nurses. The research was intended to understand and find meaning about nurses' lived experience of caring for and intervening with individuals who manifest psychosis or other severe mental health issues. Therefore, purposeful sampling, defined as seeking information-rich persons who can provide detailed information about their lived experience, was the appropriate sampling strategy.

Inclusion Criteria

The inclusion criteria for this research were registered nurses who speak English, were able to provide informed consent, and had lived experience of caring for and intervening with at least one individual manifesting psychosis. This population had the potential to give experiential data that spoke to the phenomenon of interest.

Exclusion Criteria.

The exclusion criteria for this research were non-nurses, non-English speaking, not able to provide informed consent, have no lived experience of caring for and intervening with at least one individual manifesting psychosis. Nurses without this lived experience would not be able to give first-hand accounts related to the phenomenon of interest.

Recruitment

This research employed multiple recruiting strategies. Some of the participants were identified through conversations conducted by the PI to determine interest. These included work colleagues, and also nurses who work in other healthcare settings who are

currently known to the PI. This was done with the goal to collect data from nurses working in multiple healthcare settings where the phenomenon of interest has been experienced. Hermeneutic research benefits from conversations between the researcher and potential participants. This allows the participants time to consider and reflect on their experiences related to the phenomenon of interest before the interview process (Vandermause & Fleming, 2011). It is essential to recruit participants who have stories to relate to the phenomenon of interests. It is also useful if the participant can tell the story using a common language while also being skilled at capturing and describing the mood, and emotions present during the experience (Smythe, 2011).

Another strategy utilized was the use of flyers. Recruitment flyers were provided during conversations with potential participants related to research and PI contact information (See Appendix A for recruitment flyer). Snowball sampling recruitment method was also used with each subsequent conversation and interview, whereby participants were able to assist in identifying other participants for the study.

A total of 10 registered nurses sat for 30–60-minute interviews (N=10). The study population represented nurses from across multiple healthcare settings. No particular site or facility was used for recruitment; the recruitment goal was to collect data from across healthcare settings and nurses who have worked in various locations to make up the population. Varying levels of experiences amongst the participants and the range in years of services was 2 years to 50 plus years of direct patient care at the bedside (See Table 2 for participant demographic information)

Table 2*Participant Demographic Information*

Gender		Race		Age	Education			
Male	Female	African American	Caucasian	Range	Associate's	Diploma	Bachelor's	Masters'
3	7	4	6	42-75	2	1	3	4

Retention

Participants were offered/given a \$25 Visa gift card as an incentive for their contribution to the research. No other monetary or non-monetary incentive was offered, and participants were informed that even after receiving the incentive they could withdraw their consent and participation in the study at any time.

Ethical Considerations and Data Security***IRB Approval***

A detailed application to initiate the study and data collection was presented to the University of Missouri St. Louis (UMSL) Institutional Review Board (IRB) for their approval. There were multiple components submitted in the application for their consideration. The PI completed the Collaborative Institutional Training Initiative (CITI) program for the ethical treatment of human research subjects. Also included were the recruitment flyer, research question guide, security strategies, and study demographic collection tool. The application was reviewed and approved by the IRB.

Security

Data and participant security were assured through multiple processes. Informed consent was obtained from participants, and permission was acquired from the IRB before the initiation of interviews and data collection. Each participant chose a pseudonym before the start of the interview to protect their identity and privacy. The

audio files from interviews were sent through secure password-protected software (Google Docs) to be transcribed verbatim by a professional transcriptionist. All identifying information was removed during this process, and de-identified transcripts were sent back to the PI through secure software (Google Docs).

All hardcopy material for the research study were kept in a locked safe in the home office of the PI, who is the only person with access. This includes several Items, (a) a logbook used to record the serial numbers for the \$25 VISA gift cards given to the participants, (b) BRICS NINR survey sheets that were used to collect demographic information, (c) field notes taken by the PI during interviews, and (d) hard copies of the interview transcripts and analysis. All identifying information was removed from these, and will be kept indefinitely for further research, analysis, and scholarly purposes. All audio files, and material with any identifiers were deleted as soon as the transcription process was completed. No patient or health related information was collected during the study.

Conflict of Interest and Participant Security

Some (not all) of the participants were known to the PI previous to data collection. This familiarity was a professional (nursing) aspect having worked together. Participation was completely voluntary, and the PI was not in any position of authority over any study participant. Confidentiality regarding the research project was maintained at all time and in all environments. The PI ensured the participants were fully informed of the study methods and consent to participate. Coercion was not used, and participants were informed that penalties would not occur if they withdrew their participation at any

time. The PI did not disclose the names or information shared by participants outside of the research team.

Data Collection

Participants were given a choice of in-person audio recorded interviews or remote interviews via zoom to provide their greatest level of comfort. All ten interviews were conducted in a face-to-face setting between interviewer and interviewee. The interview rooms and environments were carefully chosen to allow for the maximum comfort level of the participant with as much stimuli reduction as possible. Each participant selected a pseudonym of their choice before the start of the interview to protect identity and privacy. All interviews were recorded using a digital audio recorder or zoom audio recording for later transcription, and this was never out of the possession of the PI.

Interviews

Participants (N=10) were asked to sit for 30–60-minute interviews with the PI to share their experiences related to caring for and intervening with patients experiencing psychosis or other severe mental health crisis. In keeping with the hermeneutic approach, the PI conducted open question conversations in an effort to return the participant to the elemental components of their experiences. Smythe (2011) stated that this is to encourage them to use language and words that will add color and texture to their story.

The interview followed an open-ended question and forum format. The interviewer asked three direct questions to the interviewees. Follow-up questions were asked when appropriate to encourage dialogue and seek clarification. The interview guide was developed directly from the research questions. The rationale for this was to collect data that would have the best potential of providing a deeper understanding of the

phenomenon of interest by eliciting experiential accounts from the participants. The interview questions/guide was not piloted before the beginning of data collection (See appendix A for interview guide and demographic data collection form). The three main questions in the interview were:

1. Tell me about a time(s) when you in your role as a registered nurse were caring for a patient experiencing psychosis or other mental health crisis and needed to intervene.
2. What did you do or what was done to prepare you to care for and intervene with a patient experiencing psychosis or other mental health crises?
3. Anything else you would like to share about your experiences in caring for patients manifesting psychosis, or other severe mental health issues?

To give a description of the first interview, the participant chose the date and time. The room was chosen by the PI for the characteristics that would assist in establishing a dialogue between interviewer and interviewee and to allow the participant to feel free to share experiences. It was a small room with comfortable chairs and low light and noise. The \$25 gift card was given to the participant at this time. Demographic information including age, gender, race, ethnicity, and level of education was collected and recorded on a BRICS NINR demographic survey sheet (see Appendix A for BRICS NINR demographic questions).

Once the interview session and recording began, the PI explained and received informed consent. The first interview question was asked, and the participants directed the discussion.

From there, they shared experiences related to the phenomenon of interest. As the interview progressed follow-up questions were offered for clarification and to encourage continued discussion and sharing of experiences. Again, the participant chose the direction of the discussion in large part with only minor short interruptions by the PI. During the interview, the PI kept note of the participant's emotional state knowing that crisis events were being shared, and doing this can cause emotional trauma compelling the interview to conclude. Field notes were taken by the PI at this time to record voice inflection and body language to be used during data analysis to give further depth to the results.

Once the participant had shared all they wished, they were thanked for their time and participation in the study. The recorder was turned off at this time and the interview concluded. All subsequent interviews followed a similar pattern. After each interview, the study participants were reminded that they could contact the PI at their discretion to add any additional material they might not have brought up during the interview session. They were also reminded that they could withdraw their participation at any time without fear of reprisal or penalty.

The PI read the transcripts and reflected on each successive interview as data collection progressed. Feedback from the research team was also offered as the process continued. Through reflection and feedback, the interviews improved, and the data collected became richer and more experiential.

Data Analysis

The data from the interview transcripts were analyzed using an interpretive Heideggerian hermeneutic approach. The research team consisted of the PI who was a

novice researcher with extensive experience with the phenomenon of interest, one member, an expert in the field of hermeneutic phenomenology and other research methods, and another member, an expert in other qualitative methodologies and with notable experience using hermeneutic methods. Hermeneutic analysis works best when the research team consist of experts in this methodological approach and/or researchers with experience with the phenomenon of interest who can make insightful contributions (Crist & Tanner, 2003). The core team was also joined by other novice scholars and experts at times during the initial phase of analyzing the transcripts.

A Heideggerian hermeneutic approach to analysis is a circular process, not linear, and does not necessarily follow a step-by-step approach. Often, some of the steps may overlap or need to be repeated (Crist & Tanner, 2003).

The audio recordings of the interviews (n=10) were sent to a transcriptionist through a secure website (Google Docs). The transcribed interviews were sent back to the PI who had conducted all interviews through the same secure website and checked for accuracy. Once accuracy was determined, the transcripts were distributed to the rest of the research team via a secure website.

Applying the concept of the hermeneutic circle, the following steps were utilized not necessarily in a linear fashion but in a cyclical manner. With each revisit and re-reading of the text, the researcher revisited and revised the previous efforts. Each reading offers the investigator the opportunity to enhance, reaffirm, and/or change the existing interpretation (Dibley et al., 2020). Speaking of the analytic progression, Crist and Tanner (2003) offer that this is a circular process where narratives are examined

concurrently with the evolving interpretations without losing contact with the participants' specific story or perspective.

Data analysis in the first phase was completed through multiple processes and team members. Not all members analyzed each of the transcripts, but each analysis session utilized a team dynamic. Members of the research team or other scholars shared their own summaries, reading these aloud for the group to consider, reflecting upon and giving opinion and feedback. After this, there was a back-and-forth discussion related to the summary and the experiential data. As transcript analysis progressed during this phase, the summary discussions began to also include common stories, threads, and patterns that began to appear across transcripts.

One transcript analysis session that was particularly constructive took place at an annual hermeneutic phenomenology conference and consisted of a large group of exemplars in this methodological approach and other novice scholars. During this session, valuable advice and feedback were provided related to interview techniques and data analysis using a hermeneutic approach. This was instrumental to data collection and analysis going forward.

The data analysis continued with a consistent Heideggerian hermeneutical approach. Once the transcripts were distributed among the team members they were read and re-read line by line with each member dwelling in the text using what is referred to as a meditative thought process (Dibley et al., 2003). At this time, initial notes and coding were created by the investigator related to the text in the narratives. This dwelling in the text and coding were done with the intent to determine what themes, patterns, or concepts might present themselves with continued reflection. Dibley et al. (2020) refer to this as a

bubbling up process in which the researcher lets the narrative text stew slowly in their mind to allow ideas and thoughts to reveal what has been hidden.

Once this reflective process was completed, each of the team members authored an interpretive summary of the participant's narratives/experiences. During this process, it is important to consider the dialogue within the narrative/text. The summary should contain the detail and support necessary to express a credible and intelligible expression of the findings, which incorporates a retelling of the participant experiences and/or interpretation of developing themes and patterns with verbatim support (Vandermause & Fleming, 2011). These summaries were then read aloud to the rest of the research team members for consideration and discussion related to emerging themes and patterns found within the text and narratives.

The final phase of data analysis consisted of organizing the patterns and themes. This was done in an effort to find meaning in the participant narrative and gain a better understanding of the phenomenon. Using a hermeneutic methodological approach and applying the concept of the hermeneutic circle, the PI read and then re-read both the interview transcripts and team summaries to determine if the so far identified themes were accurate and to ascertain if any new or emerging themes would be revealed. Once satisfied that the themes identified correctly represented the participants experiences and conversations, the results were written up/disseminated using a thematic process. See chapter four for interpretation of results.

Risk and Benefits

Risks

Two risks were identified in the course of this research. First - the population of registered nurses were asked to share experiences which at times were related to crises events. These events can cause emotional trauma, and re-living them through the interview process can cause potential re-traumatization. All attempts were made during the interviews to minimize this potential by letting the participants direct the conversation and letting them share what they chose to share. Second – there is always a risk of loss of confidentiality during a research study. Efforts were made to safeguard this by using pseudonyms for the participants, secure websites for data sharing, and a safe for all tangible research materials.

Benefits

This research set out to primarily benefit the population of nurses working across healthcare settings. The goal was to (a) add to the current extant knowledge and literature of nurses caring for patients suffering psychosis or other severe mental health issues and (b) increase positive clinical outcomes through the process of assisting nurses to care for patients suffering psychosis or other serious mental health issues better.

Trustworthiness and Rigor

Trustworthiness and rigor were achieved through multiple processes and techniques. Guidance and feedback from the dissertation committee were sought and provided during all phases of data collection and analysis. This was to ensure that the research progressed with integrity to the Heideggerian hermeneutical phenomenological approach chosen for the study. Regular meetings occurred with the members of the committee to provide ongoing critique and feedback of this methodological approach.

To ensure the credibility of the research, direct quotations from the participants were utilized. This was to assist the reader to make their own determination of the truthfulness of the findings. Fleming (2003) reported that this is important so the reader can have a clear and concise view of the participant's perspective when determining the credibility of the data analysis.

The true establishment of trustworthiness will be accomplished when the results are presented to the target audience of nurses and other stakeholders in this phenomenon. Those nurses who have experienced caring for and intervening with a patient suffering psychosis or other mental health crisis will be the true and final judge of the trustworthiness and believability of the findings presented.

Rigor

Establishing rigor was central to legitimizing the study results and have these be relevant to the general population of nurses caring for patients experiencing psychosis or other serious mental health conditions. In their 2006 study, de Witt & Ploeg reported that rigor in interpretive phenomenology is a central issue and has direct consequences to the legitimacy, body of knowledge, and creation of nursing science and practice.

This research used the framework established by de Witt & Ploeg (2006) to evaluate rigor. This consists of appraising five expressions.

1. **Balanced integration:** Linking the research philosophical concepts, methods, and findings to the lived experiences of the study participants. The methodological approach, hermeneutic phenomenology, focuses on lived experiences. Data were collected from the lived experience of the participants

and target population of the study. To enrich and link the results, excerpts were taken from the participant narratives.

2. **Openness:** Systematic process of identifying and relating all decisions made during the study. The data analysis was completed using a team dynamic in which several members were able to give input and feedback. This process was observed through analysis.
3. **Concreteness:** The ability of the study's findings to be generalized and useful to nursing practice. This is yet to be fully determined as the findings have not been published for the target audience of nurses to read and consider.
4. **Resonance:** The practical effect the study findings have on its audience. This will be fully assessed once the stakeholders and target audience (RN) has the opportunity to read the published results and give peer feedback.
5. **Actualization:** The ability of the study findings to be considered and interpreted in the future. This will be fully realized once the study has been published. However, this research has good potential to lend itself to reinterpretation from the raw data in the form of participant excerpts included in the result section. Also, several possible research questions were generated during data analysis that could be taken up and considered in subsequent studies.

Reflexivity

Finally, truthfulness and rigor were established through the process of reflexivity. The PI recognized the relationship and pre-knowledge which existed with the phenomenon of nurses caring for and intervening with patients suffering psychosis or

other severe mental health issues during all phases of data collection and analysis. The purpose of this was to not only prevent bias from overly affecting the data analysis, but also to incorporate existing knowledge and experience with new data to gain a new understanding, and add to the extant knowledge of the phenomenon of interest. Smythe (2011) stated that a researcher is unable to unbind themselves from pre-knowledge which will always bias their perspective. The responsibility is for the researcher to be aware of, and acknowledge this to let the reader know how this may influence the study and the new understandings gained (Smythe, 2011)

Validity

Validity will be achieved by assuring the results for the study can be applied to the entire population of nurses providing direct patient care. This is the primary reason the population will consist of nurses across multiple healthcare settings. All nurse participants in the study have experienced the phenomenon of intervening with patients experiencing psychosis and/or other severe mental health issue.

Limitations

This research was limited primarily by geography. All data were collected in one geographical area in the Midwest. How this phenomenon is experienced in one region of the United States could be different in other areas.

Chapter Four

Results and Interpretations

Overview

The interpretations presented in this chapter focus on the lived experience of nurses caring for patients manifesting symptoms of psychosis or suffering other severe mental health issues. How nurses were prepared for this phenomenon was also of relevant interest, and part of these interpretations. The purpose of this research was to find meaning and gain a deeper understanding of this phenomenon from a nursing centric viewpoint. This is a representative population/sample, and may not present the lived experiences of the entire nursing profession. Nurses who have worked in multiple healthcare environments with a significant combined level of clinical experience shared their stories to contribute to the research data.

The accounts shared by the participants display the significance of this phenomenon. Psychosis is one of the most serious of mental health issues (APA, *DMS-5*, 2013). In addition to psychosis, patients can also experience other severe psychiatric symptoms. Almost all registered nurses working at the bedside will experience caring for patients with these illnesses at least once during their careers (Hickin et al., 2017; Jacobsen et al., 2018; Pelzer-Jones et al., 2019).

At times the stories recalled by the nurses in this research told of crisis events that resulted in physical and emotional trauma for all involved. Some of this trauma remains unresolved. Often the choice of intervention and course of action made by the nurse is the difference between harm/injury and safety. Much pressure is put on the nurse to make the correct decision without delay (Dusseldorp et al., 2011; Thompson et al., 2013).

Participant Background

Ten registered nurses (N=10) made up the sample population for this study. Varying levels of education were represented, and the degrees included Associate's (2), Diploma (1), Bachelor's (3), and Master's (4). The gender and race included 3 male and 7 female, 4 African American, and 6 Caucasian nurses. The participants ranged in age from 42 to 75 years. The clinical experience was from 2 plus years to over 50 years of caring for patients at the bedside. Multiple healthcare environments were represented in the data set. These included experiences shared from emergency departments, intensive care units (ICU), mental health/psychiatric, home health, long-term care, outpatient clinics, infusion clinics, and medical/surgical floors (see Appendix A for BICS NINR demographic questions). This may not represent all healthcare settings, but made up a good sample representation, and this led to an experience rich data set (see Table 2 for demographic information).

The participants were recruited over the course of six months. Primarily, a purposeful recruitment strategy was employed which is consistent with Heideggerian hermeneutics (Dibley et al., 2020). Participants in this methodological approach need to have experience with the phenomenon of interest to give experiential data (Dibley et al., 2020, Vandermause & Fleming, 2011). All potential participants (N=10) were asked by the PI if they had experienced caring for and intervening with a patient manifesting symptom of psychosis or some other severe mental health issue. Each participant had confronted this phenomenon at least once in their nursing careers.

A snowball recruitment strategy was also used whereby participants were able to assist in identifying other participants for the study. Flyers were also used to recruit

participants and were distributed during conversations between the PI and potential participants. No participants were coerced during recruitment, and informed consent was attained from all before the beginning of data collection. Each participant was also informed they could withdraw their consent at any time without penalty or reprisal.

The interviews were conducted over the course of 5 months. No more than one interview a week was conducted, and each transcript was analyzed before moving to the next interview. This approach was employed to give full attention and consideration to each interview and participant's experiences. This was also done for the PI to receive guidance and feedback from the research team as the data collection and interviews progressed. Through this process, the interviews and data collection improved and became richer and more experiential as the interviews continued.

Patterns and Themes

The participants (RN) shared their experiences with caring for and intervening with patients suffering from psychosis or other severe mental health issues. These stories were vivid, unembellished, and stark at times. As the interviews and transcript analysis progressed, several common threads and patterns that will be presented in this chapter began to become illuminated within the stories (see Table 3 for data analysis patterns). Quotes taken directly from the participant's conversations are also presented to support the findings.

Table 3*Data Analysis Patterns*

Pattern 1	Pattern 2	Pattern 3
Being in an Environment of Sudden Chaos	Guiding the Intervention for Security	Needing to Prepare for the Unexpected
<i>Facing the Crisis</i>	<i>Ensuring Safety</i>	<i>Beginning Unequipped</i>
<i>Deciding the Course</i>	<i>Communicating Therapeutically</i>	<i>Gaining Experience</i>
<i>Bearing the Weight</i>	<i>Getting Invasive</i>	

Pattern 1: Being in an Environment of Sudden Chaos*Facing the Crisis*

Nurses are the frontline staff caring for patients experiencing psychosis or other serious mental health issues in healthcare settings, and constitute the largest demographic of the workforce caring for mental health patients (Dusseldorp et al., 2011). The participants were forthcoming, and at times graphic during the discussions/interviews. The very first pattern to be apparent in the experiences shared by the nurses identified these episodes as crisis events.

As each participant openly communicated their stories, one after another described episodes that could be described in no other way than crises. They gave a clear first-hand account of what it meant to be a nurse attempting to navigate a mental health emergency in which urgency in action was paramount to avoiding disaster. When providing care for a patient manifesting symptom of psychosis or other severe mental health issues the whole environment is often thrown into sudden crisis.

Minnie expresses how this phenomenon can be all consuming for the nurse as he/she provides care. “We go from one crisis to another crisis to another crisis to another crisis, and we’re always preparing for the next crisis (**Minnie, l. 547-548**).

This describes a common concern faced by nurses caring for patients with serious mental health issues. Nurse’s need to continually intervene, or always feel compelled to be prepared for the next emergency. This requires the nurse to focus all or most of their attention on this, and leaves little time for other concerns regarding patient care.

These are serious events that often occur with little to no warning. Once the crisis is present, the whole environment is propelled into chaos, and the nurse is expected to quickly find a way to restore order and control. The participants in this research expressed in detail how this phenomenon quickly turns the milieu into disorder. This obliges the nurse to instantly respond in an effort to protect all from harm.

John depicts how the crisis event can arrive without warning, compelling the nurse to immediately spring into action in an attempt to restore order and security. At times, the emergent episode requires the nurse to physically lay their hands on the patient, endangering both patient and staff.

And this particular patient came from behind and was attacking the social worker. So, I had to drop what I was doing, and I had to run toward that patient and use the element of surprise and grab them in basically a bear hug from behind. This was a standard operating procedure back in the day that I had learned from my coworkers (**John, l. 281-284**).

John’s experience is common in the study population. All of the participants told stories of needing to use more invasive and restrictive interventions during a crisis.

Having to place a patient in a manual hold not only risks harm or injury to the patient, but

it also puts the staff at risk. In addition to the physical risk, these types of interventions also carry the potential to cause emotional trauma to the patient and/or staff.

Marie and Hanna further reveal how these events erupt with little to no warning, causing the nurse and staff to transition immediately into crisis management.

I happened to be on a unit where a patient unexpectedly jumped over the nurses' station and started punching a psychiatric technician who was sitting at a desk. And as a result, the technician fell back into me (**Marie, l. 22-26**).

He started swinging at anybody. It was like a blind rage. Um, it was very frightening. People were injured – severely injured. Um, I think two people were severely injured (**Hanna, l. 185-188**).

These stories are repeated among the participants; many of these incidents become violent and physical. Marie's and Hanna's stories reinforce this. Nurses across interviews expressed how challenging it is to deliver patient care when the patient is assaultive, and actively attempting to hurt themselves or somebody else.

Even when the episode does not immediately become violent or physical, these are crisis events. They can have long lasting effects on the nurse, and cause trauma that will be carried by the nurse for the remainder of their career. Yara endures an episode that would cause emotional trauma to anybody who underwent such an occurrence. She has a patient make what she believes is a credible threat to kill her. She is so fearful she is paralyzed and does not know what to do.

So I froze. I didn't know what to do. I didn't want her to know how fearful I felt because she did have a history of violence. So my first thought was, oh, my gosh, she's gonna hurt me. What do I do? So I – I froze. So much so that I was really paralyzed. I couldn't even think about what to do. All I could do was just stand there. This went on for about five minutes. So finally I did ask her in a really low-tone voice, "Can I help you?" And she said, "I'm gonna kill you." And I thought, oh, my God. I said, "Well, do you need anything?" What can I get for you?"

“I’m gonna kill you.” And I thought, oh, my God. What do I do? (**Yara, l. 32-42**).

This resulted in long lasting emotional trauma to Yara, as she goes on to describe. These events can have a profound effect on nurses. The consequences can leave a long-term emotional and psychological burden, and influence all future nurse patient interactions. Often the nurse is left to process this on their own the best they can, while they continue to provide care for the patient who traumatized them.

I was so petrified. Now luckily, nothing happened physically, but that doesn’t mean that mentally I wasn’t affected. Because I was. And eventually, it got better and, you know, I didn’t have as much trepidation (sic) as I had from that experience. It got better with time, but it – it’s, um – it left a mark that I will never forget because, you know, anything could’ve happened (**Yara, l. 75-81**)

The nursing profession experiences caring for patients suffering serious mental health issues in a way that is unique to all other healthcare providers. They are the key and central figures during these events, and act as a focal point through which these crisis move. In most emergencies faced in healthcare settings the person or team is able to direct their attention on a single patient or issue, and deliver streamlined focused care. As the crisis is being dealt with, staff do not need to consider their own wellbeing or that of others. When a nurse or team responds to a mental health emergency, frequently their attention must be divided as they have to consider the wellbeing of all within the environment.

Hanna’s experience is a typical example of divided attention. She conveys how difficult it is to supervise such episodes. In this situation she was attempting to direct several people (staff) who were overexcited and frantic to the point that they were not

following directions. This only bled into the problem, and made it worse, causing more harm and injury than necessary. She left this incident with feelings of guilt that persist.

It was difficult to instruct others, um, even though they were staff, to stop the screaming. Um, the injured people had left, and the continued hysterics by the staff was disconcerting and upsetting, not only to the client, but to anybody who was trying to help at that time. But that was a problem that always stuck with me because the staff was so hysterical that they became part of the problem. And that they all wanted to jump in, even – even people who weren't trained to handle the man physically wanted to get in there as if it was some kind of street fight (**Hanna, l. 197-208**).

Victoria also illustrates how these are crises like no other for the nurse, as he/she attempts to re-establish safety and order. In her episode, she has two patients she is trying to care for at the same time, and now she must divide her attention on both as she is also expected to give directions to the staff who are looking to her to end the crisis and find the path back to safety.

So he – we couldn't redirect him, and then all of a sudden he got so agitated he just started attacking the other patient. Well, the other patient could handle himself, so it turned into a brawl. You know, they were throwing punches, hitting each other in the head. You could hear it. It was just a – it was like a thunderous sound. And I'm standing there. I'm new. And the other – the aides, they're looking at me. So I'm like, well, let's do – I don't know. We did an all available (**Victoria, l. 56-63**).

Finally, Maria endures an experience that most nurses fear to face, but many have had to manage. In her story she has patients she must consider, but she also has staff who are her responsibility that are thrown into the emergency. To top this off, she suddenly has two crisis events to navigate at the same time. During these, she has both patient and staff in harm's way and at risk for injury. This story fully demonstrates the uniqueness of these events, and how these are unlike almost any crisis event that healthcare workers encounter.

The patient continued to struggle while we were trying to restrain. He was kicking and he was spitting, and it required several other staff to intervene. Um, in the interim, while we were trying to contain this patient, another patient who happened to be in the milieu -- um, when the door was opened to allow more staff to come into the nurses' station, another patient ran in and jumped on top of the patient we were trying to restrain. So it was a very volatile situation. So not only did we have to try to contain the patient who initially was punching the staff member, we also had to contain this other patient who was so severely upset about that patient, um, hitting a staff member. So we had actually two volatile incidents that we were trying to -- to, um, handle at the same time (Maria, l. 31-43).

Deciding the Course

Once faced with a severely mentally ill patient and a crisis, the nurse must decide on a course of action. Participants related what it is like to direct interventions during these episodes. Nurses are required to make decisions regarding patient care and interventions across healthcare environments. This is an integral function of the profession. Decision making theory is essential to informing current and future nursing practice across all environments and disciplines in healthcare (Watkins, 2020). However, during a crisis event the stakes go way up, and this is not the time to choose the wrong path or course of action. Thomson et al. (2013) reported that over half of all adverse events in patient care settings have some decision-making error as a contributing factor.

Nurses communicated what it was like to be in the environment when these crisis events erupted. This caused them to be thrust headfirst into a decision making mode. This produced stress and anxiety as they were compelled to make decisions that would potentially be the difference between wellbeing and injury, as they attempted to find a way back to safety and restore order. At times, the participants also described how they felt isolated as they struggled to make these decisions on their own.

Victoria expresses her anxiety related to losing control of the patient and the environment. Her focus is on finding a way to re-establish control and order, but as her story demonstrates, this requires the nurse to immediately make a choice on how best to do this. This caused her to feel fear and anxiety as she faced this decision.

But it was fearful for the patients and how things were gonna end with them. And, ah – and I was just thinking how are we gonna get it back under control. Cause, you know, you feel like you've lost all control when this happens. So then you're thinking, well, what – what can we do now to get things back under control (**Victoria, l. 152-156**).

John and Shelby both reinforce these emotions. As they attempted to manage their respective mental health emergencies, anxiety and doubt pervaded their thinking. The participants articulated how this can cause hesitation in action and further complicate and exacerbate the event.

I hadn't been trained to make the decision about when do you approach, when do you back off, when is it – when do certain things happen that are the deal-breaker where you – it – it clicks in your mind (**John, l. 97-101**).

And, um – so at this point in my career, I'd never experienced anything like that amount of, um, trauma. And so in my management role, I, you know, was asking, um, you know, where's the option? What do we need to do? (**Shelby, l. 37-40**).

Bob's sentiments are common for nurses during these episodes. He articulated that at times the nurse feels isolated as they have been they have been left on their own to make the decision on the intervention. In his tale, you can feel the fear and angst that overtakes him as he is attempting to restore safety and order without knowing what actions to take to accomplish this task.

So, um, you know, that – that was a – that was probably one of the first times I'd ever, um, thought, oh, my God, I need to restrain this patient, or, oh, my God, I need to keep this patient safe and everyone else safe,

but I don't know how to do that. (Laughter.) I don't – I can't do it on my own **(Bob, l. 43-47)**.

Victoria's opinion of her performance demonstrates how nurses are often very hard on themselves in their personal evaluation. This particular incident left her feeling despondent.

It was just discouraging really. Because you thought – you know, the day was going good and you thought you were doing a pretty good job until all of a sudden everything got out of hand. And then you're like, well, I didn't do – I didn't do a good job at all **(Victoria, l. 215-219)**.

Bearing the Weight

The findings from this research are consistent with previous studies concerning how nurses must make decisions on a course of action when faced with a severely mentally ill patient. These are serious events in which the nurse must suddenly transition into decision making mode for the welfare of everyone. The choice on nursing interventions for a patient experiencing psychosis or other severe mental health issue must be quick, effective, and as therapeutic as possible (Crook, 2001; Thomson et al., 2013; Watkins et al., 2020). This is a profound responsibility.

Participants across conversations conveyed their thoughts and perceptions related to choosing a course of action when confronted with a mental health crisis. One of the common patterns to emerge was that they felt a sudden heavy weight of responsibility placed on them as they were compelled to make these decisions.

Victoria's statement does a good job of representing the sentiment of how nurses feel responsible for everything that happens within the environment. "Because I'm the one there and I'm responsible for whatever happens on the unit" **(Victoria, l. 159-160)**.

Participants perceived a responsibility for the safety and wellbeing of all within the environment. These experiences were consistent with previous research. Nurses felt they carried the weight of responsibility for the safety of patients, themselves, and all other staff members (Power et al., 2020).

Nurses are required to make split second decisions with much riding on the interventions. When the crisis episode ends with someone being hurt or traumatized, the weight of responsibility can sometimes hit the nurse like a crashing wave. After reflecting on their decisions related to crises interventions, both Minnie and Victoria feel accountable for outcomes that were less than desired. This feeling of being culpable for negative results was voiced across participants.

Where could we have intervened that could've had a different outcome? And so we are very hard on ourselves. And so when you see – when your natural job is to look for all the places you could've done better, you sometimes feel bad and like, oh, like I didn't do what I could've or I didn't do enough **(Minnie, l. 241-245)**.

You're trying to get it in your mind, well, what could we have done to prevent this from happening? Or could we have gotten one of the patients something sooner? Or maybe we could have redirected the other patient away from him – or both patients away from him. Or maybe we could have, ah – I don't know – saw it coming and put him in restraints **(Victoria, l. 190-195)**.

At times, nurses feel the weight of responsibility even when they are not really responsible for the negative outcome. Yara expresses this when she shares feelings about how she was affected. In her story, her decision was to strongly advocate to the physician not to discharge a patient that was experiencing suicidal ideation. She did this in the clearest way she knew how, and implored the doctor to reconsider the discharge. The patient was released over her objections, and subsequently committed suicide once on his own. Yara felt deeply responsible for

this even though she did everything in her power to prevent this from happening.

This event traumatized her, and she still feels responsible for the death.

So it was very sad, very tragic. I thought about it for a long time. I felt a little guilt because I thought, well, maybe if we had been a little bit more forceful, then maybe the psychiatrist would've taken us more seriously, even though I don't know what else we could've done. But that really bothered me. That was – that was very traumatic **(Yara, l. 128-133)**.

After the crisis was over, the nurses reflected on the event, and were often their own worst critic as they processed their own decisions and the outcome of the interventions. This is similar to existing literature, which found that nurses felt an internal conflict when they needed to enact interventions that were more restrictive. This emotion was present even when the intervention was used to prevent harm or injury (Danda, 2022; Muir-Cochrane et al., 2014; Power et al., 2020).

This is similar to another phenomenon that affects the nursing profession known as moral distress. Salari et al. (2022) found this happens to a person when they must perform acts contrary to their moral beliefs. Because morality and ethics play a significant role, this has become one of the most pressing issues in nursing practice (Salari et al., 2022). Nasrabadi et al. (2021) reported that nurses are required at times to make decisions that disagree with their personal or moral values. This can be ethically challenging and have several negative results. These include a decreased level of patient care, negative clinical outcomes, job loss, and diminished overall wellbeing for nurses (Nasrabadi et al., 2021).

Pattern 2: Guiding the Intervention for Security***Ensuring Safety***

Nurses acknowledged that the number one factor that all interventions were predicated on was the need to maintain and/or restore a safe environment and control; safety for the patient, staff, and all others within the environment. The participants described this as a milieu without chaos or disruption, and one that poses no threat of harm or injury to anyone. This was a consistent pattern noted across interviews, and was brought up time and again during the conversations. Participants revealed that restoring or maintaining safety was the number one component they graded themselves on when looking at the outcome of an intervention.

John brings up the duty that is placed upon the nurse to ensure and maintain safety for all within the environment. His statements speak to this as being a top priority when providing care to these patients and maintaining order.

I always tried to provide for the safety of the client and the safety of the staff (**John, l. 280-281**). I made decisions very quickly based on really basic principles I knew to be true to try to keep the people in that environment safe, including myself (**John, l. 352-254**).

Safety is an important factor in all phases of patient care, and this is always in the forefront of the decision-making process. Maria speaks to this in her description of a restraint intervention. Even though the patient was acting out verbally and physically, safety remained a paramount consideration for both the client and staff. She explains this in the following excerpt.

We were able to then physically, ah, restrain with a physical hold until we could safely put that – the patient into the restraint chair. So during the restraint chair, the patient continued to struggle, um, was yelling and screaming. So it was a very volatile situation. But once we got the patient

secure into the restraint chair, we were able to safely administer some medication **(Maria, l. 51-57)**.

Gina adds to the importance of safety being first and foremost. She describes an event in which the environment deteriorated into what she described as a small war zone when a patient became so enraged, he started to cause destruction to the ward, and was throwing various items in an attempt to hurt people. Her first thought and actions were to get the other patients to safety. She describes how this can be very challenging when the environment is in pure chaos.

It's so chaotic when it first starts. It's just chaotic. And, ah, having to – to get the other patients to a safe area, ah, get them away from falling debris. It – it's like a slight – a small war zone actually. It's like a small war zone **(Gina, l. 49-53)**.

Everyone needs to feel safe in their environment. A patient can begin to get dysregulated when they feel unsafe, even when there is no basis in reality for this perception. This can cause them to act out verbally and physically and compromise the welfare for all. It is the nurse's duty to make sure everyone feels secure. Hanna shares an incident where a patient suffering psychosis became upset when he feared for his own safety. She was able to assure him that all was well, and this intervention was effective enough on its own to prevent a crisis event.

He had to be put to the floor for his safety until we could calmly do something other than, um, struggle. Um, the client continued to struggle. I got down on the floor, um, knelt down near his head. I just spoke to him in a soft voice, trying to reassure him, reorient him. I told him my name. I didn't know where he was in his psychosis. Um, I wanted him to know that I was there, someone he knew, someone that I feel he, um, trusted. Um, he was agitated, um, that he was being held. I told him that the reason he was being held was for his safety **(Hanna, l. 143-152)**.

When comparing these experiences with existing research, these findings are consistent. Maintaining an environment that is safe for all was a major pattern found in

the extant/current literature. Safety was a key factor and nurses based much of their care and interventions on this issue (Bigwood & Crowe, 2008; Danda, 2022; Felton et al., 2018; Power et al., 2020). Muir-Cochrane et al. (2014) found that nurses in their research study sought to provide a secure area of care for all, and this was one of the top priorities. Attempting to maintain safety in the face of chaos is a challenging and valiant endeavor for nurses.

Communicating Therapeutically

Therapeutic communication is a universal component to nursing practice and is utilized across healthcare environments. This is an essential skill for nurses to develop. Current research and literature reveal therapeutic communication is fundamental to nursing practice and crucial to the relationship between patients and nurses (Bigwood & Crowe, 2008; Felton et al., 2018). When nurses intervene using therapeutic communication in a crisis situation with a patient manifesting psychosis or other serious mental health issue, this is referred to as verbal de-escalation.

Effective communication and de-escalation techniques can prevent the necessity of more invasive interventions and thus mitigate the potential trauma these cause to both patient and staff. Felton et al. (2018) found that this intervention, when performed effectively by nurses quite often was all that was necessary to maintain and restore safety in the environment and no other interventions would be needed.

Nurses in this research communicated their opinions on the importance of therapeutic communication/verbal de-escalation. Participants across narratives reported that this was a crucial nursing skill to develop and, when dealing with a mental health crisis, was a necessary intervention. They also expressed the importance of timely and

effective communication in helping de-escalate a crisis event or preventing one from occurring. The conversations also conveyed that this intervention was vital to maintaining and/or restoring safety and order into the environment.

Gina points out the fundamental importance of communication to the nurse and patient relationship.

It's communication. Communication is a plus. If you can't communicate, you can forget it because it's so important to learn how to talk to a person, to learn how to respect their boundaries, to learn how to respect their choices, whether you agree with it or not. Those things. And you learn how to get along (**Gina I. 333-338**).

John illuminates that verbal de-escalation is an essential intervention when providing patient care and preventing a crisis event. He explains that this is the first intervention initiated and maintained throughout the interaction with the patient.

And so in terms of interventions of trying to keep people from being violent who were on the threshold of, I don't think there was ever a time when either the doctor or the nurses that were present or myself didn't like step up and, ah, try and calm people when it was possible (**John, I. 301-305**).

Maria and Yara support this concept as they describe the importance of therapeutic communication in all situations. In their conversations, they also add that not only is it important to communicate with patients, but also with the staff. This further demonstrates how the nurse has to continually divide their attention as they direct the interventions to restore safety and order to the environment.

I guess as you can see, therapeutic communication in all incidents of violence is so important. Trying to remain calm, trying to reassure the patient that is violent as well as reassure the staff that you're working with, um, really makes a difference in the violent situations that I have been involved in. If all the staff is hysterical while the patient is hysterical, it just makes matters worse (**Maria I. 159-164**).

And I've also learned how to be more therapeutic with my communication and how to assist staff and recognizing staff feelings and when their emotions are taking over. And I have learned how to help tap out certain individuals during those situations where they might need to tap out just to get their breath, get themselves together, before they would intervene with – with the patient that's violent (**Yara, l. 126-122**).

Hanna demonstrates the effectiveness of this intervention when performed appropriately. She stresses the importance of developing effective communication skills to address a variety of issues the nurse must confront in their day-to-day work.

It has stayed – has stayed with me and served me well through all – you know, I've been a nurse almost twenty years now, and has served me in different capacities and different ways, but has served me well. The remaining calm. The reorienting somebody. Um, quieting the room. Um, it – it has served me in so many ways. I can't tell you (**Hanna, l. 77-82**).

These findings are consistent with previous research and extant literature. Results in existing studies report that nurses will initiate and use verbal de-escalation in an attempt to avoid more invasive practices, which could result in trauma or injury for patient or staff. This was identified as the most important skill for nurses to develop and utilize (Bigwood & Crowe; 2008; Power et al., 2020). Participants in this study reported that this skill was attained mostly through clinical experience and time spent with patients. Considering the importance of this skill at addressing a mental health emergency, this is an ability that should be present on day one of nursing practice.

Getting Invasive

One of the core beliefs of the nursing profession is to do no harm. When therapeutic communication on its own is not effective at de-escalating a crisis situation and restoring safety, nurses must turn to more invasive interventions like pharmacotherapy and manual restraints. Some nurses feel these interventions go against this fundamental principal of their profession.

Previous research has shown that some nurses experience an internal conflict when having to use more restrictive practices such as these. Powell et al. (2020) found that having to use invasive interventions caused an emotional struggle with nurses in their study. Even though these interventions were initiated to restore safety and keep all from harm, nurses in previous studies experience moral distress at times when needing to utilize these (Danda, 2022; Muir-Cochrane et al., 2014; Power et al., 2020).

During conversations in this research, nurses expressed the need to use more restrictive interventions to address a mental health crisis. Most participants said that they would avoid these practices, when possible, but at times these were necessary. When describing these interventions nurses would often include the justification for needing to take these extreme measures to restore safety and prevent harm or injury to everyone within the environment. Another common theme across experiences were statements of how these interventions were implemented as ethically as possible, and that therapeutic communication was maintained throughout.

One of the issues surrounding restrictive practices was knowing when to initiate these. A nurse must learn how to assess the client and situation to know when these are appropriate. Bob brought this up in his discussions. Early in his career, he was uncertain when to initiate an invasive intervention and this made him uncertain, but this changed with time and experience.

I didn't feel like I could justify restraining patients early on in my career, I guess. That was like my – that was a big growing – growing curve for me, ah, learning how to know when to restrain a patient or know how to, um, not do that. Not use restraints in those situations **(Bob, l. 66-71)**.

John highlights the concept of needing experience to know when to use restrictive practices. During his conversation, he also explains that these interventions, restraints in particular, were applied only when necessary.

When do certain things happen that are the deal-breaker where you – it – it clicks in your mind, okay, I'm gonna have to restrain this person **(John, l. 98-100)**.

So, um, restraining people was only done out of necessity. Therefore, although you may have had some inkling that somebody was going to act out violently, um, the only preparation you had was to become more hypervigilant **(John, l. 335-338)**.

Many of the participants were sure to explain that restraint interventions were necessary at times to maintain or restore security in the milieu. As they shared their experiences with having to initiate these interventions, they took great pains to include the details of the crisis to use as a justification for the restraints. This is the case in Gina's conversation where she is describing having to place a patient in a restraint chair. She felt somewhat guilty for taking this extreme measure, but had no other option to keep the patient and everyone else safe.

And we often had to use it with a young lady who, um, is no longer there. She was transferred to our sister place and, um – because she tore down all the cameras. TVs on the wall. And we would have to go get her off the chair, bring her down, and hold her and then get the, ah, restraint chair because she would not stop. If you'd turn her loose, she'd go back. So we would have to use manual restraints **(Gina, l. 141-147)**.

Shelby brings up another consideration many other participants pointed to. Even when having to use more invasive techniques, the nurse provides constant ongoing assessment to the patient to keep them from harm or trauma during the incident. He was careful to explain how he continually looked after the patient's physical and emotional

wellbeing during the restraint episode. As he is relaying this, it is apparent that at least in part this also helped him justify taking this drastic measure.

I – anyway, we quickly, um, you know, helped the client be safe by correcting that restraint situation. You know, we made sure that she had good color, movement, and sensation in her extremities. We – we tightened the restraint, but it wasn't too tight. And then she remained in the chair for, um – I don't know – almost the full time in our institution – like a little more than two hours. And we monitored her. She continued to be safe. Um, and we did – you know, we followed the protocols **(Shelby I. 251-258)**.

To conclude, Denise further emphasizes how nurses use invasive procedures only when necessary. In her story, she does not have the option of using mechanical restraints. During this episode, she must direct a five-person team to coordinate a manual hold for the safety of the patient and others. She articulates that this is very challenging to do during a crisis event, having to focus attention on the patient and four other people at the same time. She is also careful to explain, like other participants, that this maneuver was managed as safely as possible.

So if he or any other client became, um – became really aggressive or was having some type of psychosis where they have these raging thoughts and they were a danger to themselves or others, we could put them in a five-man hold. And we didn't have restraint chairs, so it was a hold. And sometimes we would place them in a chair or we would take them down respectfully to the floor **(Denise I. 115-121)**.

These findings agree with previous research reports and current literature. Most nurses in existing studies would rather avoid restrictive interventions when possible. However, nurses felt these were a necessary component to nursing practice and at times were needed to address a mental health crisis to restore safety and keep all within the environment from harm (Bigwood & Crow, 2008; Danda 2022; Perez et al., 2022). These

results also agree with the existing literature reporting that nurses will attempt to avoid more invasive practices and limit the intervention to therapeutic communication when at all possible (Bigwood & Crow, 2008; Danda 2022; Perez et al., 2022).

Pattern 3: Needing to Prepare for the Unexpected

Beginning Unequipped

When performing any task in patient care, it is vital that nurses have developed the skills and have the knowledge that are necessary for a successful outcome. This is even more important when having to engage in a crisis situation. During an emergent episode, nurses must act quickly, decisively, and effectively for the welfare of all. They do not have the time or the luxury to hit the pause button and seek advice or guidance to reveal the pathway to success and avoid catastrophe.

Current research shows a gap in clinical knowledge with new nurses, and suggest that most of this gap was filled through informal training given by more experienced nurses (Bigwood & Crowe, 2008). This is a hit or miss way to gain important clinical knowledge. Existing literature shows that many nurses were unsure they were making the correct or wise clinical decisions on interventions and patient care, and this was related to a lack of education and guidance for best clinical practice (Danda, 2022; Jensen & Clough, 2016).

As the population in this study communicated their stories related to caring for patients suffering psychosis or other severe mental health issues, it was clear that they confirmed the current research. All of the participants spoke at length concerning their preparedness for intervening with these patients, and they overwhelmingly stated that they were not ready, at least from the beginning of their careers.

This dearth of readiness included not having developed either the clinical knowledge or the emotional intelligence to effectively navigate these events and keep everybody from harm. Many of the nurses shared how this led to uncertainty in their decision making, and this may have contributed to a higher number of negative outcomes. Many participants also expressed how this has caused them continuing emotional trauma. A lack of training from their educational experience and from employers was identified across interviews.

John is clear and succinct in his words. Even though he was made aware that he would need to provide care to patients experiencing mental health issues up to and including forcing medications and initiating restraints, he received no real formal instruction on these techniques/nursing skills. His introduction to managing a mental health crisis was when he was licensed and working on the floor.

Of course, none – none of this had I been prepared for, ah, in my clinical studies and rotations as a student nurse. **(John, l. 52-54)**. I didn't see anybody placed in a manual hold. I didn't see anybody receiving medication against their will. And so these were – although I knew the possibility was there, these were foreign concepts to me until I was actually embroiled in having to do them **(John, l. 106-111)**.

Bob is even more descriptive and vents his vexation with the lack of preparation he received to care for these patients. In his opinion, his schooling did not include adequate lectures/discussions on how a nurse must manage a mental health emergency. The frustration is clear in his voice as he speaks to this issue.

My nursing education didn't really even – I don't know if we even discussed restraints beyond the, you know, one or two incidents of this is how you, um – this is a dangerous way to restrain somebody, or this is an incident where you would, ah – where something happened. There was never like a – nursing doesn't really address this environment – this type of environment. Nursing education – my nursing education didn't – psych nursing – do any of that **(Bob, l. 75-82)**.

This theme is continued with Minnie and Shelby. The education they received in nursing school did not prepare them to care for patients experiencing severe mental health issues or how to manage a crisis event.

They talk about mental health and they talk about what it looks like and they talk about the medications that we give them, but they don't teach us anything else. And every patient is a mental health patient on some sort of spectrum. And even, you know, in a hospital, they're going to – they're sick. So they have something going on, so there's an internal struggle that they're trying to process. And again, us as nurses are not taught the basic skills of how to deal with people like that **(Minnie, l. 453-469)**.

I don't recall a lot in nursing school, um, that trained me for, um, you know, dealing with clients that were intoxicated. I do recall rotations in the psych ward in nursing school, but – and some of 'em – oh, yeah, I don't remember studying much there in the psych ward **(Shelby, l. 280-284)**

A few participants do express that school did touch on some of the facets of mental health nursing but not nearly enough to prepare them for what they would encounter once they were on the floor caring for these patients on their own. Maria's and Denise's excerpts illuminate this.

We learn very basic therapeutic communication skills in nursing school, and that's something that just develops the more years that you study and the more years that you're exposed to it. So just coming out of nursing school, I don't think I was prepared for any of this **(Maria, l. 171-175)**.

I didn't learn anything about how – about suicide prevention, digging into the psychosocial history and understanding the triggers in nursing school. We touched upon it, but it's the difference between touching upon it and actually experiencing it **(Denise, l. 33-36)**.

Participants not only identified a lack of education/training in their schooling, but they also pointed to a lack of this from their employers. Victoria speaks plainly to this as she states that once employed as a nurse, the facility she worked in did nothing to prepare her

for the types of patients and issues she would be encountering. “Cause you don’t get any type of training to deal with that at all. At that facility, we did not. None” (**Victoria, l. 167-168**).

To conclude, Yara points to a profound lack of education/training from either her school or employer. This made her feel completely unprepared to care for patients manifesting psychosis or other serious mental health issues. This statement seems all too representative of the study participants, and possibly the nursing profession as a whole.

I wasn’t prepared. Not by school. Not by virtue of my employment I was not prepared. I didn’t get that in my, ah, nursing career. In fact, I hardly even ever remember talking about patients experiencing psychotic episodes maybe other than what the symptomatology was, but not in terms of the actual behaviors and how nurses were to intervene. I don’t ever remember getting that part. I may have gotten it, but it – if I did, I don’t remember it, so it probably was the case that I didn’t get that education. So I was not prepared (**Yara, l. 217-225**).

The stories shared by these nurses are consistent with current research and literature. Participants did not feel they were prepared to effectively intervene in a mental health crisis, at least at the start of their career. Current literature identified a deficiency, and thus a need related to initial and ongoing education for nurses so they can provide more effective care for these patients and effectively manage these crises (Danda, 2022; Jensen & Clough, 2016). Nurses in this research agree with this deficiency and need for better preparation, both clinically and emotionally.

Gaining Experience

With the education and training, or lack thereof considered, how do nurses acquire the skills needed to effectively care for a patient manifesting psychosis or other severe mental health issue? How do they prepare to intervene and effectively direct care during a crisis event?

Study participants identified clinical experience as the number one factor that prepared them for this phenomenon. Knowledge is critical to caring for these patients and managing mental health emergencies. Time spent at the bedside caring for patients is an elemental component to developing nursing skills. Seeing, hearing, and being in the lived body during these crisis events numerous times is of great benefit. This allows nurses to utilize critical thinking to determine what will work, and what will not when faced with similar patients and situations as they progress through their careers.

Current research re-reinforces this concept. Jensen and Clough (2016) found that it is essential for nurses to learn and develop the skills to effectively intervene with a patient manifesting psychosis or other severe mental health condition. However, these skills do not develop on their own for most nurses, and without them and the ability to assess the patient and situation, the environment can quickly turn into a crisis resulting in compromised safety (Jensen & Clough, 2016).

The population of this research also expressed their thoughts and opinions on the importance of clinical experience. Throughout the interviews and data collection process, a very common thread was apparent in their stories. They did not feel they were prepared initially to effectively intervene with a patient experiencing psychosis or other severe mental health issue, but felt more equipped as they gained more experience in their nursing practice. This improved preparedness came from clinical experience. Having faced this phenomenon before made them more prepared to effectively handle the crisis when they confronted it again.

Bob explains the importance of clinical experience. In these excerpts from his conversation, he explains it is clinical experience that has made him prepared to care for

these patients. He also includes that his years working as a nurse have made him more confident and improved his decision-making ability.

I feel like now that I've been a nurse for whatever it's been – eight – eight years or so – I feel like I'm prepared, but that's through the experiences that I've had working much less than the experiences that I had in school **(Bob, l. 220-223)**.

I certainly have more confidence now. Um, you know, I think that, um, I feel like just like anybody in any career, once you – the longer you're in it, the more confidence and more expertise you're gonna feel like you have. Um, I think that's – ah, that's certainly true. I feel a little more confident **(Bob, l. 242-246)**.

Maria and Victoria affirm the importance of clinical experience. Much more than school, it is the clinical experience of working on the floor providing direct patient care that prepares you to intervene in a mental health emergency. Victoria adds that experience is also beneficial to the nurse in their leadership role with the staff.

Because nursing school does not prepare you for those situations, um, that you deal with – the type of severely, ah, mentally ill patients. So I think a lot of time, um, studying, learning more, and training and years of experience is what it takes, um, to become a very seasoned psychiatric nurse **(Maria, l. 200-204)**.

But if you can anticipate what they are, you can kinda prevent the – the behaviors that – that could follow so that came with experience. You know, um, knowing the patient, knowing their triggers, knowing the staff and their triggers **(Victoria, l. 263-265)**.

In Gina's opinion, experience is the only thing that will prepare nurses to intervene with a patient manifesting psychosis or other severe mental health issue.

Nobody can – nothing can prepare you if you don't have some experience. You've got to get some experience as you come through the ranks **(Gina, l. 228-230)**.

John illuminates the significance of clinical experience and signifies its importance. He does include that his nursing school did teach him theory, and this was of

great use. In his opinion, theory and practice combine to create the best path to skill development and thus make for the best preparation for a mental health crisis.

The real learning comes from your interactions with the patients. The real learning comes from seeing – I mean, I really – it’s important to know the theory, but it’s a starting place. It – it gives you a window of opportunity to make good decisions in the moment when you first experience things. But it – there is no replacing, ah, experiential knowledge (**John, l. 443-448**).

Hanna goes into great detail related to the importance of clinical experience for a nurse. In her opinion, experience has several benefits. First, she believes it will better prepare you for the inevitable crises you will face as a nurse. She also opines, that with experience, a nurse is able to develop an intuitiveness or instinct that allows them to anticipate a crisis and transition into decision making mode before the episode gets out of control.

Yeah, with the experience I’ve had, um, I am – it’s like a radar. Does that make any sense to you? Um, I – well, one thing that is in my favor is I know my clients well. Um, the – the smallest of detail can alert me to something, and I think that only comes with experience. Um, I imagine it works – would work the same, um, because you’re looking for the same signs and symptoms, um, if it was a – if you were in a facility or a different unit and didn’t really necessarily know ‘em like I know mine. But that – that intuitiveness and that education, um, comes into play when you’re on the floor after so many years (**Hanna, l. 272-281**).

The experiences shared by the nurses in this study and their statements related to clinical experience are consistent with current literature. Time at the bedside providing patient care is a key factor in developing necessary nursing skills. The decisions on nursing interventions for a patient manifesting psychosis or other serious mental health issue need to be quick, decisive, and effective (Crook, 2001; Thompson et al., 2013; Watkins et al., 2020). Clinical experience greatly aids in the decision-making process. Education and training also play a major role in the success or failure of nursing

interventions across healthcare environments (Bigwood & Crowe, 2008; Danda, 2022; Jacobsen et al., 2018). Nurses in previous research, in addition to the participants in this study, feel that education and training have been lacking up to this point (Bigwood & Crowe, 2008; Danda, 2022; Jacobsen et al., 2018).

Summary

The participants in this research shared their experiences to assist with illuminating and finding meaning in this phenomenon. Their stories give vital insight of what it means to be a registered nurse caring for a patient manifesting psychosis or other severe mental health issues, and what it is like to manage a mental health crisis. These are serious events with much riding on the nurse to make quick and knowledgeable decisions. Timely and effective intervention in a mental health emergency is often the difference between restoring safety for all, and the event leading to trauma or injury.

The participants shared that during these crisis events much chaos is injected into the environment, and this creates difficulty when directing the interventions and staff efforts. Often, the nurse's attention must be divided among more than one factor during these emergencies, as they must consider the wellbeing of patient, staff, and self. This makes these events even more challenging to navigate. The nurses in this study expressed that they feel a great weight placed on them related to feeling accountable for the wellbeing of all within the environment. They also felt guilt and remorse at times when the outcome of the intervention(s) was less than desired, and/or leads to trauma or injury to someone.

Safety was the number one factor that nursing interventions was predicated on when deciding a course of action during a crisis episode. Most of the participants shared

that therapeutic communication (verbal de-escalation) was vital to their nursing practice caring for patients with severe mental health issues, and should be immediately initiated and maintained throughout. This intervention, when effective, would at times prevent the necessity of more restrictive interventions needed to restore safety and order. When verbal de-escalation alone was not successful at ending the crisis, the nurses stated that they would need to move to more invasive practices such as pharmacotherapy and manual restraint. These interventions were initiated only when necessary, and as safely and ethically as possible.

To conclude, the nurses in this research spoke on the issue of being prepared for this phenomenon at some length. They overwhelmingly expressed that they were not ready to effectively care for a patient manifesting psychosis or suffering some other mental health issue. They verbalized that they were not adequately prepared to intervene during a crisis event, at least at the beginning of their careers as a registered nurse. Nursing schools and employers were both listed as entities that failed to prepare them.

Being able to prepare and effectively manage these crisis events came in the form of clinical experience. The nurses communicated that, although they were not prepared at the start as they gained experience and clinical knowledge, they became more confident in their skills. Clinical experience was far and away the number one factor listed as the best path for preparation to care for and intervene in a crisis with a patient(s) suffering psychosis or other severe mental health issue.

Chapter Five

Implications

This research set out to explore and find meaning to the phenomenon of nurses caring for and needing to intervene with a patient manifesting symptoms of psychosis or other severe mental health issue. Nurses in most all healthcare environments will encounter this phenomenon. This study also examined what factors and entities prepared nurses for these events. The results interpreted from the data clearly confirm the significance of these events. Nurses must act swiftly and effectively to address the crisis, or the consequences can be dire.

The implications from this research can be best determined by considering how the overarching patterns identified in chapter four answered the two research questions. These include *Being in an Environment of Sudden Chaos*, *Guiding the Intervention for Security*, and *Needing to Prepare for the Unexpected*. These have the potential to effectively address this phenomenon and nursing practice going forward.

Research Question One

How do nurses experience psychotic manifestations of confusion, aggression, and violence in patients they encounter?

The study participants gave clear data on what it means to be a nurse caring for, and needing to intervene with, a patient manifesting psychosis. The experiences shared came straight of the environment of care, and described scenes of sudden disruption that compelled the nurse to immediately transition into decision making mode. These events and research question one were effectively answered within the first two major patterns and their sub-themes.

Being in an Environment of Sudden Chaos

Facing the Crisis. Once licensed and working on the floor, nurses are charged with maintaining order, control, and security for all. This is in addition to all other patient care duties expected of nurses across all healthcare settings. Any environment in which nurses will find themselves working in has the potential to erupt into a sudden crisis, but the participants in this research described events that had a particularly high element of danger. The nurses conveyed one after another emergency event in vivid detail. Often these ended with some person (patient or staff) injured and/or traumatized.

Setting aside the component of how nurses are educated and trained, more needs to be considered concerning this phenomenon. This includes research that focuses on the nursing role directing the crisis intervention. As of their 2018 research, Jacobson et al. report that no systematic review or meta-analysis had been published. Methods of creating interventions for psychosis and other severe mental health issues needs better methodological research, rigor, and clarity (Jacobsen et al., 2018).

Deciding the Course. Mental health crises are serious events. This was plainly reinforced by the study participants. Making the appropriate choice of intervention to avoid disaster was the principal factor in this decision. Being able to select the course of action quickly is of paramount importance, and this was conveyed by the study population. More than one half of all adverse outcomes in healthcare setting result from some error in decision making (Thompson et al. 2013).

Healthcare employers need to look for ways to assist nurses with these events and decisions. This includes having resources such guidelines or action plans created with evidence based practice available in the environment for nurses to utilize. These have

been historically lacking. Presently there is too little information and EBP guidelines for the care of severely mentally ill patients and how to effectively intervene in these episodes (Dusseldorp et al., 2011; Jacobson et al., 2018). This one size fits all approach to interventions might not work in every crisis episode nurses may need to manage, but it is a start.

Bearing the Weight. All nurses working in direct patient care bear a great weight of responsibility. They must constantly assess the patient, environment, and situation, and then attempt to be perfect as they provide care. Nurses are hard on themselves when the outcome is less than desired. This is a profound obligation that is willingly taken on by all in this profession. Nurses in this study shared how they feel about this burden. Participants in this research confirmed this perception.

Powell et al. (2020) found that nurses feel responsible for the safety and welfare for patients, themselves, and all other staff members. The population in this study often included how they felt saddled with an extra responsibility for the wellbeing of everyone in the environment. This was due to the frequent violent nature of the emergency episodes, and the potential harm and trauma these can cause. Even when the outcomes were successful, nurses felt traumatized and an emotional stress at times. This has the potential to lead to job burnout, leaving the profession and reduced quality of patient care. Goa et al. (2023) found nurses in their study had to cope with an increasing number of emergency events, and high-risk working environments. For many, this led to what they termed emotional exhaustion and severe job burnout (Goa et al., 2023).

This issue needs to be addressed through multiple processes. Nurses need to take better care and responsibility for their own mental health. This includes identifying

problems such as work-related stress and trauma, and seeking help. Workplaces need to improve at acknowledging and addressing this issue. A greater number of resources need to be available to nurses when they seek out assistance. This may include counseling services, development of support groups, and time off after a severe crisis event to process and cope.

Guiding the Intervention for Security

Ensuring safety. Safety was a large factor in the way nurses in this study viewed and experienced this phenomenon. Maintaining a safe environment is integral to nursing practice and is identified as a top priority (Muir-Cochrane et al., 2014). A crisis episode compromises the security and welfare of all, and task number one for nurses is to find a way to regain order and control. Participants articulated that all other considerations are placed on hold until security has been restored to the milieu. Unless this has been achieved, patient care and clinical outcomes are at risk, and the resulting consequences can be injury or trauma.

This is another issue that should be addressed through numerous actions. Employers need to ensure and maintain safe staffing ratios. Lin et al. (2007) found a correlation between inadequate staffing and negative outcomes for patients. Healthcare employers also need to have systems in place that will reduce potential harm to patients and staff such as education/training, and other resources available that promote safe practice (Lin et al., 2007).

Communicating Therapeutically. Therapeutic communication was a frequently discussed topic during interviews. Participants expressed the importance of using this intervention when caring for a patient suffering from a severe mental health issue. Often

when used effectively, this can de-escalate and help prevent a crisis event. This will likely also mitigate the need for more invasive interventions such as pharmacotherapy and restraints (Bigwood & Crowe, 2008; Felton et al., 2018).

Therapeutic communication is a necessary skill for all nurses to have in their repertoire, and should be in place on day one of working at the bedside. Current research agrees with this and finds that therapeutic communication is fundamental to nursing practice and vital to the nurse-patient relationship (Bigwood & Crowe, 2008; Felton et al., 2018). However, this issue needs to be addressed better in nursing programs so that students are better prepared to communicate with patients once on their own. While some schools do provide simulation-based training, many students do not get enough real-life opportunity to interact with patients in clinical sites (Han et al., 2024). Students also express difficulty engaging with in this activity from fear of harming patients or interfering with therapy or treatment (Han et al., 2024).

Getting Invasive. Nurses in this research spoke at length on the topic of having to use more restrictive practices to address a mental health emergency. When a patient is experiencing psychosis and unable to think rationally, they do not always respond well to verbal de-escalation. At times, restrictive interventions are necessary for the security of everyone. This was a consideration the nurses were sure to bring up when speaking about restraint interventions. They had to constantly consider the welfare of all within the environment, and not just one patient. One of the concerns many of the participants communicated was the uncertainty of when to make the decision to put a patient in restraints, and how to direct and guide the staff during this episode to keep everybody from harm.

This is an issue that needs more attention across the board. Including more comprehensive consideration from nursing schools, employers, and research. Having to place your hands-on to restrict the movement of someone who is incapable of lucid thinking is risky at best and absolutely dangerous without proper training and education. Before attempting this intervention, a person should be required to have received thorough instruction. Most nurses in this research conveyed they had never even seen a restraint episode, much less have been educated in the proper techniques before they were working in direct patient care. Danda (2022) expressed nurses were unsure of decisions on interventions when caring for a patient manifesting symptoms of psychosis due to lack of education.

Research Question Two

How do nurses express their experiences and preparation when they must intervene with patients manifesting psychosis or other severe mental health issue?

Participants in this study effectively communicated their preparation to care for a patient experiencing psychosis or other severe mental health issue. They also spoke of the factors that made them ready to intervene in a crisis episode involving one or more of these patients. Research question two was comprehensively answered in the third major pattern and its sub-themes.

Needing to Prepare for the Unexpected

Beginning Unequipped. Each one of the participants clearly expressed that they were not prepared for this phenomenon on day one of their tenure as a licensed nurse. They did not feel that they were sufficiently made ready by their school or employers.

Prepared or not, these events happened. The nurses shared one story after another in which they were compelled to make quick decisions in an attempt to guide the environment back to safety. As they were directing these actions, there was much uncertainty related to their choice of interventions. This led many of the participants to feel anxiety and stress; some even shared experiences in which they felt traumatized by an episode because of not being properly trained.

This is not a good way to affect positive clinical outcomes. It is also not a good way to retain nurses in healthcare. More needs to be done to prepare the nursing profession to face these events on their first day of bedside care. Many nurses in this research made statements saying that they were given no clear information related to these events. The use of restrictive practices and crisis interventions were touched on at best, and not mentioned at all in some cases.

A multi-faceted approach needs to be taken to effectively address this issue. This topic needs to be addressed in the classroom lecture first. Theory is a good place to begin the learning process. Many nursing schools provide some lecture and simulations of severe mental health episodes. This is beneficial and may need to be expanded. Hands-on activities like this help students gain knowledge and awareness on how to manage these episodes. These also allow for trial-and-error learning while under the observation of more experienced nurses (Evans et al., 2025; Huggins et al., 2019). Finally, educators need to seek out learning opportunities in clinical environments, even if this is limited to observation. If students could only visualize a mental health crisis, it can be of benefit. This will give them an idea of what to expect once they are in a direct caregiver role.

Gaining Experience. There is no substitute for experience. This is a commonly accepted belief in almost all professions. Nurses in this research reinforced this idea. They did not feel adequately prepared at the start of their career, but time spent at the bedside helped them develop valuable skills and emotional intelligence. Clinical practice seems to afford the best form of preparation, and most of these nurses feel better able to manage these crisis episodes with time spent on the floors caring for these patients.

Nurses who have spent years developing valuable skills can be worth their weight in gold. Having a seasoned nurse at the helm ready to navigate an episode with a patient manifesting psychosis or other serious mental health issue is all well and good, but this is not as easy as it may seem. Benner (1984) conducted a landmark study on how nurses become journeymen at their craft and identified 5 levels of clinical proficiency nurses pass through: novice, advanced beginner, competent, proficient, and finally expert. However, attaining the moniker of expert is not a mere matter of chronology. It requires the fine tuning of predetermined ideas by encountering numerous real-life episodes that are able to merge nuance to theory (Benner, 1984). Formal education combined with clinical experience seems to be the formula for success in becoming a highly skilled nurse who is prepared for most of the situations they will face in their practice in healthcare (Benner, 1984).

Future Research

The experiences explored through the nurses in this study have gone a long way to answering the identified research questions, but it does not end there. The investigation in many research projects identifies as many, if not more questions than it answers. Such is the case with this study. A primary question that investigators should consider at the

end of all research: is future research on this phenomenon necessary, or indicated. A one-word answer to this question in regard to this report is yes.

Would standardizing practice/interventions help with the preparation? This would probably go some way to addressing this phenomenon, but would not completely solve the problem. Considering the nurse's narratives in this research, these crisis events seem to have a certain level of uniqueness and may not present enough commonality. Standardizing practice and taking a one size fits all approach may or may not help in these situations. What would work for one episode/patient may not work for the next, may only exacerbate the event, and increase the risk of harm or injury. Maybe gaining a better understanding begins with the medical community acknowledging the severity of this phenomenon, the far-reaching effects it can have on multiple people, and making a commitment to examine the issue.

If clinical experience is the key to successful intervention and positive clinical outcomes, what can be done to bridge the gap from novice to expert? This is a tough question and deserves some further investigation. We need to examine what is the best way to keep inexperienced nurses safe and able to effectively care for these patients until they gain the clinical knowledge and develop the emotional intelligence necessary.

What are the long-term emotional effects this has on nursing, and subsequently on their ability to provide effective patient care? This topic was brought up by many of the participants in this study. Several of the stories shared by the nurses ended with them describing how these episodes had negative emotional effects. Some expressed that they were continuing to process these episodes and still felt traumatized. This topic deserves

further scrutiny for the sake of the nursing profession and for the patients who depend on them for care.

How many nurses leave the profession after they experience an event such as this, even one or two times? This is a question that deserves immediate attention. Thirty three percent of new nurses leave the profession within two years of being licensed (Stovall & Hansen, 2021). While most of this attrition cannot be attributed to this phenomenon, some of it surely can. But how much, and what can be done to mitigate this and keep nurses from leaving? This was commented on by several of the participants in this research. The immediate and profound emotional strain these episodes put on nurses can be too much to bear, and this is certain to account for some leaving the profession for the sake of their own mental health.

Conclusions

This research took a Heideggerian hermeneutic approach to answer the identified research questions. The participants in this study shared their experiences to convey what it is to be in the living body of a nurse who is caring for a patients manifesting symptoms of psychosis or other severe mental health issue. They described in detail what it means to be compelled to intervene in an emergency event with these patients. They communicated that these were crisis episodes that obligated them to make quick and effective decisions on the course of action to restore security and ensure the welfare of all within the environment. Most effective interventions include therapeutic communication; this is a valuable and elemental skill that must be learned. Most nurses will turn to restrictive practices such as pharmacotherapy and restraints as an action of last resort. They also spoke of the profound emotional weight these events caused, and the trauma

that is carried forward, as they continue to provide the high level of care expected of the nursing profession.

The population in this research also shared the preparation they received to face this phenomenon. Most of these nurses stated that they were not ready on day one of their careers to effectively intervene in these situations. Educational institutions and employers were both identified as entities that failed in this endeavor. Because of this they were uncertain of the choices they were making as they directed the actions to navigate the environment back to safety. This doubt caused them stress and anxiety. It was through clinical experience that these nurses gained the knowledge and confidence needed to manage these crises, affect positive clinical outcomes, and ensure the welfare of all within the environment.

Stakeholders need to be made aware of the seriousness of this issue and begin to effectively address the problem. Nurses are a valuable commodity and, at this moment in time, are in too short a supply. There is an ongoing shortage of licensed nurses, and refusing to address phenomena such as this will not help the dilemma. Nurses are the most present profession in the healthcare environment, and make up the largest demographic of direct patient care providers. The health of the population depends on their continued participation. However, it is unfair to expect anybody to remain in an environment of constant stress and danger. We need to search for ways to better prepare nurses to care for these patients on their first day of bedside care. This has to be through education, training, and resources that will assist them in these crisis episodes. We also have to find ways to keep them safe, supported, and the space in which to grow, while

they gain valuable experience and clinical knowledge. We all need for them to become experts in their chosen profession.

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Appendix A.
Interview Guide

Interview Questions

1. Tell me about a time(s) when you were caring for a patient experiencing psychosis and needed to intervene.
 - a. Follow up questions (Possible)
 - i. Tell me more.
 - ii. Anything else to share.
 2. What did you do or what was done to prepare you to care for and intervene with a patient experiencing psychosis.
 - a. Follow up questions (Possible)
 - i. Tell me more.
 - ii. Anything else to share.
 3. Anything else you would like to share about your experiences in caring for patients experiencing psychosis.
-

Demographic Questions

BRICS NINR Demographic Survey Questions

1. Age
 2. Gender
 3. Race
 4. Ethnicity USA Category
 5. Education Level USA Type
-

Recruitment Flyer



Reserachers at the Universtiy of Missouri St. Louis College of Nursing want to learn more about nursing interventions with patients experiencing psychosis.



Research is always voluntary!

You may be a good fit if:

- You are a Registered Nurse
- You have experienced caring fo a patient experiencing psychosis at least once in you carreer

If you decide to take part in this study, you would:

- **Participate in a 30–60-minute interview in which you share your experiences taking care of and intervening with patients experiencing psychosis and other mental health crises.**

There are no direct benefits for you participating in this study. However, your participation will contribute to knowledge of nursing interventions for psychosis.

To compensate for time, participants will receive a \$25 gift card.

For more information on this research please call **Christopher Jasensky RN, PhD Candidate** at (314) 277-0822 or email cdjgx6@umsystem.edu

Consent to Participate

cdjgx6@umsystem.edu

College of Nursing

One University Blvd.
 St. Louis, Missouri 63121-4499
 Telephone: 314-277-0822
 E-mail:

Informed Consent for Participation in Research Activities

**Nursing interventions for psychosis and other mental health crises: a hermeneutical
 phenomenological study of nurses' experiences**

Please listen carefully as I read this information to you. When we begin the recorded interview I will ask you if you were provided with an informed consent reading and I will confirm that you understand your rights to participate or to stop at any time, and that you are fully willing to proceed.

Principal Investigator: Christopher Jasensky PI's Phone Number 314-277-0822

-
1. You are invited to participate in a research study conducted by Christopher Jasensky. The purpose of this research is to examine situations or experiences related to registered nurse preparing for, and intervening with patients experiencing psychosis or other mental health crises.
 2. Your participation will involve:
 - Participating in a recorded interview. Approximately 12 Registered Nurses
 - The interview is an open conversational exchange that is expected to take approximately 30 minutes, depending upon how much or little you want to share. You will be asked to describe situations or experiences related to your role as a registered nurse caring for and intervening with patients experiencing psychosis. I will ask some questions but you will direct the conversation as you wish, follow-up question may also be offered. Together we will explore your role as a registered nurse and how you prepare for and intervene in these events.

- The entire interview will be audio-recorded and transcribed by members of the research team. All of the names and identifying features will be taken out of the transcripts so that the data is completely anonymous. The audio-recordings will be destroyed once the de-identified transcripts have been checked for accuracy. The de-identified transcripts will be kept indefinitely for research and educational purposes only, and will not be shared outside of the research team without your written permission. While there is always a risk to breach of confidentiality in any study everything possible will be done to minimize the risk through the security of our data management.
3. There are no anticipated risks associated with this research. It is possible that you will experience some discomfort if you have troubling experiences to relate. Talking about your work experiences can be enjoyable or not. I will do my best to conduct a comfortable interview.
 4. There are no *direct* benefits for you participating in this study. However, your participation will contribute to knowledge of nursing interventions for psychosis.
 5. Your participation is voluntary and you may choose not to participate in this research study or to withdraw your consent at any time. You may choose not to answer any questions that you do not want to answer. You will NOT be penalized in any way should you choose not to participate or to withdraw.
 6. By agreeing to participate, you understand and agree that your data may be shared with other researchers and educators in the form of presentations and/or publications. In rare instances, a researcher's study must undergo an audit or program evaluation by an oversight agency (such as the Office for Human Research Protection). That agency would be required to maintain the confidentiality of your data.
 7. If you have any questions or concerns regarding this study, or if any problems arise, you may call me, Christopher Jasensky, at 314-277-0822. You may also ask questions or state concerns regarding your rights as a research participant to the UMSL Office of Research Administration, at 314-516-5897.

Participant's Signature

Date

Signature of Investigator or Designee

Date