Original Article

Nurses' Experiences Caring for Immigrant Patients in Psychiatric Units

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Abstract

This study was conducted for the purpose of describing nurses' experiences caring for immigrant patients in psychiatric units. The topics investigated include how nurses describe the reasons for their immigrant patients' illnesses, how nurses experience caring for immigrant patients and what kind of impact cultural factors have on nursing. Especially refugees face complex barriers in accessing the health care system, and challenges exist when it comes to delivering high-quality care to this vulnerable population. Qualitative research methods were used in the study, and the main emphasis was on focused ethnography research methods. The informants were nurses (N = 5) working in adult psychiatry wards of the study's hospitals. Data were collected by means of in-depth interviews, observation, field notes and documentation of care by nursing staff of immigrant patients (N=9). Nurses' experiences caring for immigrant patients formed four stages: admission, the beginning of care, collaboration and the finishing stage. Suspicions about the asylum process and cultural conflicts add to the workload in nursing. It was not common to use transcultural nursing methods or an interpreter. Family-oriented nursing and use of interpreter services by nurses should be increased in the care of immigrant patients. By becoming aware of the existing challenges, their manifestations and by supporting the professional wellbeing of psychiatric nurses, enables them to concentrate to the essence of compassionate nursing as well as to ensure the rights of the patients.

Keywords: immigrants, nursing, psychiatric nursing, refugees, transcultural nursing

Introduction and background

Migration to Europe has increased in recent years (Eurostat, 2017; United Nations High Commissioner for Refugees, 2017). This has led to growing demands on multicultural health care which need to be recognised and reacted to (Castaneda et al., 2012). According to the Finnish Act on the Status and Rights of the Patients (785/1992), the mother tongue, individual needs and culture of the patient have to be taken into account as far as possible in his/her care and other treatment.

The incidence of mental health problems amongst all immigrants, especially amongst refugees, is high compared with the majority of the population (Bridges et al., Andrews, & Deen, 2012; Castaneda et al., 2012; Koponen et al., 2015). A recent umbrella review found that depression and anxiety are at least as frequent as post-traumatic stress disorder, accounting for up to 40% of asylum-seekers and refugees (Turrini et al., 2017).

Previous research illustrates that nurses have an apparent lack of knowledge and skills related to

transcultural nursing (Wilson, 2010; Ahmed et al., 2011; Hultsjö et al., 2011; Kaiser et al, 2013; Alvarez et al., 2014; Mulder et al., 2015; Kallakorpi, 2017). A study (Sandhu et al., 2013) that involved the examination of the experiences of health care professionals from 16 different European countries in delivering care to immigrants reported complications with diagnosis, difficulty in developing trust and increased risk of marginalisation. (Sandhu et al., 2013). Mulder et al. (2015), in their study of the multicultural competence of Finnish nurses (N=86), illustrated that, though the nurses' cultural knowledge was good, a third of the informants had prejudiced views regarding immigrant patients. Moreover, every tenth nurse recognised racism and avoided immigrant patients. Sainola-Rodriquez (2005) reported that, based on medical records, Finnish psychiatric ward doctors did not analyse asylum-seeker patients' own perspectives on illness or care. The quality of care was uneven, and only certain nurses tended to care for asylum-seekers.

To tackle these obstacles, organisational flexibility is required, along with individualised care, sufficient time and resources, experienced interpreter services (Williams & Thompson, 2011; Kerkkänen & Säävelä, 2015), collaboration with the families and social services, increased cultural awareness among staff, good interaction, continuity of care and education (Priebe et al., 2011; Sandhu et al., 2013; Strasmayer et al., 2013). Transcultural care may involve combining different treatment methods and help create positive and confidential nurse-patient relations (Kerkkänen & Säävelä, 2015). Community-based interventions have also proven valuable for improving the mental health of refugees (Williams & Thompson, 2011).

Many transcultural nursing theories and models that have been developed to improve the quality of nursing in multicultural environments. Some of them aim to increase the cultural competence of nurses by increasing their knowledge and skills through cultural assessments of patients (Leininger, 1991; Giger & Davidhizar, 2002; Purnell, 2002), and some are focused especially on assessing the cultural competence of nurses and nursing students (Campinha-Bacote 1999, Papadopoulos, Tilki & Taylor 2004). Cultural competence has been defined by Campinha-Bacote as 'an ongoing process in which the healthcare professional continuously strives to achieve the ability and availability to work effectively within the cultural context of the patient' (Campinha-Bacote, 2008). Nurses have the opportunity to assess, guide and support refugee clients when they are adapting new life situations (Keys & Kane, 2004). In terms of psychosocial interventions, cognitive behavioural interventions — specifically, narrative exposure therapy — were the most studied interventions with positive outcomes against inactive but not active comparators in. The study consisted of 14 reviews (Neuner et al., 2010; Patel et al., 2014; Turrini et al., 2017).

This study is a pilot study and it is the second in a two-part series examining psychiatric care among immigrant patients. The aim of this study was to describe nurses' experiences with caring for immigrant patients in psychiatric units. In particular, the topics investigated included the following: how nurses explain the reasons for their patients' illnesses, how nurses experience caring for immigrant patients and what kind of impact cultural factors have on nursing.

Methodology

Design

Qualitative research methods were used in the study, and the main emphasis was on focused ethnography research methods. Focused ethnographies are commonly conducted by nurses or other professionals whose major field is not anthropology. \

They are characterised by time-limited fieldwork involving participant observation, in-depth interviews and the collection of specific research data, such as medical records, that relate to narrower research questions than those that come up in traditional ethnography. Focused ethnographies are useful for understanding organisational culture (Cruz & Higginbottom, 2013; Chesnay, 2015).

In this study, data were collected by means of in-depth interviews, observation, field notes and documentation of care by nursing staff. Field notes were detailed summaries of events and behaviour and the researcher`s initial reflections on them. Field notes are important for prompting the ethnographer ´s memory of observations (Bryman, 2012). Inductive content analysis was used to analyse the material.

Participants

The study was conducted in Finland between May 2008 and December 2009. Nurses at psychiatric units were asked if they would be willing to participate in the study. The inclusion criteria were that they had cared for or were caring for the immigrant patients who participated in the joint study. Most of these patients had been refugees or asylum-seekers. The informants were nurses (N = 5) working in adult psychiatry wards in a university hospital district in Finland. They were between 30 and 50 years old. They had 2 to 20 years of working experience in the psychiatric field, with an average of ten years. Three of the nurses had bachelor degrees, and two were practical nurses specialized in psychiatric care. None of participants had not received any training on multicultural issues, but they all had cared for immigrant patients in psychiatric units on previous occasions.

Data collection and analysis

The researcher (the first author) interviewed informants using Spradley's (1979) descriptive, structural and contrast questions. Interviews lasted from 40 to 60 minutes. A total of five in-depth interviews were conducted. Throughout the research process, the researcher confirmed her understanding of informants' meanings by asking them for confirmation of the accuracy of her interpretations. In her field notes, the researcher reflected on the interviews and observations of the wards. Observations took place on the wards of the nurses and their immigrant patients prior to the interviews. The researcher observed behaviour, atmosphere, listened to what was said in conversations both between others and with the fieldworker, and asked questions. Observations helped the researcher understand the different perspectives, communal care and other aspects that affected the care. Documentation of care by the nursing staff on those patients (N=9) who participated in the joint study gave complementary information on how cultural issues were taken into account in practice. Data from audiotaped interviews were transcribed verbatim.

Ethical considerations

In focused ethnographic studies, ethical considerations are associated with the common principles of research as well as with observing participants and conducting interviews. (Niemi & Paasivaara, 2008). In this study, the ethical aspects were considered in every phase of the process. Informed consent was obtained from all participants. Institutional approval was obtained from both the manager and ethical committee of the hospital district (14/13/03/03/2008), and it was supplemented in May 2009 concerning the documentations of care by nurses of immigrant patients who participated in the study.

Inductive content analysis was conducted. The process included open coding, creating categories and abstraction. Open coding means that notes and headings are written in the text while reading it (Elo & Kyngäs, 2008). Labels of codes came directly from the text. Codes were then sorted into categories based on how different codes were linked. Emerging categories were identified after repeated reading of data. Each category was named using content-characteristic words. Subcategories with similar events were grouped together as categories, and categories were grouped as main categories.

Results

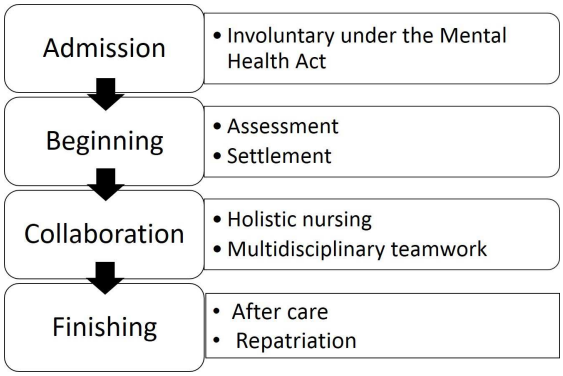
Nurses' description of patients' symptoms and reasons for illness

The nurses described a number of different symptoms in their patients: depression, pain symptoms and psychotic symptoms. Depression manifested itself as insomnia, lack of appetite and suicide attempts. Compared to Finnish-born patients, the pain symptoms were more prevalent, and nurses wished they had more training with it. From the nurses' perspectives, there were multiple reasons for illness in immigrant patients. They discovered that immigrant patients had experienced more loss and trauma than Finnish-born patients. Forced immigration, the loss of loved ones, social problems (divorce, use of illicit drugs, economic problems) and biological heritage were all given as causes or triggers for illness.

Nurses' experiences caring for immigrant patients

Nurses' experiences caring for immigrant patients fell into four stages. These are admission, the beginning of care, collaboration and the finishing stage. The four stages of nursing care for immigrant patients are described in Figure 1.

Figure 1. The four stages of nursing care for immigrant patients

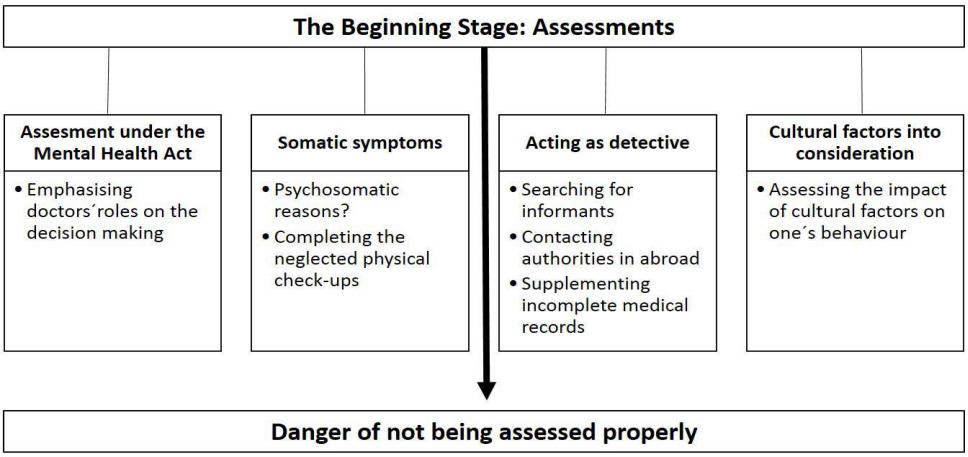


In the context of our study, admissions occur primarily via emergency clinics; patients are either escorted by police under the Mental Health Act or they come voluntary. The beginning stage consists of assessment and settlement in the unit. Assessments include assessment under the Mental Health Act, assessments of somatic symptoms, acting as ´detective`, taking cultural factors into consideration and the danger of not assessing. Some of the nurses were uncertain whether to trust patients´ story of being persecuted in their home country or whether it was a symptom of psychosis. They also had doubts on asylum-seekers´ real purpose for admission to psychiatric units. This danger is demonstrated by this description:

> *´Well, it depends in what stage of the asylum-seeking process they come. Often, the asylum-seekers come to our unit, in some reason, when they are already being repatriated, and for some reason they get mentally ill at that point.'*

The assessments of immigrant patients in the beginning stage are described in Figure 2.

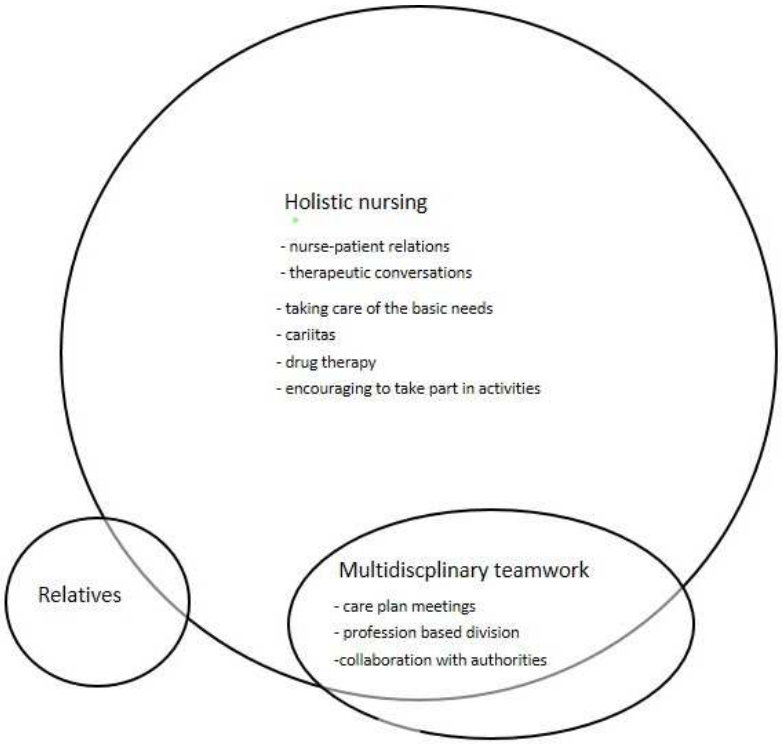
Figure 2. The assessments of immigrant patients in the beginning stage



The collaboration stage includes holistic nursing and multidisciplinary teamwork. Holistic nursing includes nurse-patient relations, therapeutic conversations with the named nurse, taking care of basic needs, caritas, drug therapy and encouraging patients to take part in activities.

Multidisciplinary teamwork consisted of care plan meetings, profession-based division of duties and collaboration with authorities (police, lawyers, staff at the reception centres). Nurses recognised the importance of family-centred care in their work with immigrants, but they seldom implement this in practice. Some of the nurses found relatives helpful for patient recovery, and some thought that relatives added their workload and hindered recovery.The collaboration stage is described in Figure 3.

Figure 3. The collaboration stage.



The finishing stage includes discharge and organising plans for after care. Some of the patients are discharged and repatriated, while others are referred to psychiatric policlinics and supported housing. Some return to reception centres. Though some patients may be recovered at this stage, some may still be suffering from suicidal ideation.

The asylum-seeking process and cultural conflicts often lead to stressful situations for psychiatric nurses working with immigrant patients. Nurses had doubts about the real purpose for patients´ admission to psychiatric units: the need for psychiatric care or a way to influence the asylum-seeking process. Cultural conflicts were caused by different views of illnesses between nurses and patients' relatives, the lack of knowledge of relatives regarding visiting hours, the lack of verbal communication, patients' cultural habits and disagreements between patients themselves (though these were rare).

In the study, the nurses described three kinds of coping skills they use to overcome stressful situations: (1) empathy — that is, imagining themselves in their patients' positions; (2) a sense of humour about immigrant patients; and (3) a refusal to editorialise the asylum-seeking

process. The third is demonstrated by this description:

> *'There are things that I cannot do anything as a nurse. It is not my duty to decide whether they have a strong case to stay in Finland or not. I don't see containment like that as a big deal, but I just need to remain myself of it.'*

Nurses' perceptions of culture care

Nurses' perceptions of effective culture care included the following considerations: flexibility with cultural habits; family-oriented nursing; sensitivity to gender issues; courage to encounter; respect; willingness to communicate with the aid of a suitable interpreter; and confidential nurse-patient relations. Some of the nurses were more interested in multicultural work than others and felt closer emotionally to immigrant patients, as demonstrated by this description:

> *'I think it's because of the patient´s culture that somehow nurse-patient relation is closer with immigrants than with Finnish patients, immigrant patients tend to get emotionally closer, like if we were friends together.'*

Nurses' experiences working with interpreters were divided into good experiences, coping without interpreters and difficulties with interpreter. Coping without interpreters consisted of nonverbal communication, speaking in the foreign language, insufficient caring, possibility for mistakes in nursing and financial concerns. This latter issue is seen in the following description:

> *'First, I think that what our financial management would say, if I for example, would start to order interpreter services, when I have discussions with this patient from South-American.'*

Interpreter services were used in the care of immigrant patients but mostly with doctors' appointments or in multidisciplinary care plan meetings and not so often with nurse-patient conversations or in therapeutic groups. Nurses noticed that the competence of professional interpreters varied significantly. Some were better suited to the psychiatric field than others.

Discussion

In this study, nurses' descriptions of symptoms included depression, pain symptoms and psychotic symptoms. Post-traumatic stress disorder was not mentioned even though rates of posttraumatic stress disorder (PTSD) are exceptionally high among asylum-seekers (Neuner et al., 2010). Traumatised refugees often report significant levels of chronic pain in addition to posttraumatic stress disorder symptoms (Teodorescu et al., 2015).

The nurses also did not mention the danger of vicarious traumatisation or secondary traumatic stress in the present study. Their methods of coping were imagining themselves in the position of their immigrant patients, a sense of humour about immigrant patients and a refusal to editorialise the asylum-seeking process. The last two of them are questionable methods of coping. Vicarious traumatisation (VT) refers to harmful changes that occur in professionals' views of themselves, others and the world as a result of exposure to the graphic and/or traumatic material of their clients. VT can result in decreased motivation, efficacy and empathy. (Baird & Krace, 2006).

Immigrants' admissions were found to be often involuntary via emergency clinics. In those cases, patients are mostly escorted by police under the Mental Health Act. A previous study demonstrated that non-Western immigrant groups have been over-represented in psychiatric emergency care and were admitted compulsorily more frequently, possibly owing to a different clinical presentation (Cornelis, 2006). Relationships with an individual which comprised effective communication, cultural sensitivity and the absence of coercion resulted in that person being attributed with a sense of trust (Gilburt et al., 2008).

The asylum-seeking process was identified as a source behind feelings of suspicion. Nurses had doubts on patients´ real purpose for admission to psychiatric units. Some of the nurses also were uncertain whether to trust patients´ story of being persecuted in their home country or whether it was a symptom of psychosis. In Sandhu et al. (2013) study the complication to reaching an appropriate diagnosis in psychiatry was the difficulty in differentiating between symptoms of

psychotic disorders and reactions to prior traumatic experiences. Additionally, they had similar results in their studies regarding the difficulties of developing a trusting relationship, but the reasons were considered to be patients' negative experiences from previous experiences of torture, oppression and ethnic conflict. (Sandhu et al., 2013).

The collaboration stage includes holistic nursing and multidisciplinary teamwork. In a systematic review by Williams and Thompson (2011), the most 'successful' mental health intervention models used a multidisciplinary approach to acknowledge different genders, age groups and mental health needs. (Williams & Thompson, 2011). Family-centred care was considered important in cultural care by nurses, but they reported implementing it only seldom in practice. Some nurses thought it helped patients' recovery, and some it as a hindrance. In Conrad and Pacquiaos' study (2005), strong family involvement was viewed as both a strength and barrier to care by health care practitioners. Family members' participation was highly influenced by their own beliefs about illness, which may be contrary to the professional worldview. The existing family hierarchy may not be supportive of the patient either. Families were conscious of the social stigma attached to mental illness, which hindered their commitment to and acceptance of the treatment prescribed (Conrad & Pacquiao, 2005).

In the finishing stage, after care is organised. The patients' conditions vary: some are fully recovered, while others still harbour suicidal intentions. Treatment in Finland for adult asylum-seekers is instructed to consist of only the necessary care (Act on the Reception of Persons Seeking International Protection and Recognising and Helping Trafficking Victims 17.6.2011/746 50 §). Incomplete or poor assessments, in addition to malpractice, are risks associated with premature discharge. There may also be a lack of sufficient after care, for example, in the case of repatriations and in reception centres. This can also lead to ethical dilemmas and extra burdens when nurses are unable to care for asylum-seeking patients as well as others. Nurses report feelings of dissonance associated with their ethical and professional commitment and the application of the general law (Gea Santzhes, 2015). There might also be a concern about what happens to patients after they are discharged. According to Meffert et al. (2010), mental health professionals can provide diagnostic information that may support applicants' claims; however, they can also evaluate how culture and mental health symptoms relate to perceived deficits in credibility or delays in asylum application. They can define mental health treatment needs and estimate the possible effects of repatriation on mental health (Meffert et al., 2010.)

The nurses who participated in this study stated that they had not received any training on multicultural issues. Based on earlier research, there exists a lack of culture care (Jones et a, 2004; Leishman, 2004; Wilson, 2010), difficulties with diagnosis (Kozuki & Kennedy, 2004; Sandhu et al., 2013) and insufficient holistic caring (Madela-Mntla & Poggenpoelin, 1999; Cortis, 2004). Patients are often viewed individually instead of part of the family and community (Madela-Mntla & Poggenpoel, 1999). Training can increase the level of cultural competence of nurses and immigrant patients' satisfaction with the level of care they receive (Jones et al., 2004; Cooper-Brathwaite, 2005; Govere & Govere, 2016).

The nurses in our study noted that, though interpreter services are used in the care of immigrant patients, they are usually reserved for doctor's appointments or multidisciplinary care plan meetings rather than nurse-patient conversations or in therapeutic groups. There are significant organisational and relational challenges involved in ensuring adequate use of interpreters by nurses. Language barriers between nurses and patients can be common and may result in adverse outcomes for patients. Miscommunication can compromise assessment and patient understanding of proposed interventions as well as violate fundamental patient rights (Carnevale et al., 2009). Use of interpreter services facilitates effective psychiatric care (Karliner et al., 2007; Bauer & Alegria, 2010).

Even though the study was conducted in Finland between May 2008 and December 2009, there has not much change happened after this in psychiatric nursing of immigrants. The number of immigrants in Finland is still relatively low, only 6,6 % of population (Statistic Finland,

2017) and immigrants use of mental health services is known to be lower than the majority of the population despite of greater need (Wittig et al., 2008; Derr, 2016). Further more recent studies show that Finnish nurses have still an apparent lack of skills related to transcultural nursing (Mulder et al., 2015) and attitudes to asylum seekers have hardened (Sen, 2016; Saarikkomäki et al., 2018).

The study was evaluated by using Leininger's and Lincoln and Guba's criteria: credibility, confirmability, meaning in context, saturations and transferability (Lincoln & Guba, 1985; Leininger, 1990). According to Roper and Shapiran (2000) and Grayn (2003), the criteria associated with focused ethnographic studies do not significantly differ from the criteria of traditional ethnography (Niemi & Paasivaara, 2008).

Conclusion

In our study, nurses were unable to recognise the prevalence of posttraumatic stress syndrome and its related symptoms among refugees and asylum-seekers. More training in trauma therapy is required as well as additional support and counselling to aid in the well-being of trauma counsellors.

Admissions were found to be often involuntary via referrals from emergency clinics. There is a need for early detection of illness, sharing information about psychiatric services and creating trusting relationships in the psychiatric community care to avoid involuntary admissions and coercion.

Insufficient treatment in psychiatric services due to misinterpretation of law restrictions poses real risks to immigrant patients. There is a need to define what necessary treatment means in a psychiatric setting as well as a need for more in-depth transcultural nursing training. Family-oriented nursing and the use of interpreter services by nurses should be increased in the care of immigrant patients. Finally, more research into the risks of VT and STS for psychiatric nurses working with refugees and asylum-seekers is necessary.

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