The Lived Experiences of Psychiatric Nurses Working as
Mental Health Clinicians in Rural Manitoba
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I have adhered to University policy regarding academic honesty in completing this project.

THESIS
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Abstract

Many issues including access to qualified and engaged community mental health staff affect the quality of mental healthcare in Canada. The rural residents of Canada experience particular difficulty accessing necessary mental health services. An effort to improve mental health care for all Canadians requires an examination of the rural mental health system, including a critical understanding of the extent of the recruitment and retention problem. The following is a qualitative research study of the experiences of psychiatric nurses employed as mental health clinicians in the rural Prairie Mountain Health region of Manitoba using a hermeneutic phenomenological approach. Significant findings of this study illustrate a better understanding of the factors that engage, support, challenge, and hinder the job satisfaction of rural psychiatric nurse clinicians in rural Manitoba.

*Keywords:* rural, community mental health, psychiatric nurses, hermeneutic phenomenology, role theory
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Essential Themes

Isolation

Feeling alone.

Needing support from colleagues

Needing support from a supervisor

Using technology to stave off isolation.

Characteristics of Individuals Who Flourish

Rurally raised individuals

Courageous personality

Privacy

Boundaries are important

Difficult to maintain public/private life

Autonomy

Richness of autonomous positions

Fosters collaboration

Positive work/life balance

Challenges in Meeting Client Needs

Difficult weather/difficult travel
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The Lived Experiences of Psychiatric Nurses Working as Mental Health Clinicians in Rural Manitoba

Chapter 1: Background Information

According to Manitoba Health (2012), approximately 25% of people aged 10 and older accessed medical care for mental illnesses such as anxiety, depression, and psychosis between 2007 and 2012. This staggering statistic mirrors the Canadian rates reported by the Mental Health Commission of Canada (2012) when comparing rural and urban residents. For the sake of comparison, rates of mental illness are similar when comparing rural and urban area residents, indicating that rural human resources are equally necessary to address the mental health needs of the rural population (Deen, Bridges, McGahan, & Andrews, 2013; Lockhart, 2006; Rural Health Research Center, 2016). Researchers suggest that mental health treatment provided close to home is ideal due to issues of access and convenience (Hoogsteen & Woodgate, 2013; Schiff, 2010; Wilson, Cruickshank, & Lea, 2012).

One of the fundamental principles of the Canadian healthcare system is that all citizens are entitled to equitable access to services (Manitoba Health, 2011; Wong & Regan, 2009). According to Statistics Canada (2012), 19% of individuals who self-reported the need for mental health services also claimed the healthcare system was failing them by not providing adequate specialized care. The provincially funded mental health program is a mainstay of service provision for rural Manitobans’ mental health needs. This program provides specialty services in the form of inpatient psychiatric services, specialty psychogeriatric services, child and adolescent services, crisis services, mental health promotion, adult community mental health services, and psychosocial rehabilitation services. In order to serve the public with good mental health care, access to quality mental health workers is essential for the rural population. Understanding the
rural health context is critical to understanding issues related to rural health care (Roots & Li, 2013; Rural Health Research Center, 2016; Spetz, Skillman, & Andrilla, 2016; Thomlinson, McDonagh, Baird-Crooks, & Lees, 2004;). Needed mental health services for the rural public requires an integration of psychiatric nurses into the service delivery system.

When professional psychiatric nurses feel engaged, remote and rural community mental health practice can be challenging, rewarding, diverse, and autonomous (Bourke, Humphreys, Wakerman, & Taylor, 2010; Dywili, Bonner, Anderson, & O’Brien, 2012). A study of rural healthcare in the United States by MacDowell, Glasser, Fitts, Nielsen, and Hunsaker (2010) indicated that healthcare is a major support to the local community economy. The healthcare professionals contribute to the economy in small, rural communities in a variety of ways including purchasing homes, buying groceries and hardware, attending sporting events, and using restaurants.

The purpose of this research study conducted was to examine the experiences of psychiatric nurses employed as professional mental health clinicians in a rural regional health authority of Manitoba. As the researcher, I strived to develop a better understanding of rural mental health practice with the overall aim of understanding the factors that attracted psychiatric nurses to this advanced practice, while understanding the supports keeping these individuals engaged in this work. Since rural experiences are similar, the results of this study may be transferred in meaningful ways to other healthcare providers such as dietitians, physiotherapists, and occupational therapists. Psychiatric nursing educators can apply the results to promote and prepare students for practice in a rural setting, inform recruitment and retention policies for human resource purposes, and key community decision makers will be encouraged to support
efforts to sustain quality staff by implementing recommended actions. Healthcare organizations may better understand how to positively influence the well-being of their healthcare staff.

**Statement of Problem**

Rural consumers of mental health care are affected by a *distance decay* phenomenon, which is a worsening of healthcare the further one lives away from urban centres (Wong & Regan, 2009). This concept is impacted by an inability to recruit and retain quality mental health professionals to service rural and remote areas of Manitoba. According to Regional Directors of Mental Health Services of Regional Health Authorities in Manitoba (personal communication, May 19, 2015), it is extremely difficult to recruit and retain speciality mental health professionals into areas geographically removed from urban centres. Of the 114 community mental health clinicians employed by Prairie Mountain Health (PMH), seven of these positions were vacant in May, 2015. All of the vacancies reported were contained in the rural offices outside of the city of Brandon. In one of the specialized sub-component programs, Mental Health Resource Nursing, a consistent 30% staffing vacancy was reported with one position having been unfilled for several years (personal communication, May 19, 2015).

It is understood that the level of engagement of rural mental health professionals and resulting job satisfaction will influence their decision to be retained, or remain with their current employer. A study by Gillespie and Redivo (2012a) highlighted varying problematic factors negatively influencing rural mental health care. This study indicated that universities provided inappropriate education for preparing students for rural work. Additionally, there was a tendency to use an inappropriate urban design of mental health care, which does not duplicate well in rural settings. Within small rural areas, high degrees of role strain and conflict for rural mental health professionals are common (Gillespie & Redivo, 2012a; Wong & Regan, 2009). Another issue
described was the lack of organizational preparation and support for rural practitioners. A predominant problem was the inappropriate recruitment of urban professionals who lack understanding of rural life and its’ challenges. A further issue was identified as an inability for rural professionals to access opportunities for career development (e.g. education, participation on committees, opportunities for promotion). Several studies indicate the importance of recruiting professionals familiar with rural life. Furthermore, the most successful retention of quality rural staff is achieved by employing individuals who were raised in a rural setting (Backman, 2000; Bodor, 2009; Gillespie & Redivo, 2012a; Wong & Regan, 2009).

Foundational Theory

Grounding research in theory is not only pertinent for gaining an in-depth understanding of the phenomenon under investigation, but also increases the validity of a study (Wacker, 1998). Role theory offers a conceptual framework that integrates the unity of persons with their environments, comprehends the social integration of individuals in congruence with their roles, integrates the meaning of their given roles, and articulates the reciprocal social interaction between roles (Hardy & Conway, 1988). Role theory, an accepted mid-range theory grounded on symbolic interaction, is arguably necessary for understanding healthcare professionals’ employment experiences. These experiences have implications related to employee recruitment and retention, workplace morale, and job satisfaction. The pertinent sub-concepts of role theory that include role transition, role conflict, role stress, role strain, role overload, role competence, and role triumph illuminate an understanding of healthcare professionals and their experiences.

Choosing to comprehend a phenomenon through the lens of a theory leads the exploration to a more informative, structured, and meaningful understanding. Moreover, a theory that considers individual thought patterns and experiences, social processes, social reciprocity,
and divergent perspectives is pertinent when seeking to understand how individuals function within a workplace (Hardy & Conway, 1988). Role theory, with its roots in sociology, psychology, and anthropology, offers a theoretical lens through which to understand role socialization (Hardy & Conway, 1988). A thought-provoking and pragmatic basis for understanding the experiences of healthcare professionals can be advanced by considering role theory and how role stress, strain, transition, overload, conflict, competence and triumph effect job satisfaction.

**Research Design**

Examining the philosophical underpinnings behind each research method is critical when determining a good fit with the purpose of the study. A qualitative research method often utilized in the healthcare field is phenomenological inquiry. The fundamental constructs of this method stress the understanding of human experience as it is lived and described by affected individuals. Phenomenological inquiry stresses the need to understand individuals as involved, active participants in their own lives who are best suited to offer the fullest account of their experiences (Ajjawi & Higgs, 2007; Allen & Jensen, 1990; Buxton, 2011; Creswell, 2012; Lindseth & Norger, 2004; Lopez & Willis, 2004; Starks & Trinidad, 2007; Streubert & Carpenter, 2011; Wojnar & Swanson, 2007). The hermeneutic form of phenomenology was chosen to elucidate the interpretation of the unique experiences of the psychiatric nurses (Creswell, 2012; Streubert & Carpenter, 2011). As the researcher, I used this method of inquiry to study the psychiatric nursing participants’ lived experiences while practising in a rural setting; this method of inquiry will be elaborated upon in Chapter three.
Summary

Within this research study of the experiences of Psychiatric Nurses practising in rural Manitoba, information gained will inform educators, policy makers, and community decision makers on how to attract and retain quality mental health workers. A hermeneutic phenomenological method of inquiry guided the research. Grounding the research with the foundational role theory allowed a better understanding of the themes that arose.
Chapter Two - Literature Review

There is a paucity of information related to the experiences of psychiatric nurses working as clinicians in rural Manitoba. As I examined wider avenues for information including grey literature, there continued to be a dearth of relevant literature related to mental health clinicians in rural Canada. Limited information led the writer to believe that further evidence is required to add to the knowledge base. The choice of a theoretical framework for the present study was informed by the existing literature base.

Studies of rural health care providers in a more generic sense, highlight isolation as a noteworthy, negative factor effecting recruitment of rural healthcare providers (Canadian Mental Health Association of Ontario, 2009; Drury, Francis, & Dulhunty, 2005; Hoogsteen & Woodgate, 2013; Moore, Sutton, & Maybery, 2010; Wong & Regan, 2009). In their study of nurses in rural and remote areas of Canada, Stewart et al. (2005) highlighted the need to recruit younger nurses in order to sustain the workforce. Stewart et al. (2005) encouraged educational institutions to take initiative in preparing students for this work, and encouraged workplaces to improve the satisfaction of workers with supportive measures.

Some studies suggested that staff raised in rural areas were more likely to practise rurally (Manahan, Hardy, & MacLeod, 2009; Perkins, Larsen, Lyle, & Burns, 2007; Strasser & Neusy, 2010). Studies have proposed financial incentives (Canadian Mental Health Association of Ontario, 2009; Drolet, Christianson, & Clark, 2011) and educational opportunities (Gagnon, Pollender, Trepanier, Dupla, & Ly, 2011; Healey-Ogden, Wejr, & Farrow, 2012; Strasser & Neusy, 2010) as a means to retain health care providers in the rural setting.

It is accepted that the use of theory is required for advancing scientific knowledge (Wacker, 1998). To understand the human resources aspect of the healthcare profession, it
requires consideration of the social processes involved in the provision of healthcare, namely the role of the employee. The following section offers an overview of role theory and proposes that it is a valuable framework to consider when conducting research with the healthcare profession. Role theory provides the theoretical foundation to assist in understanding the unique experiences of psychiatric nurse clinicians practicing in rural Manitoba. This chapter provides an overview of role theory and its pertinent subcomponents with an integration of its applicability to the phenomenon presented in this study; the unique experiences of psychiatric nurse clinicians in rural Manitoba.

**Role Theory**

Some practitioners and academics disagree about the practicality of theory and its application (Wacker, 1998). Wacker (1998) explains that some individuals within the academic field believe the application of theory is very limited, so question the use it’s utility. However, grounding one’s research pursuits on theory is not only pertinent for gaining an in-depth understanding of the phenomenon being investigated, but also increases the validity of a study (Wacker, 1998). Hardy and Conway (1988) stressed the inseparable connection of theory and research within the development of scientific knowledge in their extensive study of role theory. The word “role” often construes thoughts involving the arts, such as theatre, actors, and drama. From a sociological perspective related to the workplace, however, a *Role* is the expected and actual behaviour associated with an individual’s particular position in society (Thomas & Biddle, 1979). Role theory offers a conceptual framework that integrates the unity of persons with their environments, comprehends the social integration of individuals in congruence with their roles, integrates the meaning of their given roles, and articulates the reciprocal social interaction between roles (Hardy & Conway, 1998). In the present study, role theory, an accepted mid-range
theory grounded on symbolic interaction, is necessary for understanding healthcare professionals’ employment experiences. These experiences have implications related to employee recruitment and retention, workplace morale, and job satisfaction. First, this researcher offers a brief summary of the history of role theory. This will be followed by a description of role theory sub-concepts: role transition; role conflict; role stress; role strain; role overload; role competence and role triumph. These sub-concepts will be presented in the context of how they relate to healthcare professionals’ experiences.

The development of role theory began in the 1930’s by social theoreticians (Hardy & Conway, 1998). A German psychiatrist named Jacob L. Moreno immigrated to the United States in 1930 and founded psychodrama therapy. Psychodrama therapy required individuals and groups to role-play as a method of treatment for psychiatric illness with the goal of sociocultural reintegration. This innovative treatment provided the basis for further study of role behaviour. A social philosopher, George Herbert Mead, who founded the concept of symbolic interaction and studied role-taking behaviour, inspired Moreno’s work. Moreno was credited with developing a quantitative study of interpersonal attraction in which data were summarized in sociograms. Role behaviour was viewed as linked to expectations and as such, the beginning work of linking the theoretical world with the practical was established. Mead’s methods of understanding the mind, the self, and human nature within societal groups allowed further study into the concept of reciprocity within social interaction. Mead proposed that individuals act together and shape society by affecting the goals of groups. A colleague of Mead’s, Robert Ezra Park, focused on the concept of roles and their structural positions. Similarly, Ralph Linton, an anthropologist, made conceptual breakthroughs related to understanding individuals’ status within societal structures. The contributions of Mead, Moreno, Park, and Linton led to a domination or focus on
the interplay of the individual and social structure by the 1950’s and 1960’s. These works provided further stimulus for the study of symbolic interaction.

Role transition. Biddle (1979) offered significant contributions to the understanding and history of role theory by asserting that each individual has various roles within their life (e.g., mother, sister, professional). Some roles end and are replaced with new roles (e.g., childless woman to mother). Thus, role transition, a sub-concept of role theory, in life is normal and frequent. Role transition is a dynamic process involving change and transformation of one’s professional identity (Twedell, 2011).

In the nursing profession, the transition periods between roles often involve stressors and are common (Chernomas, Care, McKenzie, Guse, & Currie, 2010; Hardy & Conway, 1988; Nicholson, 1984; Twedell, 2011). Numerous transition points occur during the healthcare employee’s professional career. Examples involving role transition include when the graduating student nurse begins paid employment, when a hospital nurse moves to community nursing, and when promotion of a nurse to a management role occurs. Transitional points in one’s career often involve changes in autonomy (Nicholson, 1984; Twedell, 2011). Changes or transitions in personal roles (e.g., marriage or the birth of a baby) may also impact individuals and cause positive or negative changes in the capacity of the individual’s professional role (Barnett & Gareis, 2006). Without a positive transition, negative outcomes such as burnout, poor productivity, absenteeism, and illness may occur (Chernomas et al., 2010). Eventually, this affects the capacity to retain quality staff. The human resource issues of recruitment and retention within the healthcare field thus merits an understanding of what factors promote successful transition. Specifically, to promote retention and reduce turnover, a successful
transition that promotes quality, competent, and confident staff is required (Chernomas et al., 2010).

Within nursing, the use of mentoring or preceptorship is a practice that offers promising results in promoting positive role transition. Once an individual has transitioned into a role, there are other sub-concepts of a role that may or may not develop.

**Role conflict.** Not only is role transition stressful, but when two or more roles compete, role conflict can create tension for an individual. Role conflict can often occur between two or more roles, such as work-life and family-life (Barnett & Gareis, 2006). Barnett and Gareis (2006) studied the inability of individuals to psychologically separate roles while at home or at work and found that when workplaces insisted on complete role distinction there were negative consequences to the overall well-being of staff. For instance, role conflict and the resulting ambiguity in large, complex organizations was found to negatively impact individuals’ abilities to cope and work at optimal capacity (Patrick & Laschinger, 2006; Rizzo, House, & Lirtzman, 1970). Furthermore, when certain professions dictate the expectation of particular types of emotional expression, role conflict is often evoked (Rafaeli & Sutton, 1987).

Workplace relationships may result in role conflict. A common conflict within workplace structures is between the employee and the management role. Role conflict results when staff report feeling undervalued and overworked, when staff have low control over their workload, when managers express role overload, when personalities among colleagues are incompatible, when managers provide unclear or ambiguous expectations of staff, when opinions and value systems clash, when feedback is discouraged, and when significant structural change is imposed (Biddle & Thomas, 1966).
Another form of role conflict occurs when the goals of an organization clash with the goals of employees. For instance, efficiency and cost-saving measures often prioritized within healthcare organizations may conflict with healthcare professionals’ perceived abilities to provide the best possible care they were educated in and prepared to offer. The effect of multiple roles as a type of role conflict was a focus of study by Barrett and Gareis (2006). The inability to meet the demands of multiple systems such as family and workplace, can contribute to the role conflict that healthcare employees experience (Barrett & Gareis, 2006). An effort to improve workplace wellness by enhancing programs aimed at addressing work-life balance has become increasingly popular (Keyes, 2002). The common practice of shiftwork within the healthcare profession contributes to role conflict and is inevitable when prescribed multiple roles (Barrett & Gareis, 2006). Therefore, alleviating role conflict is a goal that leaders within organizations strive towards healthier, more functional workplaces.

**Role stress.** Role stress often results from an externally imposed condition, resulting from difficult, negative, vague, or impossible expectations (Hardy & Conway, 1998). Role stress can have varying effects on individuals in accordance with the magnitude of the actual stressor and the capacity of the individual to cope and adjust. As such, role stress is central to the study of role problems (Biddle & Thomas, 1966). The fact that healthcare employees face serious issues related to the well-being of individuals and society creates an understanding that stress is an inherent component within their prescribed role. This merits the consideration of role stress and possible solutions in the healthcare profession.

**Role strain.** In contrast to an externally imposed role stressors, role strain is a subjective and emotional state internalized by an individual in response to stress (Hardy & Conway, 1988). Role strain is a negative experience and can manifest as anxiety, distress, or generalized illness.
Healthcare professionals affected by multiple stressors imposed by the roles at work and in their personal life are at high risk for role strain (Barnett & Gareis, 2006; Eagly & Karau, 2002; Sieber, 1974). Rafaeli and Sutton (1987) studied the social expectation of certain emotions and their expression within given roles. Society expects that healthcare employees repress genuine emotion or express disingenuous emotion, causing strain with this incongruence (Babenko-Mould & Laschinger, 2014). Hardy and Conway (1988) described the effect of performing less optimally, or partial withdrawal, as a response to role strain. As such, this negative effect upon the quality of healthcare work has the potential to affect patient health outcomes. Partial withdrawal may also affect the interpersonal bonds within collegial relationships, further reducing the quality of healthcare (Laschinger & Fida, 2014).

**Role overload.** One major form of role stress common in the healthcare field is role overload. Role overload occurs when individuals are unable to accomplish all role obligations within the time allotted to them (Hardy & Conway, 1988). As described by Hardy and Conway (1988) a central tenet of role overload is the excessive, often impossible role expectations placed upon individuals. Employees affected by role overload report that low control over their responsibilities erodes their overall job satisfaction (Barrett & Gareis, 2006). Role overload can result in absenteeism, poor workplace morale, and like the perils of role transition, illness (Barrett & Gareis, 2006).

**Role competence.** Role competence is a positive experience related to quality employee performance (Hardy & Conway, 1988). Healthcare employees with role competence are motivated, able, skillful, knowledgeable in her specialty, and has good interpersonal skills. Social interactions influence and teach competence. Competence is necessary for job performance, and enhances individual and organizational capacity (Hardy & Conway, 1988).
The goal of role competence inspires educational institutions to strive for excellence and organizations to provide the best possible human resources for their employees.

**Role triumph.** Role triumph occurs when a staff member has successfully transitioned into his or her role and is functioning in a highly competent manner (Hardy & Conway, 1988). An individual experiencing role triumph will have successfully attained competence. This individual feels a high degree of satisfaction within his or her role. High functioning organizations celebrate success with engaged staff who have triumphed in their roles. This role competence and role triumph reduces staff turnover, retains employees, and in turn can improve patient outcomes.

Choosing to comprehend a phenomenon through the lens of a theory leads to a more informative, structured, and meaningful understanding (Wacker, 1998). Moreover, a theory that considers individual thought patterns and experiences, social processes, social reciprocity, and divergent perspectives is pertinent when seeking to understand how individuals function within a workplace. A thought-provoking and pragmatic basis for understanding the experiences of healthcare professionals can be advanced by considering role theory and how role stress, strain, transition, overload, conflict, competence and triumph are achieved or impacted within workplaces.

**Summary**

The paucity of information related to the experiences of rural psychiatric nurse clinicians in Manitoba and Canada motivated me, as the researcher of this study, to address this gap of knowledge. As the conceptual framework for this study was developed, role theory was chosen as the appropriate foundational theory as it aptly lent a sociological understanding of the unique experiences of psychiatric nurse clinicians in rural areas of Manitoba. Assessing the various sub-
concepts (e.g., role stress, strain, transition, overload), lead to a specified understanding of role and in turn, allowed for a comprehensive identification of themes reported by the population of interest.
Chapter Three - Research Methodology

Method of Inquiry

Streubert and Carpenter (2011) described the evolving movement of phenomenology as both a philosophy and a research method with roots dating back to the early 20th century. Franz Brentano (1838-1917) and Stumpf (1848-1936) articulated the concept of intentionality of consciousness, providing an early understanding of the philosophy for phenomenology (Streubert & Carpenter, 2011). Husserl (1857-1938) and Heidegger (1889-1976) contributed to phenomenological inquiry by introducing concepts of essences, intuiting, and phenomenological reduction (Streubert & Carpenter, 2011). The concept of embodiment, the belief that the entire mind and body experience brings a phenomenon to consciousness, is central to the philosophy of phenomenology.

The two main forms of phenomenology are descriptive and interpretive. The works of Paul Ricoeur, Martin Heidegger, and Hans-Georg Gadamer provide the basis for interpretive or hermeneutic phenomenology (Streubert & Carpenter, 2011). The foundation of hermeneutic phenomenology stresses the use of expertise and knowledge to guide research while searching for the meaning in the phenomena of lived experiences. This concept emphasizes that a person’s experience is interrelated with their individual history, values, culture, traditions, relationships with nature, and political views (Ajjawa & Higgs, 2007; Allen & Jensen, 1990). This process of inquiry acknowledges the interrelatedness between the interpreter and interpretation, and discourages the use of “bracketing”, or setting aside of preconceptions (Creswell, 2012; Streubert & Carpenter, 2011). Additionally, hermeneutic inquiry allows for interpretation within the framework of a hermeneutic circle. Allen and Jenson (1990) describe the hermeneutical circle as
a fluid process resulting from interactions between the self and the event, allowing for an enriched understanding of the phenomenon.

Text interpretation, a key feature of hermeneutics, allows further discovery of the essential meaning of individuals’ lived experiences (Lindseth & Norberg, 2004; Lopez & Willis, 2004). This interpretive account illuminates participants’ voices and concerns inherent in the text, offering a full account of experience.

**Design and Methodology**

I used a hermeneutic phenomenology mode of inquiry to interpret the experiences of the participants; rural psychiatric nurses working as mental health clinicians. This methodology provided a mechanism for illuminating the experience, including hidden meanings, of psychiatric nurse clinicians working within a rural health region in Manitoba. Phenomenological research allowed the analysis of lived experience of professional psychiatric nurses to shed meaning through the sharing of their embodied perception. Consistent with the phenomenological approach, it allowed a deeper understanding of these nurses’ lived experiences by elucidating and describing their ways of knowing (Starks & Trinidad, 2007). I sought data that provided insight into factors that enhanced or challenged engagement of rural mental health professionals to obtain a better understanding of the recruitment and retention issue in the rural area.

**Rationale.** Hermeneutic or interpretive phenomenology was chosen to investigate the everyday experiences and world of psychiatric nurses working as clinical specialists in the rural context. This method allowed me to uncover and interpret the hidden meanings of their experiences. The method of inquiry, as described by van Manen (1990), allowed for analysis and interpretation of lived experiences to find the essential themes, then integration of the themes together to allow the meaning of the experience to emerge as a whole.
Hermeneutic phenomenology is a research method that blends art and science within a qualitative framework. The hermeneutic interpretation allowed an essential examination of body language, tone of voice, and even silences during the interview process.

The purpose of this hermeneutic phenomenological study was to uncover the essence of the experiences of psychiatric nurse clinicians working within a rural context in Manitoba. Hermeneutic phenomenology, in Heidegger’s view, studied this method as *desein* or being in the world (Wojnar & Swanson, 2007). Wojnar and Swanson (2007) emphasized that the researcher and participants generate an understanding of the concept being studied through their interactions and interpretation, and their respective backgrounds provide assistance to the illumination of this understanding. Following the interaction and increased understanding, the process of listening to interviews, reading and re-reading the transcripts, re-contacting the participants for affirmation of the accurate portrayal of the interview, and coding of the themes allowed a process that is true to the standards of hermeneutic phenomenology research.

**Sample.** This study used purposive sampling following ethical approval from Brandon University, and Prairie Mountain Health (PMH). This researcher sought out Psychiatric nursing participants within PMH who worked as mental health clinicians for a minimum of two years in a rural area of Manitoba. Two years was determined as a minimum amount of time immersed in this work and geographical area. This immersion in rural life represented a thorough experience of the phenomenon. For the purposes of this study, rural is defined as a “population living outside the main commuting zone of larger urban centres of 10,000 or more” (Statistics Canada, 2010).

Sample pool sizes vary in qualitative research; generally, data collection ends when saturation occurs. Streubert and Carpenter (2011) describe the concept of saturation as the
process where data does not add substantially to the themes. Qualitative sample sizes need to be large enough to elicit a large variation of perspectives while finding similar themes (Starks & Trinidad, 2007). The ten interviews with ten participants was a reasonable amount of data to collect. Stark and Trinidad (2007) state that typical sample sizes for phenomenological studies range between one to ten individuals.

**Recruitment.** Following ethics approval, I sent information about the study in the form of an email attachment to a regional administrative assistant working for the mental health program in Prairie Mountain Health. I requested the Assistant to distribute the information about this study to psychiatric nurse clinicians within PMH who did not work and live in Brandon. This administrative assistant sent a prepared letter of invitation with my contact information to all suitable participants. Within the letter of invitation (see Appendix A), I invited participants to contact me by phone or email to indicate their interest in participation. I sought out maximum variation in participant characteristics of education, age, background, and gender, with the intention to enrich data (Creswell, 2012). This writer ensured posters were placed (see Appendix B) in visible areas of the community offices to attract participants who may have missed or disregarded the email.

**Data Collection and Analysis**

Candidates contacted me by email or phone to indicate a willingness to participate in the study. I made appointments to interview individual participants with a willingness to accommodate their schedule while protecting privacy, respecting their anonymity, and ensuring comfortable surroundings. The face-to-face interviews took place in offices, meeting rooms, and in a restaurant. I obtained written consent (see Appendix C) at the initial face-to-face interview that explained the purpose of the study, assurance of confidentiality, possible benefits of this
study, possible associated risks, and the right to withdraw at any time. Participants were informed they had the option to receive a copy of the study’s results. Interviews employed exploratory open-ended questions (see Appendix D), and lasted an hour to 1.5 hours in length.

The initial phenomenological question was: What is your experience of working as a professional psychiatric nurse clinician in a rural area of Manitoba? The interviews were conducted in a conversational manner. Subsequent questions that aimed to elicit further information included:

- What attracted you to work in a rural area as a mental health professional?
- What keeps you engaged in this role?
- What are the main challenges to this role?
- How does your manager best support you as a rural psychiatric professional?
- Are there specific challenges that are unique to the rural area?
- Do you envision improvements to recruitment and retention?
- What suggestions do you offer educational institutions to improve recruitment and retention?
- What suggestions do you offer decision makers of your organization to improve recruitment and retention?
- Do you plan to stay in the rural area as a mental health professional?
- How do you practise self-care?

The use of probes clarified participant descriptions and silences were respected to generate meaning and understanding. van Manen (1990) suggested several methods of collecting experiential descriptions from the participants including interviewing, observing, artwork, and other literature. The interviews provided the basis of collecting the experiential descriptions to
address the purposes of this study. It is important to recognize that both the interviewer and participant are partners within the phenomenological interview; they both contributed to the process of discovery.

Following the interview, I gained validation of content with follow-up phone calls to confirm data gained; this member checking provided necessary triangulation (Streubert & Carpenter, 2011). I sought ongoing or process consent from participants at this point. After completion of data collection, data analysis confirmed that data saturation had been achieved. Meticulous note keeping during the research process offered structure and provided an audit trail (Streubert & Carpenter, 2011). As suggested by van Manen, (1990), data analysis with text interpretation involved: formulation of a phenomenological question with an introspective process of understanding; generating data from subjects that offers experiential descriptions; a reflection of the phenomena while searching for ideas and impressions; and engaging in interpretive writing. Extensive data gained during the interviews provided a thick, rich description of experiences (Creswell, 2012). I minimized bias with the use of reflexive practice of journaling and conscious reflection. The writer used metaphors and quotes when writing study results to achieve transferability through the resultant rich, thick description.

A research assistant who had signed an agreement of confidentiality (Appendix E) transcribed the audiotapes verbatim. The transcriptions were captured on a password encrypted USB. Transcriptions were printed, read, and re-read to begin the thematic analysis. As the researcher, I highlighted areas, captured quotes, and kept notes in the margins of the printed transcripts. While examining the extensive data, I kept an open mind, continuously searching for new interpretations of the interpretations (van Manen, 1990).
**Data analysis.** The process of analysis involved three steps: (1) naive reading of the text; (2) noting patterns of meaningful connection with interpretation of a structural analysis; and (3) interpretation of the whole text with verification that analysis is complete (Buxton, 2011). As the researcher, I was able to extract themes from the data, allowing a contextual understanding of common experiences. The participants’ rich description of experience illuminated hidden meanings behind the phenomenon, thus enriching the readers’ understanding.

There are a number of sub-steps involved in the analysis of data within the phenomenological research method. van Manen (1990) recommended conducting thematic analysis in order to uncover the thematic aspects of the lifeworld description. Ajjawi and Higgs (2007) describe immersing oneself in the data by organizing it into texts, reading and re-reading of it, and preliminary interpretations. Then, Ajjawa and Higgs (2007) encourage the researcher to create second order constructs with grouping and the creating of sub-themes. Further elaboration of the themes allow for comparison and synthesis into themes that are linked to the literature (Ajjawa & Higgs, 2007). The themes that arise provide an understanding of the focus and meaning of individuals’ lived experience. The next sub-step involves isolating the thematic statements of the data (van Manen, 1990). The writer utilized a selective approach to uncover these thematic statements by listening to the interviews, reading the transcripts, and searching for the statements that were essential to understanding the experiences of the rural psychiatric nurses. Following the isolation of the thematic statements, I articulated the themes with linguistic composition. Finally, determining essential themes was necessary (van Manen (1990) recommended finding themes that speak to the shared experience of the phenomenon.

**Phenomenological writing.** The writing up of phenomenological findings involves an artistic composition that articulates the themes and sub-themes of the data. The use of metaphors
and quotes within the rich data expressed allows for a personalized understanding of the articulated experienced. It is helpful to use a variety of examples in order to illustrate the hidden meanings while making them more meaningful to the readers. The actual writing of the findings assisted in a deeper understanding of the themes by the researcher. Re-writing of the findings allowed for a fine-tuning of the findings in a manner that is coherent, expressive, and artistic.

**Trustworthiness.** Developing a proposal, applying for ethics approval from the University of Brandon and then the Regional Health Authority, recruiting participants, following the guidelines of ethical research, and staying true to the professional standards of the psychiatric nursing profession integrated rigour into this research project. The use of Lincoln and Guba’s (1985) criteria of credibility, transferability, dependability, and confirmability enhanced the trustworthiness of this study.

**Credibility.** A credible study is one that offers truthful findings (Lincoln & Guba, 1985). My extensive experience working as a psychiatric nurse in rural areas of Manitoba enhanced the credibility of this study. I used a number of quality enhancement strategies with participants that Polit and Beck (2012) highlighted including intensive listening, careful probing, and prolonged engagement. This writer re-visited the interview material with participants in a process described as member checking as described by Streubert and Carpenter (2011).

**Transferability.** Transferability refers to the findings of research offering personal meaning or applicability to the individuals receiving the findings (Streubert & Carpenter, 2011). The thick rich descriptions captured in the detailed account of experiences provided transferability to this study. There is the potential for generalizing the results of this study to other health professionals working within rural and remote areas of Manitoba and Canada.
Dependability. As Lincoln and Guba (1985) state, a dependable study is an accurate and consistent one. Extensive field notes were kept that allowed for an authentic and trustworthy. This study found consistent themes allowing for dependable findings. Adherence to research ethics protocol (E.g. Tri-council Policy Statement) ensured the dependability of this study.

Confirmability. Lincoln and Guba (1985) described confirmability as the objective or neutral findings of a study. The extensive field notes kept by myself reduced bias and evoked self-awareness. Actions and efforts to reduce researcher bias allowed for confirmability. Some actions to reduce this bias included journaling and member checking. I conducted a short interview by phone call with most participants to ensure that the material collected was truthful and accurate, lending further confirmability to the study.

Dissemination. Dissemination of the findings, including knowledge translation, is an essential component of research and may require novel approaches in rural areas (Drury & Hart, 2013). This researcher plans to submit scholarly papers to journals, offer presentations to rural mental health staff, submit abstracts and present at suitable conferences, and present an issue brief with recommendations to decision-makers such as Manitoba Health policy makers, and RHA leaders. Interest has already been generated with preliminary findings being presented at the Mental Health on the Prairies Conference held at Brandon University, October 2016. Dissemination of these findings will benefit future studies related to recruitment and retention, and possibly assist in efforts to prepare students for rural employment (Drury & Hart, 2013; Rural Health Research Centre, 2016). It will be particularly important to engage decision makers who inform human resource policy when considering the audience.
Summary of Research Significance

There is extremely limited research investigating the unique experiences of rural mental health workers in Canada. The Mental Health Commission of Canada has identified the need to reduce disparities in access to mental health services to rural and remote communities in its most recent strategic plan (2012). This study will enhance the strategic efforts to recruit and retain quality mental health professionals to rural and isolated areas. As decision makers mobilize localized plans to respond to the public mental health needs, examining the professed needs of the rural mental health workforce is essential.
Chapter Four - Presentation of Findings

Data Analysis

This researcher sought a deeper understanding of the lived experiences of psychiatric nurses working as clinicians in rural settings with the health region of Prairie Mountain Health in the province of Manitoba. This chapter presents the findings of the study and includes: (1) a description of the natural setting where participants lived and worked; (2) pertinent characteristics of the participants; (3) a synopsis of their stories; (4) a presentation of essential themes; and (5) a hermeneutic circle of interpretation.

The Natural Setting

PMH is comprised of the North Zone, the South Zone, and the city of Brandon. Contained within this large region are four escarpments: the Duck Mountains, Porcupine Mountains, Riding Mountain National Park, and the Turtle Mountains. There are many recreational and outdoor opportunities within this health region.

According to Allan et al. (2015), the population of the region of PMH was 167,121 in 2013 or about 12.9% of the entire Manitoba population. The combined population of the North Zone and South Zone of PMH at that time was 116,467 or 69.7 % of the PMH population (Allan et al., 2015). The population density decreases significantly from 657.8 persons per square kilometer in Brandon to 2.2 persons per square kilometre in the North Zone, and 2.3 persons per square kilometer in the South Zone (Allan et al., 2015). The illustration of Figure 1 offers a visual representation of PMH within the province of Manitoba (Allan et al., 2015).
Figure 1. Manitoba Health Regions
A government appointed board of 15 members governs the non-profit organization of PMH. This health authority is the managing body for all of the publicly funded health programs and services, including the mental health system (Allan et al., 2015). PMH employs over 8500 individuals (Prairie Mountain Health, 2017). According to a regional administrative assistant, S. Rathwell, approximately 114 mental health clinicians from a variety of professional backgrounds work in PMH; at present, 60 of these professionals work and live outside of the urban setting of Brandon (personal communication, February 14, 2017).

For the purposes of this study, all PMH psychiatric nurse clinicians working within the PMH determined zones of North or South were eligible to participate. I interviewed the participants in settings of their choosing which included offices, meeting or boardrooms, and a restaurant.

**Pertinent Characteristics of Participants**

Ten individuals participated in this project; seven were employed and lived in the South Zone and three worked and lived in the North Zone. Nine of the ten participants had initially worked in an urban setting as a psychiatric nurse prior to their rural professional work. The homes of participants represented eight community settings. The participants serviced a total of 60 + rural communities within their professional practice as a PMH employee.

Eighty percent of the participants spent their childhood in a rural setting in Manitoba. One individual that lived in urban settings with his family during childhood stated that he would remain in a rural setting upon retirement. All claimed to enjoy the outdoors that the rural setting offered. All intended on staying in the communities they currently lived within.

All of the participants were married with a family, eight had dependant children, and one participant had entered her second marriage. Their nuclear family sizes ranged from three to five
in total. One individual was pregnant with her second child and two participants had grandchildren. They ranged in age from 31 to 62 years old. Their years of experience as a psychiatric nurse varied from 4.5 years to 40 years (inclusive of any leaves such as a maternity leave). There were nine females and one male participant in this study.

Three of the participants were diploma prepared and seven were baccalaureate prepared psychiatric nurses. In addition to her psychiatric nursing degree, one participant had completed a graduate degree course in counselling. They all had pursued specialty courses in addition to their professional designation. Several of the participants offered education to others in the form of mental health promotion, mental health literacy courses, suicide prevention training, and consultative services.

A variety of specialty program areas within the mental health service delivery system represented the services offered by these psychiatric nursing professionals. Special program areas included child and adolescent mental health, seniors’ mental health, mental health promotion, psychosocial rehabilitation, clinical education, and adult mental health services. Staff regarded these professional psychiatric nurse positions as highly autonomous roles. One of the participants had formerly held a management role.

Participants described their personalities with a variety of terms and phrases including courageous, willing to take risks, community-oriented, team player, collaborative, able to reach out for support, and flexible. All of the participants described pride as well as passion for the service they provided to their communities.

A Synopsis of Their Stories

The articulation of participants’ narratives is a critical element when reporting the findings of qualitative research. Within phenomenological research, the creation of the story is a
collaborative process between researcher and participant (Creswell, 2012). These narrative stories illuminate individual experiences in an artistic and literary manner (Streubert & Carpenter, 2011). Sandelowski (1991) stressed the importance of placing all involved in qualitative research – researcher, participant, and readers of the research - as narrators within the hermeneutic circle of interpretation. The themes that arose from the psychiatric nurse participants’ data arrived from a process of co-generated narratives. I used pseudonyms to protect the participants’ identity and privacy.

**Dolores.** Dolores is a 62-year-old woman with 40 years of experience as a psychiatric nurse. She was formally educated with a Diploma in Psychiatric Nursing that she achieved in 1977. Dolores was born and raised in a small-town setting. She is family and community oriented and currently resides with her second husband in a rural area in the South Zone of PMH. Her professional psychiatric nursing experience was geriatric care, child and adolescent mental health care, forensic services, mental health promotion, and healthcare management. She has retired with stints of work interspersed in her formal retirement years and is currently pursuing further professional opportunities.

Dolores spent the majority of her professional work life as a rural community mental health specialist. She described feelings of pride in the highly autonomous service she provided. Dolores worked in unique settings in the rural environment such as a courthouse basement infested with mice. She described the collaborative teamwork in the rural area as especially fulfilling as captured by the statements, “I really felt a part of the team and know that people really respected me” and “I really felt valued in the multi-disciplinary team”. Dolores also described enjoying the positive, caring characteristic of small towns.
Dolores described privacy issues as a challenge to overcome. The nature of the service Dolores offered allowed her into very private elements of individuals’ lives. Dolores described this as a privilege as well as a curse given the stigma of mental health problems. Resultantly, Dolores believed she suffered with heightened scrutiny of her personal life. Stigma within the small town she worked and lived in caused her children to be excluded from many events.

Dolores described travel as a unique struggle for rural workers in PMH. The weather creates difficult driving conditions, resulting in heightened risk for accidents. The weather challenged the clients who needed to travel to her services.

Dolores also described isolation in her professional life. As the only community mental health worker, she did not have the same degree of support from colleagues, mentors, and supervisors one might receive in an urban office. She felt a lack of understanding of rural work by her urban counterparts. She described needing a supportive manager to experience satisfaction in her role.

**Lori.** Lori is a 36-year-old woman with 11 years experience as a baccalaureate prepared psychiatric nurse. Upon graduation, she worked as a rural psychiatric nurse in a position within a personal care home, then successfully pursued employment as a geriatric specialist, a position she holds today. Lori loved the small town life; she was born and raised in a small town environment.

Lori described the need to understand the dynamics of small town life while protecting confidentiality as paramount to feeling satisfaction in one’s professional role. She also described necessary personality characteristics for success in one’s role as being determined, flexible, willing to compromise, and understanding.
Lori described isolation as a negative factor to overall job satisfaction in a rural professional position. She believed that a willingness to reach out to colleagues with the aide of technology is necessary. She also expressed that in-person support from a supervisor counterbalances feelings of isolation. Lori described a “willingness to become involved in committees” is necessary in order to flourish in one’s role.

Lori recommended that Universities place rural students in rural sites during clinical rotations as a manner of attracting students to the rural professional. She believed that individuals raised rurally are more attracted to rural positions. Lori described her opinion that community members will experience heightened trust in a professional that originates from the area. That said, she also stated, “Privacy and confidentiality is the biggest concern for both professional and for client.” Lori described the challenge of rural travel as a negative factor for rural psychiatric nurses providing a professional service.

**Barbara.** Barbara is a thirty-six year old woman who graduated with a baccalaureate degree in psychiatric nursing in 2002. Following employment in an urban environment for a few years, she returned to the rural environment where she spent her childhood years to work as a community mental health worker. Her stage of life attracted her to the rural position and resulting lifestyle. She described the desire to be close to her family of origin in order for her children to be close to their grandparents as the driving force to work as a rural clinician. She particularly enjoyed the slower paced life in a rural position as described in this statement, “It’s literally a three minute commute walking”.

Barbara described privacy for clients and herself as a significant challenge when working rurally. She perceived her clients as uncomfortable when inevitably crossing paths in the lone grocery store or at the school. Their discomfort resulted in her own feelings of discomfort.
Barbara also described isolation as a defeating factor in job satisfaction. She stated, “One of the biggest downfalls is the isolation out here”. Barbara stated that professional development was lacking for rural workers as well as opportunities for advancement. She described feeling somewhat jealous of the workers within urban settings who have the opportunity for a larger support network.

Barbara described travel within a large geographic area as a challenge for workers as well as clients. She also expressed concern about the intolerance and judgement that is evident within smaller communities. She countered that comment with an expression of gratitude for the “astounding caring” evident in small towns at times.

Barbara was appreciative of the relationships she developed with other providers in a spirit of collaboration. She also was grateful for the advances in technology such as telehealth and electronic health records that allowed improvements in the continuity of care for her clients. When contemplating suggestions for improvement for recruitment and retention to rural positions, Barbara suggested that universities offer rural rotations to psychiatric nursing students. She also suggested that rural high school students would benefit from subsidies for psychiatric nursing education.

Katie. Katie is a 31-year-old woman with ten years experience as a baccalaureate prepared psychiatric nurse. In addition to her baccalaureate degree, she possessed a master’s degree in counselling. Her professional base was a rural community that she felt affinity for given the fact that her husband’s family resided there. Her family raised her in rural Manitoba. Katie proudly declared, “I’ve always been a small-town girl”.


Katie described the autonomy and collaborative environment as highly positive factors in rural professional work. She was able to offer comparisons of urban experience as a crisis response professional in Winnipeg to the rural education position she currently holds.

Katie described isolation as a possible defeating factor to overall job satisfaction for rural workers, but described counteracting this negative factor by reaching out for support, staying connected with colleagues, utilizing technology, and pursuing professional development.

Katie described driving in bad weather conditions as a unique challenge for rural workers. She also believed that opportunities for colleagues to connect in person were essential for role satisfaction. Mentoring was a concept that Katie spoke passionately about as she described, “Seasoned psychiatric nurses have a responsibility towards mentoring the younger ones”.

Katie described her opinion about the factors that could enhance recruitment to rural positions. She expressed her recommendation that universities place rural students in rural environments and educate students about the variety of rural positions available. It was evident that Katie loved her rural position as summed up in her statement, “So to me, it’s just amazing I’ve had this opportunity”.

June. June is a 38-year-old baccalaureate prepared psychiatric nurse employed as a children’s specialist with 16 years professional experience. Her parents raised her in the rural area she was currently living and working in. Her working background included international nursing. June had children and appreciated being in close proximity to her family of origin.

June described isolation as the key negative factor in rural professional work. She believed that support from colleagues and supervisor was essential to counteract this negative isolation factor. She described feelings of fear and lack of preparedness to face the autonomy of
the rural position when she initiated her employment in the North Zone of PMH. June described a lack of understanding for rural worker by her urban counterparts.

June described the lack of privacy as a negative working condition for rural professionals. She once received an angry phone call at her home from a client’s father. She described the difficulty of maintaining boundaries when continuously interacting with families in community settings such as the mall, school, or recreational settings.

June described activities that employers could use to enhance job satisfaction such as paid benefits for rural preceptorship and rural placements for psychiatric nursing students. June expressed appreciation for the autonomy within the rural setting, the responsiveness of the service delivery system, and the flexibility to offer mental health promotion activities in her work.

**Kristen.** Kristen is a 37-year-old woman with 13 years experience as a baccalaureate prepared psychiatric nurse. She planned to continue in graduate studies initiated a few years ago. Kristen’s parents raised her in the community that she currently works in. Upon having children, she described an urge to return to community roots. She provided specialty psychiatric nursing service as a rehabilitation specialist.

Kristen described more positives than negatives in her community role. She especially appreciated the autonomy and challenge of rural mental health work as summed it up as, “It’s lovely, absolutely lovely”. Kristen expressed her belief in the connectedness in her small town, one that serves her clients well and enhances her role satisfaction. Collaboration between service providers was evident in her rural community. She also attributed her capacity to flourish in her role as partly due to her rural background. Kristen believed that urban individuals would have great difficulty experiencing the same degree of satisfaction.
Kristen described the need for rural professionals to maintain boundaries carefully. She also recommended these professionals endorse a creative and flexible approach in client care. She was cognizant of the fact that transportation was a significant barrier for her clientele; she offered credence to this by stating that only two of her eighteen clients possessed a driver’s license.

Kristen acknowledged isolation as a negative factor in her job, but believed there were ways of combatting this with technology, support for one another, and opportunities for involvement in committees and education. Kristen encouraged decision makers to offer flexibility in work-life balance as a means of recruiting experienced psychiatric nurses. She also recommended rural placements for students that included accommodations. Kristen recommended that promotion rural life is a good recruitment strategy for rural regional health authorities since, “Living rurally gives a more balanced lifestyle”.

Mary. Mary is a baccalaureate prepared psychiatric nurse with twelve years experience as a psychiatric nurse. After a short period working in an urban setting, she successfully attained a front line psychiatric nursing position in a personal care home in the South Zone of PMH. This led her to a specialist position in senior’s mental health service. Her parents raised her in the area where she currently works.

Mary expressed that being a rural person was the key factor in her desire to return to the rural area. She believed that rural professionals “form better relationships” and that there is higher degree of caring in rural communities. She also stated that, “people that fall in love with rural folk are more likely to stay”.

Mary expressed feeling isolated in her role as, “I’ve never been more isolated in my life”. She also appreciated the autonomy that is inherent in her specialist role, and appreciated the
collaborative practice she has developed. She believed that developing relationships with other providers was critical to job satisfaction. Privacy was an issue that required maintenance of strong boundaries.

Mary described the need for individuals to be prepared for highway driving in a variety of conditions when contemplating rural positions. Mary also described a courageous and positive attitude as necessary attributes for job satisfaction. She believed that rural work was rewarding and satisfying for the right individuals.

Mary expressed that universities could better prepare psychiatric nurses for rural work by providing clinical rotations in rural areas. She believed the RHAs could improve recruitment by increasing the number of permanent, full-time rural positions. She also recommended that PMH strive to create and offer the same collegial support for rural workers that are inherent in the urban setting of Brandon.

**Bob.** Bob is a 60-year-old diploma prepared psychiatric nurse with 26 years experience. His parents raised him in a variety of urban and rural communities throughout Canada and he described this background as adventurous but transient. He was looking forward to retirement from his geriatric specialty role in the near future. His plan upon retirement was to remain in the northern community he was working in.

Bob took great pride in his rural professional role. He took his consultative role seriously and experienced great success in sharing his knowledge with other providers, assisting clients to remain in their home communities, reducing the use of chemical restraint, and improving overall outcomes for clientele. His colleagues showed respect for his autonomy by their willingness to endorse his recommendations.
Bob expressed concern about young, inexperienced nurses entering the rural workforce with little support or mentorship. He described a high degree of responsibility with the position, “When you’re out here, you’re it. They call you up and they want you to come fix this person NOW, and sometimes you cannot. As a new grad, it would be more intimidating than it is for me.”

While recognizing the privacy concerns in a small town setting, Bob offered examples of how he maintained good boundaries. He believed that the caring in a small town is a positive factor contributing to job satisfaction. He also believed the collaborative practise he was able to establish as another positive factor.

A supportive supervisor reduced Bob’s equivalency of full-time (EFT) status to assist him in his pursuit of work-life balance. Bob recommended further flexibility by PMH in order to retain quality staff. Bob also believed that employers such as PMH could promote the rural lifestyle. He strongly endorsed an approach that encouraged current employees to pursue higher education as psychiatric nurses. For example, he recommended that the rural towns invest in local licensed practical nurses (LPNs) to allow them to pursue psychiatric nursing by subsidizing their education. He also recommended that PMH establish a formal process for mentoring younger nurses as a means of recruiting and retaining quality staff. Finally, he recommended that Brandon University promote long-term-care as a desirable specialty for psychiatric nurses.

**Jamie.** Jamie is a 47-year-old woman with 26 years experience as a diploma prepared psychiatric nurse. She described herself as an urban-raised individual who was courageous and willing to take risks in her professional and personal life. At age 19, she entered a rural practicum with an area that offered her employment upon graduation. She reluctantly declined the offer in order to gain experience and confidence in an urban setting with less responsibility.
After working for a period in an urban setting in another province, she returned to Manitoba where she secured work as a rural community mental health specialist. She married a rural man and this solidified her rural status. Jamie had recently made a change into the specialty area of mental health promotion after several years as a community mental health worker (CMHW).

Jamie described work-related suffering that she endured because of her description of poor boundaries. At the outset of her CMHW work, she became immersed in this satisfying, albeit demanding rural work. Clients and other providers depended upon her and she responded to their needs enthusiastically. In the early years of her work, few resources existed; she provided care with little support from other providers. Clients contacted her at home and requested her assistance with their personal needs and she usually responded. She described uncomfortable community encounters with clients when she felt an inability to distance herself. A perfect storm arose during her last five years of work that injured her emotionally; seven of her clients died by suicide. On one particularly traumatizing occasion, Jaimie attended to her client’s home and found him deceased in his barn. She performed CPR for 45 minutes until the emergency services personnel arrived. She took a leave of a few months to recover from this highly traumatic event. Following an unsuccessful attempt to return to work, she took further time off until a job change became available.

Jamie offered recommendations to decision makers to ensure they provide adequate and strong support to rural clinicians. These clinicians benefit from ongoing support from one another and face to face contact with their supervisor. She also recommended that PMH provide educational opportunities; this would improve retention. Although she believed that individuals who were raised in a small town are most suited to rural psychiatric nursing positions, she did not recommend returning to the same community one was raised in.
Leah. Leah is a 48-year-old woman with 4.5 years experience as a baccalaureate prepared psychiatric nurse. After working in an urban setting for a time, she was attracted to a rural specialty position for two reasons. The reasons that she described were related to work/life balance. The position did not require night shifts, and the position was based in a community close to her home.

The proximity to her workplace, the autonomy the position offered, and the diversity in her role led to a strong degree of satisfaction in her role. When asked further about these work qualities, she stated, “You can kinda think outside the box, I like that”. She also offered that her personal characteristics of diligence, leadership capacity, and being a self-starter contributed to her overall satisfaction in her role.

She described isolation and the lack of resources in the rural area as challenges to overcome. Leah noted transportation as a challenging factor for many of her clients. Technology assisted in overcoming some of the barriers to support. She described the multi-disciplinary approach to client care as a positive factor. She recommended that the university offer rural placements to psychiatric students as a manner of promoting rural work.

Essential Themes

The analysis of data in this phenomenological inquiry required reading and re-reading of the text to highlight significant statements and elucidate meaningful quotes and metaphors contained within the rich data (Ajjawi & Higgs, 2007; Creswell, 2012). While immersed in the data, I developed an understanding of the participants’ experience of the phenomena (Creswell, 2013). I developed groups or clusters of meaning from the significant statements; these were grouped into themes. van Manen (1990) encouraged the process of transforming lived experience into meaning with contextual expression of its essence with the use of themes and subthemes.
The main themes derived from the interviews with rural psychiatric nurse clinicians included: (1) isolation; (2) specific characteristics of individuals who flourish in their rural roles; (3) privacy issues; (4) autonomy; (5) travel; and (6) recommendations. A discussion of each theme includes sub-themes or thematic statements. An illustration of the themes and thematic statements is provided in Table 1 on the following page.

Isolation. This theme denoted a sense of involuntary detachment from similar psychiatric nurse clinicians. Every participant described this phenomenon in a negative manner. Four thematic statements composed this essential theme: (a) feeling alone, (b) needing support from colleagues, (c) needing support from a supervisor, and (d) using technology to stave off isolation.

Feeling alone. Feeling alone is a sad and lonely state that requires attention in order to achieve satisfaction in one’s role (Hardy & Conway, 1998; Keyes, 2002). Mary described her feelings of loneliness as a rural clinician with the comment, “I’ve never felt more isolated in all my life”. Dolores described her isolation as, “Kind of on an island”. Barbara stated, “One of our definite downfalls is the isolation out here”.

Needing support from colleagues. This theme is a concept iterated by many of the participants interviewed. Several expressed the desire and need to stay connected with similar colleagues. One participant described how she missed the connectedness with colleagues, “well, I miss just not having that connection with other people who are working mental health, other people who get it in the same say. Like sometimes you need to vent…..”

Needing support from a supervisor. This thematic statement was articulated by the need for validation, clinical support, encouragement and general feedback from their supervisors. Several workers identified that it is necessary to reach out when needing support. Katie stated,
Table 1.

*Essential Themes and Thematic Statements of Study*

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<tr>
<th>Essential Themes</th>
<th>Thematic Statement</th>
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<td>Isolation</td>
<td>Feeling alone</td>
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<td>Needing support from colleagues</td>
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<td>Needing support from supervisor</td>
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<td>Technology staves off isolation</td>
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<td>Characteristics of Individuals Who Flourish</td>
<td>Rurally raised individuals</td>
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<td></td>
<td>Courageous personality</td>
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<td>Privacy</td>
<td>Boundaries are important</td>
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<td></td>
<td>Difficult to maintain public/private life</td>
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<td>Autonomy</td>
<td>Richness of autonomous positions</td>
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<td></td>
<td>Fosters collaboration</td>
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<td>Positive work/life balance</td>
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<td>Challenges in Meeting Client Needs</td>
<td>Difficult weather/difficult travel</td>
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<td></td>
<td>Long distances to providers</td>
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<tr>
<td>Recommendations</td>
<td>Universities provide rural rotations</td>
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<td>Educational subsidies</td>
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<td>Promote rural life/work</td>
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<td>Remunerate preceptorship</td>
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“make sure you have those connections whether it’s a mentor, manager, supervisor, someone to go to if you need help”. June described feelings of isolation from her supervisor, “out of sight, out of mind”.

**Using technology to stave off isolation.** Most participants identified the use of technology as a tool to connect with colleagues and supervisors. The use of the email, phone, and telehealth were identified technological tools. During this discussion, Katie stated, “You have to have the ability to stay connected in any way you can”.

**Characteristics of Individuals Who Flourish.** All participants discussed the desirable quality of flourishing in one’s role. Keyes (2002) described the positive quality of flourishing in which one attains high levels of mental health, resilience in the face of adversity, and social connectedness. The individuals of this study who were seen as flourishing were rurally raised and had a courageous personality.

**Rurally raised individuals.** Participants regarded this concept as the most significant attribute that contributed to a sense of contentment in their role as a rural psychiatric nurse clinician. When asked whether an urban psychiatric nurse could flourish in her role in a rural setting, Kristen replied, “I think they would have a real hard time”. Participants took pride in their lifelong rural status as stated by Katie, “I’ve always been a small town girl”.

**Courageous personality.** Many participants described an adventurous, courageous personality as one who would flourish in a rural role. One person travelled to a Caribbean island to work following her graduation from psychiatric nursing. Another participant described this courage as a positive attribute; she always met challenges head on. During her interview Jamie stated, “I was really out to prove myself at the beginning and I worked like a dog trying to do that. Like I really did.”
Privacy. Most participants discussed difficulty-achieving privacy in the rural communities in which they worked and lived. Most discussed how small towns did not allow individuals space in which they could maintain this privacy.

Boundaries are important. The participants discussed how effort was necessary to maintain professional boundaries. Their personal and private roles overlapped for themselves and for their own families. One worker presented her insight that she learned to maintain boundaries after many difficult years, “I probably didn’t set the healthiest of boundaries at first because what I began to know is that the more responsible you are, the more people want of you.”

Difficult to maintain public/private life. Participants described awkward situations in which they could not escape their professional role, even while in a public setting. Many described how they would be in a public setting such as a grocery store when clients approached them to discuss their situation. One worker described, “Even the doctor would phone me at home. I felt like I was on call 24 hours a day”. Jamie described withdrawing as a result, “slowly but surely I didn’t have a social life. It didn’t matter where I went, since a client would see you and would talk to you.” She went on to describe how her children were affected by her role: “my daughter had three sexual abuse disclosures made to her”.

Autonomy. The autonomy described in rural positions was a highly positive quality. Skar (2010) describes professional autonomy as encompassing the authority to make decisions and the freedom to act within one’s professional knowledge base. All participants described how they appreciated the autonomy their job offered. This autonomy was the most often identified positive attribute of their professional rural service.

Richness of autonomous positions. The rural psychiatric clinicians utilized creativity in their approach and this expanded their capacity to offer a rich service. The clinicians were
obliged to practice autonomously by the fact of their distance from colleagues and a supervisor. When asked how she would describe her autonomy, Kristen stated, “It’s lovely, absolutely lovely.”

**Fosters collaboration.** Levels of satisfaction increase when one’s role is valued in a collaborative manner. Many of the participants described the interdisciplinary team as their main colleagues; this collaboration improved the continuity of patient care, leading to improved feelings of professional esteem. A collaborative practice leads to improved confidence and social connectedness, thus improving upon feelings of autonomy. Kristen described her work in a rural area, “we are less siloed, and less reliant on institutions.....we are more team focused”

**Positive work-life balance.** Participants described the benefits of living and working in a rural setting as outweighing the negative factors. They described a slower pace of living with the benefits that are inherent in a balanced lifestyle. One worker described how he avoids city travel and a few articulated the positives of the proximity to their office. The unique situation of being the only specialty mental health practitioner in a small town, added to feelings of being valued within an autonomous practice. One laughed while she stated, “it’s a three minute commute to work, walking”.

**Challenges in Meeting Client Needs.** The sparse population of the North and South Zones of PMH often contributed to the extensive travel required with psychiatric nurse clinician positions. Most of the workers covered large geographic areas and their role required significant travel. Decisions needed to be made about how often to travel to certain communities, and when to cancel services to areas.

**Difficult weather/difficult travel.** The reality of prairie winters is that they are harsh and long. Participants described frequent travelling in difficult conditions. Risk was often weighed to
determine if travel was necessary. A pregnant participant described her worry about road conditions, "some of us rural people drive in situations where we’re not probably should just cause were used to it right. There’s been a few times I’ve had to, my husband’s been like, no, and you’re not driving today."

**Long distances to providers.** The participants described their conflicted feelings when contemplating their clients’ struggles, including travel to providers. One worker described the social isolation her clients experience because of lack of transportation. The rural communities do not have public transportation and many clients live in remote locations. Kristen stated, “only two of my 18 clients have a driver’s license”.

**Recommendations.** I offered the participants the opportunity to suggest recommendations. This indicated that their opinion mattered. This invitation resulted in rich information being gathered.

**University provide rural rotations.** Many participants encouraged Brandon University to offer rural clinical rotations to psychiatric nursing students. One participant encouraged the university to secure accommodations for students in rural spots: “that would enhance the capacity to bring in people”.

**Educational subsidies.** Participants identified that subsidies to committed rural individuals would encourage individuals to pursue education and return to the area as a psychiatric nurse. Bob identified a novel approach to encourage PMH to identify LPNs that would be suitable psychiatric nurses and to subsidize their education, “Some are naturally good with their approach with individuals”.

Promote rural life and work. Most participants loved the lifestyle of rural life and believed that rural regional health authorities could promote the benefits of living and working rurally. Kristen summed it up nicely by stating, “Living rurally gives a more balanced lifestyle”.

Remunerate preceptorship. The participants described that it is necessary to create competent rural staff with mentoring. When describing young inexperienced staff, Bob stated, “They may be confident, but they’re not competent”. One participant described the challenges with mentoring a student in a rural area, as there are no colleagues to share the workload with as, “It takes a lot of energy when you are by yourself to have students”. Remuneration for preceptoring rural students and mentoring new staff was mentioned as possible benefits to taking on this extra work.

The Hermeneutic Circle of Interpretation

According to Streubert and Carpenter (2011), the hermeneutic method of inquiry does not require bracketing of preconceptions or theories, so the interviewer did not bracket her own conceptions during the process. The hermeneutic circle began with a naïve understanding of rural psychiatric nurse experiences, and moved on to a clear and detailed understanding explicated from the analyzed data. Allen and Jenson (1990) described the hermeneutical circle:

The hermeneutical circle of interpretation moves forward and backward, starting at the present. It is never closed or final. Through rigorous interaction and understanding, the phenomenon is uncovered. The interpretive process that underlies meaning arises out of interactions, working outward ad back from self to event and event to self. (p. 245)

Attawi and Higgs (2007) described the hermeneutic circle as a metaphor for understanding and interpreting or the movement between the data parts and the whole, while understanding that each offer meaning to one another. The circular manner in which participants’ stories or
experience illustrate themes to erupt, allow an integration of the parts into a whole – forwards and backwards or in a circular fashion.

First, I sought an understanding the participants’ ideas by listening to their stories of their unique experiences as rural psychiatric nurse clinicians. This provided a first order construct of understanding of the phenomenon (Attawi & Higgs, 2007). Member checking allowed validation of these understandings. Second order constructs were generated with the theoretical knowledge gained during the literature review while integrating this knowledge with her vast experience as a rural psychiatric nurse clinician. I read and re-read the transcripts to validate or correct first order constructs. As interpretation of the text took place, third order constructs resulted with a richer and deeper understanding of the phenomenon of the psychiatric nurse clinicians. The subthemes assisted in developing an understanding of the six essential themes identified. Key findings from the data allowed an illumination of the phenomenon. Finally, an integration of the essential themes allowed me to appreciate the knowledge with increased understanding of the phenomenon.
Chapter Five - Discussion of Findings

The phenomenon of interest of this study was the lived experience of psychiatric nurse clinicians working in rural areas of Manitoba. I chose phenomenology as an appropriate research method to study the uniqueness of the subjects’ experiences. Hermeneutic phenomenology allowed me to utilize an approach outlined by an educator, van Manen (1990). I used his instructions to study the phenomenon of interest, by reflecting upon the essential themes and their sub-sets of these experiences and then integrating them into a whole (Creswell, 2012; Streubert & Carpenter, 2011). The hermeneutic phenomenological method allowed me to interpret the unique experiences that were articulated, reflected upon, discussed, transcribed, analyzed, and captured with phenomenological writing.

The phenomenological method allowed me to use my entire self within the process of inquiry. I was able to draw upon her extensive experiences of 31 years as a rural psychiatric nurse specialist while conducting the research; interactions between researcher and participant enhanced the shared understanding that developed. The study method evoked a heightened understanding of the lived experiences of this subject group. Allen and Jenson (1990) describe the being-in-the-world embodiment as a result of this awareness:

The value of knowledge in nursing is, in part, determined by its relevance to and significance for an understanding of the human experience. In order to obtain that understanding, nursing requires modes of inquiry that offer the freedom to explore the richness of this experience. Hermeneutics offers such a mode of inquiry. With this interpretive strategy, a means is provided for arriving at a deeper understanding of human existence through attention to the nature of language and meaning. (p. 241)
Significance of the Study

As the Mental Health Commission of Canada (2012) strives to achieve two of its goals - workforce development and improvements to care in rural and remote areas of Canada - it is imperative that we develop an understanding of the issues that contribute to job satisfaction in the current rural professionals. Rural recruitment and retention of quality mental health professionals are ongoing challenges. To address the recruitment and retention issue and improve our health care services, evidence-based policy and practice changes are needed. The findings of the study suggest there are a number of factors that contribute to recruitment and retention of quality mental health professionals, namely psychiatric nurses. The participants who expressed a willingness to become involved in the study were eager to tell their stories and contribute to the body of knowledge required to improve the human resource strategies that currently exist. There is currently very little scientific knowledge about the subject area.

I determined a problem statement indicating the difficulties recruiting and retaining quality mental health professionals to rural and remote areas contributes to the concept of distance decay, which is a worsening of healthcare the further one lives away from urban centres (Wong & Regan, 2009). Regional Directors of Mental Health Services of Regional Health Authorities provided evidence that it is extremely difficult to recruit and retain specialty mental health professional into areas geographically removed from urban centres (personal communication, May 19, 2015). Some specialty positions in rural areas were extremely difficult to fill; one was reportedly vacant for several years.

Congruency between the Literature and Study Findings

Although a dearth of literature exists related to the subject area, the findings of the study is consistent with the current knowledge base. Australian studies by Gillespie and Redivo
(2012a; 2012b) highlighted a variety of problematic factors influencing mental health clinicians’ level of satisfaction while working in rural areas. In particular, they noted that universities provided inappropriate education preparing students for the rural mental health profession (Gillespie & Redivo, 2012b). Additionally, they reported the inappropriateness of using an urban design for mental health care in a rural area. Gillespie and Redivo (2012a) studied the high degree of role strain and conflict that results with the personal-professional boundary issues inherent while living and working in such a profession. An interesting finding of their studies aligned with results of this study – urban professionals who lack understanding of rural life do not flourish in a rural working environment. Several studies indicated the importance of recruiting professionals familiar with rural life, which contributes to retention of quality mental health staff (Backman, 2000; Bodor, 2009; Gillespie & Redivo, 2012a; Manahan et al., 2009; Perkins et al., 2007; Strasser & Neusy, 2010; Wong and Regan, 2009).

All of the participants in this study referenced isolation as a noteworthy factor effecting their job satisfaction. Role socialization is a phenomenon that Hardy and Conway (1988) discuss as a predominant need of individuals; this socialization is hindered when staff is isolated from peers and supervisors. Participants of this study discussed the need for collegial support from peers and administrative/clinical support from their supervisors. One participant stated, “I’ve never felt so isolated in all my life”. Several studies highlighted this factor as requiring significant attention from employers (Canadian Mental Health Association of Ontario, 2009; Drury et al., 2005; Hoogsteen & Woodgate, 2013; Moore et al., 2010; Wong & Regan, 2009). Isolation leads to role stress and possibly feelings of incompetence, thus defeating feelings of engagement (Hardy & Conway, 1988). Study participants offered suggestions to employers to mitigate this isolation such as ensuring staff have the opportunity to meet regularly, providing
clinical support, and maintaining contact with managers. Several participants stressed the need for staff to recognize when they need support and to address this need by reaching out to colleagues, mentors, or a supervisor. One participant stressed the importance of addressing this isolation by maintaining strong relationships outside of work.

The issue of role overload is inherent in a position with a high degree of responsibility (Hardy & Conway, 1998; Laschinger & Fida, 2014). Although most participants indicated appreciation for the autonomy of their rural positions, they also indicated that significant stress comes along with this responsibility. One nurse stressed the need to hire individuals who were confident and competent. Several individuals indicated that maintaining boundaries is paramount when working and living in a rural community as a psychiatric nurse clinician. In rural areas, the probability of interacting outside of the work setting with clientele is high. One participant described how clients approached him at the local grocery store, while another participant described her children’s friendship with her clients. Gillespie and Redivo (2012a; 2012b) stressed this personal-professional boundary maintenance in their studies. The discomfort evoked with the boundary issues contributed to the role strain that Hardy and Conway (1988) studied. The findings of this study are consistent with the personal-professional boundary maintenance that Gillespie and Redivo describe (2012a; 2012b).

Participants in this study offered novel approaches to recruitment and retention such as offering educational subsidies to existing staff such as LPNs to become psychiatric nurses. Consistent with the literature, a variety of considerations need to include offering extrinsic incentives and addressing intrinsic disincentives (Campbell, McAllister & Eley, 2012; Mbemba, Gagnon, Pare & Cote, 2013). One participant suggested that financial incentives be offered to experienced psychiatric nurses to precept new psychiatric nurses. These suggestions aligned with
the studies by the Canadian Mental Health Association of Ontario (2009) and Drolet et al. (2011) proposing that financial incentives could improve recruitment and retention. Several studies indicated that educational opportunities could improve retention of health care providers in rural settings (Gagnon et al., 2011; Healey-Ogden et al., 2012; Strasser & Neusy, 2010); several participants in this study reiterated this recommendation.

Role triumph, or flourishing in one’s role, is a desirable state that strongly contributes to heightened job satisfaction and retention of quality mental health professionals (Hardy & Conway, 1998; Keyes, 2002; Mental Health Commission of Canada, 2012). Participants in this study described the positive quality of life with a rural lifestyle, the positive aspects of autonomy, the collaborative practice that exists in rural areas, and the creativity that abounds in their practise. As described by Cho, Laschinger, and Wong (2006), autonomy is a significant issue contributing to the empowerment of nurses. Autonomy, rewards, empowerment, quality of rural lifestyle, and opportunities for advancement are contributing factors to their flourishing states, or role triumph.

**New Evidence**

The participants of this study highlighted travel as a noteworthy, challenging factor for rural professionals. The sparse population of many areas of rural Manitoba requires significant travel for community members to access needed services, or even purchase necessities. The harsh conditions of winter heighten risk during storms such as vehicle breakdowns. All of the participants interviewed travelled to satellite communities apart from their main base offices. This travel was a necessity to bring needed mental health services to clients. When weather was bad, decisions to risk travel, suspend services, or remain home resulted. This was anxiety provoking and stressful. This is a harsh reality for rural individuals requiring acknowledgement
by employing bodies such as rural regional health authorities. The current employment contracts do not acknowledge the safety concerns that arise over travel and harsh weather. This researcher recommends explicit acknowledgement of the harsh weather and travel concerns for rural workers within the negotiated employment contracts, allowing accommodation to alter their work regime.

Several study participants suggested that the educational system should make more effort to provide rural rotations for psychiatric nursing students, preparing them for rural positions following graduation. Participants offered innovative ideas such as ensuring accommodation for students during this rotation at rural sites. Participants also suggested that the rural regional health authorities should promote the lifestyle of the rural areas to students as a recruitment strategy. This study recommends that the Brandon University collaborate with the RHAs in an effort to increase rural placements, accommodate living needs of students during their placements, and promote the rural lifestyle.

Two participants suggested that employers could offer increased flexibility for staff working hours as a means of retaining quality staff. One individual stated that opportunities to reduce EFT statuses could benefit some, enticing them to remain employed in a rural area. This opportunity would be particularly attractive to young families or individuals who were close to retirement. Another individual stated that flexible work hours might contribute to enhanced job satisfaction. This study recommends that the employers identify this flexibility within the negotiated employment contract as a manner of improving retention of quality staff.

Limitations

General criticisms of qualitative research tend to focus on the perceived lack of scientific rigour involved (Creswell, 2012). The numbers of participants are generally much smaller than
quantitative study pools. Results of qualitative research are difficult to reproduce and researcher bias is inevitable through the inherent use of self. The readers of qualitative studies must keep an open mind and be willing to accept a variety of viewpoints. Within this study, I focused on a specific geographic area of Manitoba, potentially limiting the transfer results of the study to areas that differ in geography. Critics of qualitative research claim that generalization of study results are difficult (Streubert & Carpenter, 2011). Lincoln and Guba (1985) qualify this criticism with their statement, “The only generalization is that there is no generalization” (p.110).

The writer’s extensive experience as a rural mental health professional may have affected researcher bias within this study. Experiences are embodied and impossible to disconnect in order to achieve objectivity. Bracketing or a shelving of one’s preconceptions is not a required technique within hermeneutic phenomenology; the use of self is an inherent technique (Creswell, 2012; Streubert & Carpenter, 2011). I minimized this bias with notes, journaling, and reflexive practise.

**Strengths**

My extensive experience as a rural psychiatric nurse added credibility to this study. The participants were eager to share their experiences with her. The need for further evidence to improve human resource development in rural areas has been identified within the Mental Health Strategy of Canada (Mental Health Commission of Canada, 2012). Consistent themes were identified in this study.

**Generalizability**

The results of this study could potentially be generalized to other mental health professionals such as psychologists, social workers, or psychiatrists. The experiences of other mental health professionals may be similar to the experiences of psychiatric nurses. The issues
raised by the participants were not necessarily specific to their psychiatric nursing profession, but related to the issue of their professional practice in a rural setting. Understanding this, rural health authorities could apply these results to recruitment and retention of a variety of health professionals outside the mental health service system. The educational system could apply these results when planning curriculums for psychiatric nursing and other professions that service rural and remote areas by implementing rural practicums, incentivizing preceptorships, and promoting the rural lifestyle that supports autonomous practice and work/life balance.

Summary

As we advance the provincial and national strategic mental health strategies in Canada, it is imperative that we consider ways to improve the engagement of the workforce, particularly, the engagement of psychiatric nurses. The results of this study indicate that it is possible to address the recruitment and retention problem of staff effecting the rural Manitoba mental health care system, which in turn, will improve the mental health of the population.

The participants of this study were eager to discuss their unique stories working in rural and remote areas of PMH. There were varying degrees of reported engagement and job satisfaction. When assessing their narratives for themes, however, two main areas for improvement were recommended: 1) Brandon University implement educational strategies to improve readiness for rural employment; and 2) employers improve upon initiatives to recruit and retain quality psychiatric nurses into rural areas.

The participants also illuminated a number of innovative actions that would support the education, readiness, recruitment, and retention of quality staff. Some of these actions were to offer educational support in the form of financial incentives, enhance supportive relationships with colleagues and supervisors, increase opportunities for career advancement, provide
flexibilities with EFTs, provide consideration for travel and suspending it when necessary within the negotiated contracts, and continue to encourage and support empowerment and autonomy of the psychiatric nurses.
References


Rural Health Research Center. (2016). *Supply and distribution of the behavioral health workforce in rural America (Policy Brief 160).* Retrieved December 9, 2016, from


Appendix A – Letter of Invitation

Dear Sir or Madam,

I am writing to invite you to partake in a research study examining the unique experiences of Psychiatric Nurses working as Mental Health clinicians in rural and remote settings. The overarching goal of this project is to improve the recruitment and retention of qualified mental health professionals into rural and remote settings. The information gathered will help with improvements to human resource policies and allow the University to improve upon curriculum preparing students for this work. This project has the capacity to positively influence the profession of psychiatric nursing and subsequently the service delivery in a variety of ways. The results of this project will be published in professional journals, will be presented to others within our profession, and will be presented to policy makers.

I, Kim Toews, will be the principal investigator of this research project. This project will fulfill the final requirements of the Master’s in Psychiatric Nursing (MPN) program at Brandon University in which I am currently enrolled. With most of my 30 years psychiatric nursing experience as a rural clinician, I have a vested interest in this topic area.

I would like to interview you about your experiences as a psychiatric nurse working in a rural or remote setting. If you are a psychiatric nurse that has been employed for at least two years as a mental health professional, and work in a rural setting, you are eligible to participate. If you work within the city of Brandon, you will not be eligible to participate. Participation in this research is completely voluntary and you may withdraw at any point during the interview.

If you are interested and willing to participate in this study, I will be available for an interview in a setting of your choosing. Please contact me at kkct1@mymts.net if you are willing to participate so that we may make arrangements for this interview. If you have any questions about
the study now or into the future, please do not hesitate to call me, Kim Toews at 204-712-5363. You may also call my supervisor, Dr Dean Care at cared@brandou.ca or 204-727-7456.

Thank-you very much,

Kim Toews, RPN, ADPN, BScPN
Appendix B - Poster

If you are a rural psychiatric nurse interested in participating in a study about your working experiences, please
contact Kim Toews at

kkctl@mymts.net or

204-712-5363
Appendix C - Consent

The Lived Experience of Psychiatric Nurses Working as Mental Health Clinicians in Rural Manitoba

I consent to participating in a study to share my experiences and reflections on my experiences while working as a Psychiatric Nurse in a rural setting of Manitoba. The knowledge that I will share will contribute to human resource policy development aimed at improving recruitment and retention of psychiatric nurses into rural areas. Additionally, this information gathered may be of assistance to Brandon University as they seek to improve upon educational curriculum that prepares psychiatric nursing students for employment in rural areas. These goals will essentially improve the mental health service delivery in rural areas. I understand that my name will be kept confidential and my described experiences will not identify me in any way. A summary of the results will be shared with Brandon University, will be published in journals, will be presented at conferences and shared with human resource policy makers. In order to ensure confidentiality, precise details of the interviews will not be shared with my employer. My participation is completely voluntary and I can withdraw at any time or refuse to discuss issues with which I am uncomfortable. I understand that participation will not affect my employment in any form. As a consenting participant, I am not waiving any rights to legal recourse in the event of research-related harm.

The interview with me will take 1.0 – 1.5 hrs of time. The interview will be audio taped by the researcher. The researcher may utilize a transcriber and research assistants as the interview is transcribed and themes captured. A brief follow up phone call may be required to verify the main themes. I understand that once the audiotapes are transcribed the original tapes and transcription will be returned to the Principal Investigator (PI) of the study. These tapes and transcripts will be
secured and kept under lock and key. Any electronic data captured by the PI will be guarded with
password encryption. My name will not be kept with the transcripts and data will be destroyed
after seven years.

Although the interview is not anticipated to cause distress, the researcher will stop the interview
at any point that you wish it to stop. Kim Toews, a Master’s in Psychiatric Nursing student is
conducting this study. Should I have any questions about this study, I will contact Kim Toews at
kkct1@mymts.net or (204) 712-5363 or her supervisor Dr Dean Care at cared@brandonu.ca or
204-727-7456. Any concerns I may have about the ethics of conducting this study may be shared
with the Brandon University Research Ethics Committee (BUREC).

____________________________________

Participant Signature and Date

____________________________________

Witness and Date
Appendix D - Questions Guiding Interview

The Lived Experience of Psychiatric Nurses Working as Mental Health Clinicians in Rural Manitoba

Researchers who utilize hermeneutic phenomenology ask open-ended questions to facilitate discussion and gain information about participants’ experiences. The information is usually gathered in a conversational format between the researcher and participant. Questions related to professional background may be difficult to completely separate from questions about personal background since this study expects there are issues that are intertwined.

Interview Guide:

“The purpose of this research is to better understand your experience as a mental health professional about providing services in a rural setting. This requires some sharing of basic information about you first, then further information about your actual work experience.”

“Please tell me about your experiences working as a psychiatric nurse in this rural setting.”

“What are the most significant challenges you encounter within your work in your geographic setting?”

“What do you like the most about your work?”

“How do you feel supported in your day-to-day work?”

“What keeps you in this work setting?”

The participants’ responses guide and prompt the interviewer to pose further open-ended questions. I expect that themes will arise related to job satisfaction, challenges that arise, support from supervisors, and unique experiences related to their geography and service provision. Interviews will last up to 1.5 hrs. A follow-up phone call of about 20 mins will allow the
participants to confirm the content of their interview and will offer on-going consent of participation.
Appendix E - Confidentiality Agreement

The Lived Experience of Psychiatric Nurses Working as Mental Health Clinicians in Rural Manitoba

I acknowledge myself as an individual who is providing assistance to the Principal Investigator, Kim Toews, of the above project. My involvement requires me to handle data that potentially offers sensitive and confidential information about participants. I agree that I will handle this data with the utmost of respect with an agreement of keeping data confidential. I will not share information with anyone other than the Principal Investigator.

Signature and Date

Witness and Date