

**PERCEIVED NEED AND WILLINGNESS OF A SAMPLE OF REGISTERED
CASUALTY UNIT NURSES TO ENGAGE IN SUPPLEMENTARY COUNSELLING
SKILLS TRAINING**

by

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ABSTRACT

In 2002 there were an estimated 1.5 million people admitted into casualty emergency units within the Republic of South Africa. Many of these admissions dealt with events that were traumatic for both families and practitioners and these traumatic events have effects on the biological, psychological and social wellbeing of these individuals. Coupled with this is an ever increasing demand for mental health services and a worldwide shortage of qualified individuals to provide these services. Registered nurses in casualty units deal with the majority of these issues and the effect of these traumatic events. The crisis intervention model may provide these registered nurses with the necessary skills to deal with these problems not only for patients but possibly for themselves. Furthermore the biopsychosocial model of health allows these registered nurses to assess the impact of these events on the individuals. Yet, some registered nurses feel that they lack the necessary skills to deal with and assess these problems and intervene in these crisis situations. This study was exploratory descriptive in nature and aimed to examine whether there was a perceived need for registered casualty unit nurses to engage in supplementary counselling skills training. These perceptions were obtained through purposively sampled interviews and analysed qualitatively, using Tesch's model of content analysis. Findings indicated that the registered nurses do perceive a need for supplementary counselling training, both for use with the patients and for themselves, and are willing to engage in this training although there are problems that inhibit this willingness. Recommendations regarding the implementation of a supplementary counselling skills training course as well as future research in the field were made.

Keywords: psychology in public health care, cross-disciplinary training, multidisciplinary clinical teams, biopsychosocial model of health, crisis intervention model, integrated health care, registered nurses in casualty units

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In accordance with Rule G4.6.3, I hereby declare that the above-mentioned treatise/ dissertation/ thesis is my own work and that it has not previously been submitted for assessment to another University or for another qualification.

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CHAPTER 1

INTRODUCTION

1.1 Chapter Overview

Chapter one provides the rationale for this study into the perceived need and willingness of state based registered casualty nurses to engage in supplementary counselling skills training. Through understanding the motivation to investigate this phenomenon, the aim of this research study is clarified.

1.2 Rationale

With the ever increasing demands made on the health sector each year, and an estimated 450 million sufferers of mental and behavioural disorders, it is apparent that there is a need for the field of psychology to take action regarding these increasing statistics (World Health Organisation (WHO), 2001). This increase on the demands of health care affects not only developed countries, but also developing countries such as the Republic of South Africa (RSA). In the year 2002 there were an estimated 1.5 million people admitted into casualty emergency units within the RSA (Informatics Directorate, 2003). Many of these admissions dealt with events that are traumatic for both families and the medical practitioners who treat these individuals. Many of the psychologically traumatic effects related to these casualty admissions have not been dealt with as there are not enough psychologically trained individuals to deal with these problems. With an inadequate representation of psychological practitioners within the public health sector to attend to the increasing number of patients requiring their services, an alternative means of filtering low risk and low priority psychological concerns must be found.

The profession that faces the majority of these increasing demands are the registered nurses working within the public health sector. Registered nurses are seen to be at the forefront of both medical and psychological services as they are the first to see the vast

majority of patients that require these services. In addition to being the first point of call for many patients, they are also the members of the multidisciplinary team that have the highest levels of contact with the patients. As such they are in a unique position to ascertain potential problems before they can manifest into more serious conditions. This unique situation creates a need for the registered nurses within casualty units to be more appropriately equipped to be able to deal with any problems that they might be faced with.

According to Leff (2001), an approach utilizing all the available community resources has the attraction of empowering individuals, families and communities to make mental health an agenda of people rather than professionals. This approach allows for governments and hospitals to narrow the treatment gap between untreated mental health patients by incorporating psychological services within the public health sector. A possible technique that may be applied is the inclusion of supplementary counselling skills training to registered nurses. The inclusion of this training has the potential to better equip these registered nurses within casualty units to deal with patients and also to allow for the self management of other registered nurses within the casualty units.

A study conducted in 2002 in the Ehlanzeni District of Mpumalanga Province in South Africa demonstrated how mental health care can be provided using other health practitioners within state run clinics. This study made use of a skilled registered nurse who saw all patients with mental disorders within the state run clinic and managed their treatment accordingly (WONCA, 2008). This model showed that effective mental health care can be provided by other health care practitioners depending on the complexity of the treatment programmes.

1.3 Aims

The aim of this study was to determine whether a sample of registered nurses working in a casualty unit in a hospital in the Eastern Cape Province of RSA perceive a need for the inclusion of supplementary counselling skills training within their professional development.

This study aimed to examine these perceptions and to determine whether these professional health care workers are willing to engage in a supplementary counselling skills training course in order to address the problem of mental and behavioural disorders in a public context.

1.4 Chapter Outline

Chapter one provided an overview of the focus of this study. Chapter Two discusses the various roles of psychology within public health care as well as the roles, scope of practice, relevant training and problems that registered nurses in South Africa experience with specific reference to casualty nurses. Chapter Three provides a comprehensive discussion of the biopsychosocial model of health as well as reviewing the crisis intervention model.

Chapter Four reviews the methodology that was implemented in this study. This review examines the benefits of qualitative research designs as well as providing detailed information of the implementation of this design for the purposes of this study. The sampling procedures as well as the data collection and analysis are discussed in this chapter. The various ethical considerations that were pertinent to this study are discussed in detail.

Chapter Five of this study provides a description of the results and discussion of this study's findings. In this chapter the perceptions and willingness of registered casualty nurses are explored and described and used to provide insight into the experiences of these nurses. Chapter Six provides a summary of the study and highlights some important outcomes pertaining to the findings of the research. The chapter concludes with the implications of the present study and provides recommendations for further research as well as for practical application.

1.5 Chapter Conclusion

This chapter provided information relating to the background and motivation for this study. Chapter discusses the role of psychology in the public health care system as well as the dilemmas and the benefits of integrating this field into public health care. It also provided information relating to the objectives of this study and provided an outline of the subsequent chapters as they are presented in this treatise.

CHAPTER 2

PSYCHOLOGY AND PUBLIC HEALTH CARE

2.1 Chapter Overview

This chapter aims to examine the role of psychology in primary health care as well as the difficulties that have occurred in including psychology within primary health care in the Republic of South Africa. The chapter then goes on to examine the role of nursing and mental health care, specifically within casualty units, by examining the nursing scope of practice and nursing curriculums as a method to facilitate the integration of psychology into primary health care. The experiences and effects of trauma are then examined to further explore some of the more specific factors that affect the mental health not only of individuals, but their families, relationships and the professionals providing services to the individual. This chapter finally examines the inclusion of supplementary counselling skills as a possible solution to the problems expressed within this chapter.

2.2 Psychology in public health care

According to the World Health Organisation's (WHO) World Health Report 2001, the sheer magnitude of behavioural and mental health problems which affect an estimated 450 million people worldwide, as well as the multifaceted etiology, widespread stigma and discrimination, and the significant treatment gap that exists around the world, make a public health approach the most appropriate method of response to this growing problem. This increase on the demands of health care affects not only developed countries but also developing countries such as the Republic of South Africa (RSA). In the year 2002 there were an estimated 1.5 million people admitted into casualty emergency units within the RSA (Informatics Directorate, 2003). Many of these admissions dealt with events that are traumatic for both families and the medical practitioners who treat these individuals. Many of

the psychologically traumatic effects related to these casualty admissions have not been dealt with as there are not enough psychologically trained individuals to deal with these problems. With an inadequate representation of psychological practitioners within the public health sector to attend to the increasing number of patients requiring their services, an alternative means of filtering low risk and low priority psychological concerns must be found.

The WHO Statistical information from the year 2006 indicated that the population of the RSA has reached approximately 48.2 million individuals, with a growth rate of 0.7% (World Health Organisation Statistical Information System, 2006). These 48.2 million individuals were serviced by 8,779 individuals registered with the Health Professional Council of South Africa (HPCSA) in categories ranging from Psychotechnicians to Psychologists working within both the public and the private sector (HPCSA, 2007). This number of registered mental health practitioners equates to a treatment ratio of approximately 5561 patients to one practitioner. This ratio is based upon the assumption that all registered mental health professionals in the RSA work in the public health sector, which is not the case. As such, it is becoming increasingly important for some action to be taken to address this apparent treatment gap in order to better provide mental health care services for the majority of the population.

2.2.1 Need for psychology in public health care

The practice of psychology has had difficulties being integrated as a field within public health care. As such it is still seen mainly as a specialist care field (Cummings, Cummings, & Johnson, 1997). It has been predicted that primary health care is the next frontier for psychology in the form of its integration of into public health care; as such it is important for the profession to make the transition from primarily a secondary-order or tertiary-order service to a first-order intervention as smoothly as possible.

Studies conducted in the RSA have found that there is evidence that mental health literacy, or knowledge regarding mental health and mental health issues, is suboptimal (World Health Organisation (WHO); World Federation for Mental Health (WFMH), 2004). Many ordinary people, patients, patients' family members and even community health care personnel have gaps in their knowledge regarding mental illness and also hold negative attitudes, which are heavily based on stigma towards people with mental illness (Emsley, 2001). With this lack of knowledge throughout the various levels of the public that make use of public health care, it becomes apparent that there is a great need for not only the inclusion of psychology and psychological skills within public health care, but also for psychoeducational programmes to explain this need. Due to this lack of knowledge, there are relatively few resources made available for the treatment of mental disorders in South Africa, including relatively few mental health practitioners (Emsley, 2001). This lack of resources further exacerbates the problem of the treatment gap that exists between those that suffer from mental health conditions without treatment and the exceptionally smaller number of those that provide these services. Studies conducted by the WHO hypothesised that providing education on mental health issues can help the public to realise the high prevalence of mental disorders and also draw attention to the need for the early recognition and treatment of these mental health conditions (WHO; WFMH, 2004).

These studies also found that in many parts of the world, mental health professionals are realising that there is a need for alliances and integration with other health professionals in order to address issues of de-stigmatisation, early diagnosis and improved management, and rehabilitation for those with mental illness (WHO; WFMH, 2004). These alliances make it possible to train, or retrain health professionals, as well as other multidisciplinary public servants, such as journalists, judges, police officials, teachers and other professionals, to recognise many of the early signs of mental health problems and to minimise many of the risk

factors associated with mental illness (Frank, McDaniel, & Heldring, 2004). This training has been found to be essential for the promotion of the positive aspects of mental health and is aimed at de-stigmatising the concepts of mental illness.

The World Health Organisation and the World Organisation of Family Doctors (WONCA, 2008) have found that mental disorders can influence physical health and illness in several ways. Anxious and depressed moods could lead to a variety of subsequent physical complaints due to the effects that they have regarding the physical systems that exist within the body (WONCA, 2008). An example of the effects of this mood and anxiety component can be found in the predisposing factor of stress and its relation to the development of the common cold and the effects that stress has been found to have in prolonging recovery from wounds (WONCA, 2008). Mental disorders have also been found to compromise general health behaviours. Studies conducted worldwide have found that certain mental disorders such as schizophrenia and depression have a high association with the use of tobacco as well as reduced compliance with regards to medication adherence (WONCA, 2008). People with mental disorders are also associated with heightened risk of contracting HIV as well as tuberculosis. These individuals also have trouble accessing the required physical health care due to discrimination both from the general public as well as health care providers (WONCA, 2008). The collective result of these factors means that people with mental disorders are more likely than others to develop significant health problems and conditions and therefore the need for integration of these services into public health care is becoming increasingly needed.

Even though these activities have been attempted in many countries, some studies have found that even with the reduction of past scepticisms regarding the importance of the role of mental health, these improvements in attitude have not translated into improvements in the situation for mental health (Crossley, 2001). These changes in attitudes with regards to mental health issues are important and are also an important step, but it should be noted that

even with the increase in compassion for mental health sufferers, within the South African context the problem is more complex (Kagee, 2006). In South Africa, with its past neglect regarding provision of even basic health care services to the majority of the population and with its geographical difficulties of providing these basic health care services to the rural areas, it is understandable that psychological and psychiatric care, previously viewed as secondary and tertiary order interventions, have taken a back seat (Freeman, 2000). There are substantial demands on the available resources within South Africa as there are concerns such as overcrowding of hospitals and clinics, dilapidation of health care facilities, low immunization, poor nutrition, and neglect for preventive and promotional programmes that are all competing for these limited resources and in political terms, mental health promotion is not seen as an urgent goal (Freeman, 2000). With the movement of psychology and psychologists away from second and tertiary level interventions and into public health care and primary interventions, the difficulty lies in the integration of these services into the appropriate health care structures (Kagee, 2006).

2.2.2 Integrating psychology into public health care

It has been argued that the current provision of mental health care does not meet the needs of mental health care patients or those of the referring professionals (Strosahl, 2005). Due to this lack of provision, studies have found that the primary care providers such as physicians and general practitioners find themselves as the “defacto behavioral health provision systems” (Strosahl, 2005, p. 16). This is a system that also affects the majority of individuals who seek help for a variety of psychiatric conditions within this country, and find themselves being treated for a medical condition that is merely a symptom of their underlying psychiatric problem (WONCA, 2008). Strosahl (2005) also argued that when a referral is made to psychiatric or psychological professionals, the referred patients often find themselves

conversing with voice mail recordings, confronted with exceptionally long waiting lists or confusion as to how to go about acquiring the necessary psychiatric services.

WONCA (2008) provides ten essential steps that will aid in the integration of psychological and mental health services into public and primary mental health care (p. 49-55):

1. Policy and plans need to incorporate primary care for mental health.
2. Advocacy is required to shift attitudes and behaviour.
3. Adequate training of primary care workers is required.
4. Primary care tasks must be limited and doable.
5. Specialist mental health professionals and facilities must be available to support primary care.
6. Patients must have access to essential psychotropic medications in primary care.
7. Integration is a process, not an event.
8. A mental health service coordinator is crucial.
9. Collaboration with other government non-health sectors, nongovernmental organizations, village and community health workers, and volunteers are required.
10. Financial and human resources are needed.

These essential steps provide the basis for a sustainable integrative process for psychological and mental health care to move into the public health care sector. The inclusion of policies and plans to incorporate primary care for mental health refers to the commitment from the various governmental structures to provide an integrated mental health care service. These formal policies and legislative documentations aim to establish a concrete commitment from the governmental structures and facilitate the integration of mental health services into primary and public health care (WONCA, 2008). These policies should not only be limited to mental health policy but should also include general health policy to facilitate the inclusion of

mental health interventions as part of the core package of primary and public care services as is the case in both South Africa and Uganda (WONCA, 2008).

Adequate provision of training to public care workers is a key component for the integration of mental health services into public health care. This training should include basic education with regards to the epidemiological, identification and treatment factors of the major mental disorders (WONCA, 2008). The importance of this training lies in providing public care workers with the necessary tools to accurately identify and appropriately refer or address the particular mental illness. This education also allows public care workers to actively engage in discussion of information, prognosis, treatment plans and the motivation of patients and their families with regards to the importance of treatment adherence (WONCA, 2008).

The limitation and practicality of public mental health care tasks is vital as public care workers have been found to function best when there is understanding with regards to the limits of the care that they provide (WONCA, 2008). It is important to note the point where public health care workers will manage psychiatric conditions and when they will refer complex cases to secondary and tertiary services.

The availability of specialists and mental health experts in public care centres is vital as these mental health specialists should be available to deal with any complex cases as well as standard consultations (WONCA, 2008). Another factor to consider is the definition of complex cases and the scope of practice that will determine when a primary public care worker will deal with the case and when a referral mental health expert is required. As such it is important to develop appropriate and effective referral and back-referral processes whereby each professional is aware of the level of responsibility they have for various cases and to facilitate the development of collaborative care models (WONCA, 2008).

WONCA (2008) reports that even after the idea of integration has gained general acceptance it is still necessary to develop appropriate screening instruments, training manuals and treatment guidelines to guide the primary care workers in the provision of their services. There will also have to be appropriate changes made to budgets in terms of fund allocations and additional training and additional staff may have to be hired. The availability of relevant psychotropic and psychopharmacological medication resources is a key component in the integration of mental health services into public health care. The supply and distribution of these medications directly to primary care facilities allows for better patient management (WONCA, 2008).

Interdepartmental co-operation at a government level can effectively work to help patients with mental disorders gain access to appropriate educational, social and employment initiative support. The provision of these extra services to these vulnerable individuals helps them access the many psychosocial services that they require. Although the integration of mental health care services has been found to be cost effective, it is still necessary for there to be financial resources available in order to establish and maintain an effective service (WONCA, 2008).

The integration of mental health services into the public sector is essential, but must be accompanied by the development of complementary services, particularly at secondary levels (Gatchel & Oordt, 2003). In essence, to effectively move psychology into a public health setting, it is necessary to create supportive services as well as clear referral, back-referral and linkage systems that should be implemented in consultation with health managers and health workers at all service levels (WONCA, 2008). These supportive services could take the form of psychoeducation for other health professionals to facilitate their understanding regarding the role of psychology within the public health sector. This psychoeducation would include training regarding supplementary counselling skills that other professionals can use to offer

first-order psychological interventions and then make appropriate referrals to psychological services. With psychologists providing the psychoeducational training to other registered professionals, there is a potential to decrease the chances of professionals working out of scope of practice unintentionally. This process allows for a smoother integration with a key element being the provision of mental health specialist services being made available to aid the public care workers in situations that may exceed their level of expertise (WONCA, 2008).

The value of psychology being integrated into a primary health care setting is that it makes psychological care accessible, affordable and acceptable to patients, families and communities by placing it into a scenario that they know well (WONCA, 2008). A key method of integrating psychiatric care into general health care, which includes the opening of psychiatric admission wards in general hospitals, has the added advantage of reducing the stigma of an admission for psychiatric illness (Leff, 2001). A reduction of this stigma creates a perception that psychiatric illness is not something to be ashamed of and could increase the amount of patients seeking treatment for psychiatric disorders before they become worse. Registered nurses will most likely provide the first contact for many of these individuals and as such are in a unique position to inform their opinions.

2.3 Nursing and mental health care

As of the end of 2008 there were 107978 registered nurses registered on the South African Nursing Council's (SANC) role within the various provinces of South Africa (SANC, 2008). These registered nurses service a population of over 48.2 million people and within the Eastern Cape Province there is a ratio of 497 patients to one registered nurse (SANC, 2008)

With the ever increasing demands of physical health problems as well as the difficulties posed by mental health problems, it is evident that some action must be taken to effectively deal with these emerging problems. The profession that faces the majority of these increasing

demands are the registered nurses working in the public health sector. Registered nurses are seen to be at the forefront of both medical and psychological services as they are the first to see the vast majority of patients that require these services. In addition to being the first point of call for many patients, they are also the members of the multidisciplinary team that have the highest levels of contact with the patients. As such they are in a unique position to ascertain potential problems before they can manifest into more serious conditions. This unique situation creates a need for the registered nurses within casualty units to be more appropriately equipped to be able to deal with the problems they might face that may require the implementation of counselling skills. This study therefore examined the perceptions of casualty nurses regarding the relevance of supplementary counselling skills training. This supplementary counselling skills training could allow them to engage with their patients, their patient's families as well as provide some debriefing for other casualty nurses due to the trauma that they are exposed to.

2.3.1 South African nursing scope of practice

Before the provision of the proposed supplementary counselling skills training, it is important to ascertain whether there is the possibility of providing registered casualty nurses with these counselling skills within their scope of practice. Within the RSA, registered nurses are governed by the South African Nursing Council (SANC) and this organisation has published documentation relating to the nursing scope of practice as set out in Regulation R2598 (SANC, 1984). This regulation, in Chapter 2, states that the scope of practice of a registered nurse entails, in section C of Chapter 2, the treatment and care of and the administration of medicine to a patient, including the monitoring of the patient's vital signs and of his reaction to disease conditions, trauma, stress, anxiety, medication and treatment (SANC, 1984). This section of the nursing scope of practice indicates that nurses need to be able to deal with and treat trauma, stress and anxiety. In section P of Chapter 2, it becomes

apparent that this knowledge of supplementary psychological principles is necessary in the performance of their work as it states that nurses should be able to establish and maintain, the execution of the nursing regimen, within an environment in which the physical and mental health of a patient is promoted (SANC, 1984). With this in mind, one can see that the inclusion of a supplementary counselling skills programme for nurses will not only benefit the patient but also allow the nurses to better fulfil the scope of their practice.

The inclusion of supplementary psychological principles within the field of nursing is also acknowledged at a training level through Government Notice No. R.425 (SANC, 1985, p. 4) which states under section 6 of the document, that the:

“curriculum shall provide for personal and professional development of the student so that, on completion of the course of study, he shows respect for the dignity and uniqueness of man in his social-cultural and religious context and approaches and understands him as a psychological, physical and social being within this context and that he is skilled in the diagnosing of individual, family, group and community health problems and in the planning and implementing of therapeutic action and nursing care for the health service consumers at any point along the health/illness continuum in all stages of the life cycle (including care of the dying), and the evaluation thereof”.

It is possible to see with this in mind, that SANC and the institutions that provide the various levels of training for registered nurses are cognisant of the broad scope of practice in which their students must work. This article indicates that it is appropriate for registered casualty nurses to receive supplementary counselling skills training and the curriculum guideline indicated in this article also focuses on the personal and professional development of nurses and as such allows for the intra-disciplinary debriefing for nurses by nurses.

2.3.2 South African nursing curriculum

The previous section of this document also indicated that any curriculum for the purpose of training of registered nurses requires at least two academic years of psychiatric nursing sciences (SANC, 1985). All nursing training institutes within RSA are obliged to adhere to these guidelines. The University of Witwatersrand includes modules on the introduction to psychology, basic principles of groups and individual psychology, psycho-social health and health psychology (University of Witwatersrand, 2008) and the University of Johannesburg offers an introduction into psychology and nursing for psychiatric patients (University of Johannesburg, 2008). University of the Free State offers several psychiatric nursing courses that deal with general psychiatric conditions, caring for mentally retarded patients as well as courses on social psychology and an introduction to the theory of psychotherapy and counselling skills (University of the Free State, 2009). The Nelson Mandela Metropolitan University's Department of Nursing Science (2008) provides training in an introduction to psychology, child and adolescent development, adult development and aging, social psychology, and coping skills training. This institution also provides training in a nursing focus on affective pathology, nursing focus on pathology and mental cognition, scientific approach to affective and cognitive mental disorders as well as modules on theory of psychiatric nursing skills and psychiatric nursing in comprehensive health care (Department of Nursing Science, 2008).

These institutions offer adequate theoretical psychological training as well as in-depth psychiatric nursing courses for psychiatric patients. These courses also cover theoretical basic counselling skills and psychological crisis management and imply that registered nurses already have some experience regarding these skills and are trained in them in accordance with their scope of practice. However, the greater inclusion of basic counselling skills in the

training of nurses will better equip them as first line counsellors, particularly those who will find themselves working in trauma or casualty units.

2.3.3 Casualty unit nursing

The use of registered casualty nurses for this study was based on the wide variety of patients that are seen within casualty units as well as the possibility for the development of secondary psychiatric or mental health concerns post exposure to the casualty or crisis situation (Benedek & Ursano, 2001). This sphere for the development of secondary mental health concerns comes from the situations that are associated with the reasons for admission into casualty units. Generally the use of casualty units is more focussed on emergency situations whereby the patient and their families are dealing with a great amount of stress and anxiety due to the stressful or crisis event that led them to the casualty unit (Kearney, 2007). These stressful situations have the potential to cause trauma, which is defined as an experience that is emotionally painful, distressful, or shocking and which may result in lasting mental and physical effects (Medicine Net, 2002). Due to the nature of the context of the casualty room, there is considerable concern for the patient's wellbeing and the possibility of developing more serious, long term psychiatric problems for not only the patient and their family, but also for the registered nurses and other professionals working within these units (Carter, 1993). If untreated, these factors could lead to the development of post traumatic stress episodes in patients and their families. For the professionals, this constant exposure to highly stressful situations with little or no opportunity for debriefing could lead not only to Post Traumatic Stress Disorder (PTSD) but can also affect work efficiency, work satisfaction, and increase burn out and vacating of positions (Kearney, 2007). This situation can have profound effects on the maintenance of services in the public care setting as a whole and worsen an already overburdened service and further expand the treatment gap (Horton, Tschudin, & Forget, 2007)

Due to these factors and the possible worsening of short staffing situations, it was decided to use registered casualty nurses for this study as they have the highest level of exposure to potential psychiatric problems and are in the position to better assess the situation as a whole (Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006). The contact that registered nurses in casualty units have with the patients and their families puts them in the unique position to gather fuller and more meaningful data and to use the nursing-client relationship to affect necessary change within the lives of the client and their families (Horton, Tschudin, & Forget, 2007). By providing supplementary counselling skills to these registered casualty nurses, it becomes possible to further increase this influence to create change, it helps to develop an appropriate and effective referral system and it provides the registered casualty nurses with specific skills by which they can manage and affect the influence of trauma within their own lives and the lives of their colleagues (Carter, 1993).

2.4 Supplementary counselling

Lay counselling is defined as a form of helping that is focussed on the needs and goals of an individual provided by non-psychological professionals in order to maintain and develop personal growth and deal with non-clinical problems that emerge within an individual's life (Nelson-Jones, 2005). Lay counselling forms the basis of the supplementary counselling skills training that this study aims to examine. These supplementary counselling skills programmes would be aimed at improving the registered nurses working within casualty unit's ability to provide psychological first aid to both patients and their families within the unit as well as to make appropriate referrals to psychological services as needed. Another factor to consider is that with the ever expanding sphere of public health care, there needs to be improvements in the training of public health care providers as the assessment and management of mental disorders is becoming a priority for both developing and developed countries (Leff, 2001).

Typically, professional counselling sessions are limited in both time and frequency whereas lay counselling, and subsequently supplementary counselling, can provide instruction and observe the responses of the individual immediately (Candotti, Mason, & Ramphal, 1993). As such, the feedback provided from the counselling process is more direct and there is the opportunity to provide encouragement and correction as appropriate. A key element of the supplementary counselling process is the decision on what factors should be dealt with by lay counsellors and which will require the attention of a specific psychological or therapeutic professional (McCallum, 2009). This difference will be determined by the training provided and a key component of this training will be in the instruction of which mental difficulties require the use of specifically trained professionals. Another inclusion in the training of supplementary counselling skills will be the ability to identify specific behaviours and attitudes that are prevalent in the diagnosis of mental disorders so as to be aware of when referral to a professional is necessary (McCallum, 2009). This incorporates the basic psychological care of the patients into their primary health care concerns whilst also equipping these registered nurses with the skills to deal with possible problems that other nurses in the unit may be experiencing.

According to Leff (2001), an approach utilizing all the available community resources has the attraction of empowering individuals, families and communities to make mental health an agenda of people rather than professionals. This approach allows for governments and hospitals to narrow the treatment gap between untreated mental health patients by incorporating psychological services into the public health sector.

2.4.1 Need for supplementary counselling and nursing

Nursing as a profession makes use of preceptors or senior registered nurses, nurses with experience who have been working in the unit for some time, to train and induct the newly graduated nurses into the profession (Mee, 2007). These preceptors are generally nurses who

have been trained in some counselling skills and they not only orientate but also provide the new nurses with support, guidance and instruction on how to perform at work as well as how to manage the difficulties in their own lives (Mee, 2007).

Within the field of nursing, therapeutic relationships with clients are considered essential across all fields and use of this relationship in both direct and indirect methods is vital in effectively administering health care (Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006). Its use in an indirect manner is related to the basis of the interactions and the client's subjective experience of the nurse-client relationship and can have direct benefits for recovery and adherence concerns (Horton, Tschudin, & Forget, 2007). The use of nursing therapeutic relationships in a direct manner is more focussed towards the nurse actively using the nursing-client relationship to provide education and appropriate information for their clients (Carter, 1993). The inclusion of supplementary counselling skills training can add to these multileveled interactions with the patients and provide nurses with additional skills to better cope with any problems that might arise. This skills training can also be used to strengthen the nurse-patient bond and provide both the patient and the nurse with a fuller experience of treating the patient. Some studies, as reported in Larson (2004), relating to the inclusion of certain predominantly psychological skills have found that they have aided the nurses in becoming more 'present' when dealing with patients and these nurses have reported that they have few problems and mistakes when dealing with their patients. This study focussed on the nurses taking some time out to actually interact with the patient on a one to one level and whilst some nurses were initially worried that it would take time away from dealing with patients, they found that they had easier patients to deal with and more time to provide the patients with higher levels of service (Larson, 2004).

2.4.2 Example of an effective programme

A study conducted in 2002 in the Ehlanzeni District of Mpumalanga Province in South Africa demonstrated how mental health care can be provided using other health practitioners in state run clinics (WONCA, 2008). In this model, skilled registered nurses saw all patients with mental disorders in the state run clinic and managed their treatment accordingly (WONCA, 2008). The registered nurses' primary functions were to conduct routine assessments of all the patients within their district that had mental disorders, to monitor their treatment and recommend any treatment changes to the medical officer whilst also providing basic counselling services and identifying social problems to be dealt with (WONCA, 2008). The nurses in this clinic scheduled specific mental health consultations and the patients were advised when to come to the clinic to have their concerns seen to and if there were any problems, those patients were referred to secondary specialist services as needed (WONCA, 2008). The nurses were responsible for the detection of mental health problems, management of chronic mental disorders, counselling and intervening in crisis situations (WONCA, 2008). This study shows that with appropriate training, registered nurses can effectively provide basic psychological services and connect patients with appropriate referrals as needed.

The aim of this study is to determine whether a sample of registered nurses working in a casualty unit in a hospital in the Eastern Cape Province of RSA perceive a need for the inclusion of supplementary counselling skills training within their professional development. This study aims to examine these perceptions and to determine whether these professional health care workers are willing to engage in a supplementary counselling skills training course in order to address the problem of mental and behavioural disorders within a public context. This inclusion of a supplementary counselling skills programme for registered nurses within casualty units could have a wide array of benefits not only for the patients but also for the registered nurses themselves.

2.5 Chapter Conclusion

This chapter explored some of the factors and problems that are affecting the public health sector. It examined the need for psychological services and discussed several methods by which these methods may be integrated. This chapter also examined the roles, scope of practice, and training that registered nurses receive and looked specifically at the registered nurses that work in casualty units. Some of the problems that registered casualty nurses deal with were discussed and a possible need for supplementary counselling skills training programmes was explored. This chapter concluded by examining a case study in which a registered nurse provided the relevant and necessary psychiatric and psychological care to the community in which the nurse worked. The subsequent chapter examines the theoretical underpinnings, namely the crisis intervention model and the biopsychosocial model of health that will be applied to this study.

CHAPTER 3

THEORETICAL FRAMEWORK

3.1 Chapter Overview

This chapter examines the two primary theoretical frameworks that were used in the analysis of the data that has been gathered during this research study. These two primary theoretical frameworks are the crisis intervention model and the biopsychosocial model of health. Each of these theoretical frameworks are examined in turn and through this examination the development of the framework, an explanation of the intricacies of the framework, its place within the concept of integrative and multidisciplinary healthcare and the applicability of each framework for use within this study is expanded upon.

This chapter initially examines the crisis intervention model and then expands on the biopsychosocial model of health before examining both of these theoretical frameworks in conjunction with regards to their applicability for use in this study. These frameworks provide the basis for the thematic analysis of the data collected that is presented in chapter five of this document.

3.2 Overview of the Crisis intervention model

The crisis intervention model is a comprehensive model for dealing with various types of crisis situations on both the primary and secondary levels. The crisis intervention model defines a crisis as a situation which exceeds the resources or coping mechanisms of an individual (Slaikeu, 1990). A crisis can frustrate an individual's important life goals, disrupt the life cycles or routines of the individual, and cause distress and generate feelings of immobility and loss of control (Slaikeu, 1990). The nature of crises are time limited and usually persist for a period of six to eight weeks at the end of which the subjective distress of the individual diminishes. The events that occur during the immediate aftermath of a crisis event determine whether or not the crisis will cause significant subject distress for the

individual (Slaikau, 1990). This model provides assistance for individuals experiencing various types of crises and provides guidance for dealing with the characteristics of a crisis in both primary and secondary settings.

3.2.1 Description of the Crisis intervention model

Slaikau (1990) describes three major types of crises, namely developmental, situational and existential crises. Developmental crises refer to the various transitional stages which are age or developmentally related such as the transitions during adolescence, mid-life and old age (Slaikau, 1990). These crises tend to affect the individual at certain documented stages in their lives. Situational crises are related to specific circumstances that have occurred in the individual's life such as any form of trauma, work occurrences, natural disasters or wars (Slaikau, 1990). These crises can affect the individual at any time in their lives and generally have no pre-determined predictable factors. Existential crises are related to changes that an individual experiences with regards to their own life, sense of meaning, existence, belief systems, value systems or understanding (Slaikau, 1990). These crises are often seen to be the result of a developmental or situational crisis that the individual is currently experiencing.

The characteristics of a crisis situation are that there is a presence of both danger and opportunity and that this situation has the power to overwhelm the individual but also contain the seeds of growth and self-realization (Hetherington, 2001). Crisis situations often involve complicated symptomology that defy normal cause and effect descriptions as they are often made up of many compounding problems that affect a variety of areas in the individual's life (Slaikau, 1990). This crisis situation can cause disequilibrium and disorganisation in the form of anxiety, distress and impetus for change. According to Slaikau (1990), when presented with a crisis situation, the individual is presented with a choice on how to react to the situation and it is this choice regarding reaction that affects how the crisis will impact on the individual.

Systems theory is defined as an interdisciplinary theory about the nature of complex systems in nature, society and science, and is a framework by which one can investigate and describe any group of objects that work together to produce some result (Taylor, 2003). This theoretical approach forms the basis for the crisis intervention model. The systems approach to crisis theory postulates that a crisis does not take place within a vacuum but will generally occur within a social context (Slaikou, 1990). Systems theory allows the practitioner to examine and view crisis situations by examining the individual as a system, the context in which that system resides and the interactions between the system and its external environment (Slaikou, 1990). It is a holistic approach to understanding not only the individual but also the context in which the individual resides as well as the potential effects of a crisis situation on the system as a whole (Slaikou, 1990).

This holistic approach makes use of the BASIC-ID modality to assess individuals and the systems in which they reside (Corey 2005; Lazarus & Folkman, 1984). This modality views the individual within the domains of their Behaviour, Affect, Somatic, Interpersonal relationships, Cognition, Images and Drug factors that influence their lives (Corey, 2005; Lazarus & Folkman, 1984). Using this assessment modality, it is possible to determine the probable responses an individual may have to crisis situations. These responses to a crisis situation will have effects within these various domains which emerge as disruptions within one or more of these domains (Slaikou, 1990).

3.2.1.1 First-Order Interventions

The primary element of the crisis intervention model lies in providing first order psychological interventions. Within first-order interventions, psychological first aid is provided usually within minutes to hours of the occurrence by front line caregivers such as physicians, nurses, teachers, supervisors and social workers (Slaikou, 1990). These first line interventions usually take place within community settings such as hospitals, churches,

homes, work and school settings, with the aim of re-establishing the immediate coping abilities of those suffering from the crisis situation. The aim of first-order interventions within this crisis model is to give support, reduce lethality and to link the client to helping resources (Slaikou, 1990). These first-order interventions provide the necessary basis for the client to begin to re-establish themselves in terms of the crisis that they have experienced.

3.2.1.2 Second-Order Interventions

The secondary element of the crisis intervention model lies in providing second order psychological interventions. The second-order interventions within this model occur within the time period of weeks to months after the event and are usually provided by psychotherapists and counsellors (Slaikou, 1990). These second-order interventions take place in therapy and counselling settings such as clinics, mental health centres and churches. The aim of this intervention is to resolve the crisis by helping the client work through the crisis event, by beginning to integrate the event into the fabric of their lives, and by establishing an openness and readiness to face the future (Slaikou, 1990).

Crisis intervention aims at resolving the crisis and the subsequent trauma that the individual experiences with it. The first task for surviving trauma and crisis lies in the physical survival of the individual and these factors are registered in the somatic domain of the BASIC-ID model. The aim for the individual is to preserve their life and maintain their physical health (Slaikou, 1990). The second task for surviving trauma and crisis relies upon the expression of feelings and relates to the affective domain of the BASIC-ID model. The aim for this task is to identify and express the feelings related to the event in a socially appropriate manner (Slaikou, 1990). The third task for the individual is to achieve cognitive mastery and this affects the cognitive domain and the aim is to develop reality based understanding of the crisis event, to understand the relationship between the event and the individual's own beliefs, expectations, unfinished business, images, dreams and goals for the

future as well as to adjust and change the beliefs, self-image and future plans that the individual may have in light of the events (Slaikou, 1990). Finally, the fourth task for the individual to achieve is behavioural and interpersonal adjustments and this task deals with the behavioural and interpersonal domain. The aim of this task is to make appropriate changes to daily patterns of work, play and relationships with people in light of the events that the individual was involved in (Slaikou, 1990).

3.2.2 Crisis intervention model and integrative health care

The applicability of this model to the proposed study is that it explores the utility of other health care practitioners, namely registered nurses, in providing first-order psychological interventions. This exploration allows for registered nurses to provide relevant counselling services to the client in order to help them to deal with their current situation and then referring them on to more qualified counsellors who help the client deal with and integrate the stressful situation into their everyday lives. With the varied aspects of trauma and crisis that the registered nurses in casualty units are dealing with, this model provides a means for these professionals to address some of these problems, and in so doing facilitate the efficacy of cross-disciplinary provision of services to patients.

The crisis intervention model also lends itself for use within integrative health care as it makes use of the BASIC-ID modality to assess the effects of the crisis situation on the individual. As discussed, the BASIC-ID modality and the crisis intervention model are based upon a holistic systems approach and this approach aims to take multiple factors, such as the biological, psychological and social into account when dealing with a crisis situation. This approach lends itself well to integrative health care teams as it takes cognisance of the various information areas that different professions make use of and it allows for the provision of psychological first aid by other professionals. The next section of this chapter

examines a model that explores not only the biological, but also the psychological and social elements of health and illness.

3.3 Overview of the Biopsychosocial model of health

The biopsychosocial model of health can be defined as a view of health and illness involving the interplay of biological, psychological and social factors in people's lives (Sarafino, 2006). This model of health sees an individual not only as a person suffering from a biologically caused disease or disorder but rather as the culmination of a variety of not only biological but also psychological and social, including cultural, factors (Taylor, 2003). This model also coincides with the WHO definition of health, which defines health as "a state of complete physical, mental and social well-being, and not merely the absence of disease" (World Health Organisation, 2009). This definition implies that the concept of health is not only related to physical health, but that it is also necessary to take into account the psychological and social factors that can affect health.

Initially this model was predominantly used by mental health practitioners in various settings; the effectiveness of the biopsychosocial model of health has led to it being increasingly used within more generalised settings in both public and private healthcare (Zittel, Lawrence, & Wodarski, 2002). It's effectiveness for general practitioners has been found in that it allows these practitioners to broadly assess the patient and the factors influencing the patient's conditions as opposed to merely viewing the biological factors influencing the condition (Dombeck & Wells-Moran, 2006).

The biopsychosocial model of health also lends itself to improving patient-provider relations as its holistic approach allows for better interactions between the patient and the practitioner. The basis for this improvement in patient-provider relations lies in the development of more effective communication between practitioner and patient and through this improved communication, greater inclusion of the patient in treatment plans (Smith,

2002). This approach also allows practitioners to promote preventative measures with their patients by accessing and changing dysfunctional psychological and social interactions before they become problematic for the patient (Zittel, Lawrence, & Wodarski, 2002). In the sections that follows, the biopsychosocial model is elaborated upon commencing with a description of the biomedical model of health, which it aimed to replace.

3.3.1 The Biomedical model of health

The biomedical model of health is defined as a conceptual model of illness that excludes psychological and social factors and includes only biological factors in an attempt to understand a person's medical illness or disorder (Mondofacto, 2000). The biomedical model of health states that illness and disease can be dealt with as an entity independent of social behaviour and it also demands that behavioural aberrations be explained on the basis of disordered somatic processes (Engel, 1977). According to the biomedical model, illness can be fully accounted for by deviations from the norm of measureable biological variables and treatment for illness focuses on returning the individual to the norm by addressing the biological problems (Engel, 1977). Criticisms of the biomedical model are that it is too reductionistic and exclusionistic in nature. According to the biomedical model, a human illness does not become a specific disease initially; it follows a process that moves from the recognition of symptoms to the characterization of a specific disease in which the etiology and pathogenesis are known and the treatment is rational and specific (Engel, 1977). In biomedical terms, a disease is identified by its smallest isolable component and it is this component that has causal implications for the treatment of the disease. This process is not in dispute as it describes the successful application of the scientific method. Engel (1977) argued that the reductionist tendency of the biomedical model has the potential to distort the viewpoint of disease. This reductionist tendency distorts the interpretation of illness and disease through its exclusion of other factors that could influence the course of the illness and

disease. Engel (1980) stated that the biomedical model, whilst appropriate to discover the form that the illness takes, cannot explain why the illness took a certain form or what the effects of that form of illness is for the organism. As such he proposed a replacement model in the form of the biopsychosocial model of health in order to better address these issues.

When Engel postulated the biopsychosocial model of health he did so with the focus of attending simultaneously to the biological, psychological, and social dimensions of the individual's illness (Borrel-Carrio, Suchman, & Epstein, 2004). His approach was seen to be a holistic alternative to the prevailing biomedical model that had dominated industrialised societies since the mid-20th century (Borrel-Carrio, Suchman, & Epstein, 2004). Engel (1977) stated that the biomedical model of health had become limited through its lack of recognition of the psychological and social factors affecting the individual's life and as such proposed the biopsychosocial model of health to replace the biomedical model.

3.3.2 Development of the Biopsychosocial model of health

The Biopsychosocial model of health was developed by George Engel in 1977 as a possible response to and replacement of the biomedical model paradigm (Borrel-Carrio, Suchman, & Epstein, 2004). Engel maintained that to adequately respond to and treat a patient's condition, as well as to provide the patient with the feeling of being understood, the clinician must attend to the patient's biological condition as well as the psychological and social dimensions of the illness (Borrel-Carrio, Suchman, & Epstein, 2004). According to Engel (1977, p. 133), a doctor "must weigh the relative contributions of social and psychological as well as biological factors implicated in the patient's dysphoria and dysfunction as well as his decision to accept or not accept patienthood and with it the responsibility to participate in his own health care". With the formulation of this model, Engel began shifting the paradigm away from the Biomedical approach, where the assumption is that disease can be fully accounted for by the deviation from the norm of

measurable biological (somatic) variables (Engel, 1977), to a more integrated model in which genetics, biological make-up, psychological functioning, cognitive coping styles, lifestyle choices, socioeconomic status, culture, support network and environmental factors all factor into how illness and disease progresses and manifests in individuals (Taylor, 2003).

Engel stated that the new proposed model would include a worldview that would allow for the patient's subjective experience alongside their objective biomedical data, be more comprehensive and naturalistic than simple linear reductionist models, give a perspective on the patient-clinician relationship that would accord more power to the patient in the clinical process, and transform the patient's role from passive object of investigation to the subject and protagonist of the clinical act (Engel, 1977). Engel's aim throughout the development of this model and his goal for it was to respond to and change the dehumanising nature of healthcare (Smith, 2002). Engel's contributions to healthcare as a whole involved the provision of a conceptual framework and a way of thinking that enables the clinician to act rationally even when dealing with potentially irrational material (Smith & Strain, 2002).

3.3.3 Description of the Biopsychosocial model of health

As mentioned earlier, the biopsychosocial model of health attempts to view health and illness as not only the result of biological influences but also of psychological and social factors that influence the development and course of the condition (Zittel, Lawrence, & Wodarski, 2002). This section provides a more detailed description of the interactions and intricacies of the model.

The basic premise of the biopsychosocial model of health and illness attempts to view the patient not only as an individual with an illness, but also as an individual within a greater social context whilst still taking the individual's own unique psychological processes into account (Sarafino, 2006). This model of health attempts to view the interaction between the biological factors that are affecting the individual internally, the psychological factors that are

affecting the individual as well as the greater social environment in which the individual resides when assessing health and illness. The three components or factors of the biopsychosocial model are now discussed. These include biological, psychological and social factors and their interaction.

3.3.3.1 Biological factors

The biological factors referred to in the biopsychosocial model of health are more closely linked with the traditional biomedical model of health and as such deal with the physical factors that are affecting the individual at any point (Dombeck & Wells-Moran, 2006). These biological factors include all the inherited genetic components and processes that an individual receives from his or her parent in terms of their genetic make-up as well as the inclusion of the function and structure of the individual's unique physiology (Sarafino, 2006). These biological factors also include any external pathogens such as viruses or bacteria that may be having an effect on the individual as well as any defects or malfunctioning organic systems (such as the renal or hepatic systems) or organs that are affecting the individual's health in any manner (Suchman, 2005). According to Sarafino (2006), it is this efficient, effective and healthful functioning of these systems and organic components that for many years was seen to be the only aim of healthcare. This focus on the biological factors has been the basis of the biomedical model for some time and its empirical approach to the treatment of disease has been effective in the treatment of illness and diseases and as such it deserves a place within the biopsychosocial model of health (Engel, 1977).

3.3.3.2 Psychological factors

The psychological factors that are included in the biopsychosocial model of health deal mainly with the behavioural and mental processes of the individual. These behavioural and mental processes can be viewed in terms of multiple factors but more frequently can be

examined by looking at the cognition, emotion and motivation of the individual (Taylor, 2003).

Cognition is a mental activity that encompasses perceiving, learning, remembering, thinking, interpreting, believing and problem solving (Sarafino, 2006). The manner in which these features affect an individual's view of their own health and illness lies in perception (Taylor, 2003). It is the individual's perception that develops an individual's attitudes towards health and illness and these attitudes then affect the behaviours and thoughts that the individual would have around a variety of health behaviours (Dombeck & Wells-Moran, 2006). Cognitions affect not only the individual's current behaviours but also help to develop and predict the individual's future health behaviours based on their changing attitudes towards certain health behaviours or activities (be they positive or negative) due to the consequences and illnesses that the individual is facing and has faced in the past (Sarafino, 2006).

Emotion is a subjective feeling that affects and is affected by our thoughts, behaviour, and physiology (Sarafino, 2006). These subjective feelings can be either positive and pleasant, such as joy and affection, or negative, such as anger, fear and sadness. The emotional reactions and experiences of people can affect their perception of health and illness in many ways (Taylor, 2003). People who experience emotions that are relatively positive have been found to be less disease-prone and more likely to take good care of their health and to recover quicker from illness than those whose emotions are relatively negative (Sarafino, 2006). These factors are closely linked with the concept of psychoneuroimmunology. Psychoneuroimmunology is the field of study that investigates the link between the psychological processes and the nervous and immune systems of the body (Quinlan, 2003). Within this field of study it is possible to actively affect one's own levels of health based upon changing certain attitudes, beliefs and dealing with stressors (Quinlan, 2003). As one

can see, an individual's emotional experiences will not only serve to affect how they cope with health and illness but it will also affect how willing they are to seek out treatment as these factors begin to affect their lives (Sarafino, 2006).

Sarafino (2006) describes motivation as a term that is applied to explanations of why people behave the way they do. Motivation provides us with an explanation of why people will start some activity, choose its direction, and persist in it. In relation to health and illness, motivation can affect the course of a condition by the amount of desire that an individual has to take a specific course of action, how much planning they put into it and the level of determination that they have with regards to achieving their goals (Sarafino, 2006).

3.3.3.3 Social factors

The social component of the biopsychosocial model of health deals with the interrelatedness of the relationships that individuals have with each other and the external world as a whole (Taylor, 2003). The interactions that occur between different people as well as their environments affect not only the individuals but also have an effect on the environment itself (Sarafino, 2006). There are multiple variables that affect the social factors of the biopsychosocial model of health and illness but the most prominent of these variables are society, community and family (Engel, 1977).

According to Sarafino (2006), society affects the health of individuals on a macro level by promoting certain values of the culture that the individuals find themselves in. A common method of promoting these values is through the mass media, who reflect these values by setting certain examples and promoting certain activities (Sarafino, 2006). An example of this is illustrated through the promotion of healthy eating habits and exercise where the mass media, through mediums such as television, radio, and print media would encourage individuals to eat the right foods, avoid fast foods and alcohol and find time in their daily schedules to exercise accordingly. Society often affects people in ways that they might not

realise and whilst its influence can be positive it can also promote negative health behaviours (Dombeck, & Wells-Moran, 2006). These negative health behaviours can become as much a part of an individual's life as the positive ones and can also be promulgated through the mass media in the form of promoting certain activities such as celebrities smoking and seemingly having a good time, to advertising that can affect the way that individuals view certain products (Sarafino, 2006).

The community can be defined as a group of individuals who live fairly near to one another (Taylor, 2003). The influence that communities have been found to have on individuals and their health behaviours show that it is suggested that they differ depending on the location of the community (Sarafino, 2006). In some communities it is acceptable to exercise out of doors due to the presence of various facilities such as parks and open communal areas whereas in other communities it has been found that due to the lack of these facilities or crime rates that are affecting the area, some of these health behaviours are discouraged (Sarafino, 2006)

Family is seen to be the closest and most continuous social relationships for most people and tend to include non-relatives who live together or share a strong emotional bond (Taylor, 2003). This variable affects the social element of the biopsychosocial model of health in an important way as individuals grow and develop within family systems and it is these systems that have an especially strong influence on the development of the individual (Sarafino, 2006). Many people learn the behaviours that they carry throughout their lives from the family system early on and as such it is important to ascertain what behaviours and health attitudes have been developed in order to assist treatment (Dombeck & Wells-Moran, 2006). Through the process of development, an individual will model the behaviours of the other members of the family, so for example, if members in the familial system engage in positive health behaviours such as eating nutritious food and exercise, these behaviours will be

rewarded by the system. However, if they engage in negative health behaviours such as alcohol or drug abuse, these behaviours will not be discouraged as they form part of the greater system (Sarafino, 2006).

3.3.3.4 Biopsychosocial Interactions

Engel (1977) proposed that we can conceptualise the whole person by applying the biological concept of 'systems'. A system can be defined as a dynamic entity with components that are continuously interrelated (Sarafino, 2006). In terms of the biopsychosocial model of health and illness, the system in question is the one that affects the individual as a whole, it comprises of the biological factors such as the organs, tissues and cells, the psychological factors such as the cognitions, emotions and motivations, and the social factors such as the society, community and family that the individual associates with (Engel, 1980). This model of health can further be described as taking two major factors into account, namely the person themselves as is reflected by their own genetics, physiology, experience and behaviours (or the biological and psychological factors), and the world that the individual resides in, as is reflected by the social systems that affect the individual (Dombeck, & Wells-Moran, 2006).

To place this within the context of the individual, there are multiple systems that interact and affect the individual at all levels and it is these systems that should be assessed in order to ascertain the effects that they might have on health or illness (Sarafino, 2006). For example, if a person falls ill, then this illness affects not only the biological systems of the individual in terms of these systems mobilising to counteract the illness but also the psychological and social systems in which the individual resides. In psychological terms, this illness can affect the individual's sense of control over their life. This loss of control could affect the individual emotionally by making them feel despondent or depressed and this could affect their motivation as they might not want to engage in any activities until they feel better. In social

terms, the illness might keep them away from work, so they might not be able to provide adequately for their family, they will engage less in the community in which they reside and their levels of discomfort might affect their relationships with their community and family.

Taylor (2005) further explained how the biopsychosocial model of health and illness is embedded in systems theory. Systems theory maintains that all the levels of organisation within any individual are linked to each other hierarchically and that any change that occurs on any level will have some effect on all other levels. Within the systems approach, the individual is seen as being made up of a variety of interrelated systems that interact with each other on a micro, meso and macro level. In terms of the biopsychosocial model of health and illness, these micro, meso and macro levels are viewed in terms of the biological, psychological and social factors that affect the individual or system. A change on the biological micro level, for example cellular changes, can have consequences for the whole system within the micro, meso and macro levels across the biological, psychological and social domains of the individual.

With this understanding, research presented in Sarafino (2006) illustrated that the biopsychosocial model of health and illness can have profound effects on dealing with health promotion and recovery from illness for individuals. This research stated that there is a link between the use of psychological methods to reduce anxiety for surgery patients and the speed at which they recover post surgery and that people who have a higher degree of social support from friends and family are healthier and live longer than people who do not (Sarafino, 2006). Other studies have also found that stress impairs the functioning of the immune system and that the inclusion of psychoeducation programmes for chronic disease patients can reduce their levels of depression and boost their immune systems (Smith & Strain, 2002). Studies have also found that the biopsychosocial model of health and illness is also particularly well suited for the treatment of traumatic occurrences. Findings reported in

LeVine and Orabona Mantell (2007) state that the biopsychosocial model of health and illness lends itself well to treating traumatic incidents as it allows and encourages the integration of biological and pharmaceutical treatments with certain specific cognitive and behavioural techniques and combines these both with ongoing education and support in the social environments of the individual.

3.3.4 Criticisms of the Biopsychosocial model of health

Over the past thirty years, since the proposition of the biopsychosocial model of health, there have been as many critics of the model as there have been proponents (Borrel-Carrio, Suchman, & Epstein, 2004). This section outlines some of the criticisms of the biopsychosocial model of health.

One of the major criticisms of the biopsychosocial model of health is that many practitioners see it more as a vision or approach to practice rather than an empirically verifiable theory (Epstein & Borrell-Carrio, 2005). This viewpoint has caused difficulties with regards to reconciling the biopsychosocial model of health with clinical practice. This difficulty is raised because clinicians have had trouble in determining whether the biopsychosocial model of health is a theory and therefore empirically verifiable, a philosophy and therefore logically consistent, a descriptive model to expand the scope of clinical inquiry, a belief system and therefore not subject to empirical proof, or a guide to practice and therefore with an implicit methodology (Epstein & Borrell-Carrio, 2005). This confusion arises from the fact that the biopsychosocial model was proposed without specific variables and hierarchies of systems that would govern its use and as such each practitioner is allowed to adapt the model to fit his or her own habits of the mind (Borrel-Carrio, Suchman, & Epstein, 2004). The individualised nature of the biopsychosocial model leads to difficulties in developing a uniformed approach to using the model and as such its use differs with each practitioner and setting in which it is applied.

Another criticism of the biopsychosocial model of health is that when Engel proposed the model he did not define the model. He was criticised for only describing the model as a description of a model at work is not the same as a definition of a model (McLaren, 1998). McLaren reported that the “act of nominating a model by demonstrating its output cannot simultaneously serve to define it separately from all other models which may have a similar output” (p. 88). As such, it is reported that Engel did not define his model but hoped its definition and function would emerge from a description of how it might function. He proposed the model as a replacement for the biomedical model of health and described what it should achieve but provided no clear cut definition on how the model is to be implemented (McLaren, 1998).

Finally, another criticism of the biopsychosocial model of health is the emphasis on integration of the biological, psychological and social factors without a clearly defined overarching theory to integrate the information obtained from these areas (McLaren, 1998). Without the overarching theory to integrate the information obtained, it is difficult to arrive at meaningful associations between the differing classes of information as there is no common element by which to understand the various types of data obtained (Epstein & Borrell-Carrio, 2005).

3.3.5 Biopsychosocial model of health and integrative health care

The biopsychosocial model of health and illness finds itself in the unique position to be incorporated within the field of multidisciplinary health provision teams through its focus not only on the biomedical but also the psychological and social factors that it takes into account (Smith & Strain, 2002). The effectiveness of this model for use in integrative health care derives from its basis that not only the biological factors, as in the biomedical model, but also the psychological and social variables have an effect on the health and illness of individuals. The inclusion of psychological and social factors lends itself to work within multidisciplinary

clinical teams as it allows for the inclusion of information from psychologists, social workers, occupational therapists and nurses as well as the doctors involved in the treatment of the patient (Smith, 2002).

Another way in which the biopsychosocial model of health can be applied in integrative health care is its inclusion in patient-centered medicine. Patient-centered medicine was developed as an approach to implement or operationalise the biopsychosocial model by placing the patient's needs foremost whilst still addressing the health issues affecting the patient (Smith, 2002). The use of the biopsychosocial model in this field can also enhance patient-provider relationships (Taylor, 2005) as well as communication between the various health professionals (Smith & Strain, 2002) as its focus is on the holistic provision of services and the use of consultation with other professionals is indispensable (Taylor, 2005). This increase in communication between the various health professionals working with the patient has the effect of providing a more holistic picture of the patient's status, both from the patient's perspective and also their environment (Smith, 2002). The biopsychosocial model of health and illness allows for the inclusion of various professional opinions to provide a more holistic service for the patient. It is with this in mind that the biopsychosocial model of health and illness was applied to this study. The biopsychosocial model's holistic inclusion of the psychological and social factors of health and illness in relation to the biomedical factors makes it applicable in examining the perceptions of cross-disciplinary application of psychological skills and training to registered nurses.

3.4 Applicability of the Crisis intervention model and the Biopsychosocial model of health

This chapter has examined and described the workings of the crisis intervention model and the biopsychosocial model of health and illness. It has also examined each model's appropriateness and use within integrative health care teams. The applicability of both the crisis intervention model and the biopsychosocial model of health to this study are that their basis is similar in that they both lend themselves for use in multidisciplinary clinical teams through their focus on the multiple variables that affect the health and wellness of an individual. Both these models are embedded in systems theory and both aim to provide change by affecting the system as a whole. The crisis intervention model makes use of the individual as a system to affect the various necessary changes and is cognisant of the effects that these changes may have on the individual as a whole. The biopsychosocial model of health and illness views the individual as a unique system and its approach to assessment allows for a more holistic approach when attempting to make changes to the system as a whole.

As such, the crisis intervention model and the biopsychosocial model provide the basis for the inclusion of supplementary counselling skills training for registered nurses within casualty units as it will allow for a more holistic approach to the treatment of patients and their families. It also allows for the intra-professional assessment and intervention of crisis and trauma situations that registered nurses in casualty units deal with and has the potential to eliminate the demand to make unnecessary referrals to the psychologists that are working in the public health sector. It also emphasises the value of the registered nurses counselling capacity within these trauma and casualty unit.

3.5 Chapter Conclusion

This chapter explored the crisis intervention model and the biopsychosocial model of health and illness. It examined the crisis intervention model and explained the dynamics of how this model can be applied. This chapter also explored the origins of the biopsychosocial model and provided a synopsis of how the model works. The applicability of both the crisis intervention model and the biopsychosocial model of health and illness to the study was then examined. The subsequent chapter examines the relevant methodology that was used for this study.

CHAPTER 4

RESEARCH METHODOLOGY

4.1 Chapter Overview

Chapter Four provides a description of the methodology of the present study. It states the aims that the study investigated and discusses the qualitative research approaches that were used to conduct the study. A review of the research design provides a description of the interpretivistic paradigm, the qualitative procedures that were used in the study as well as the multiple case study design that this study was based on. In addition, the chapter highlights how these processes were incorporated into the present research design.

The chapter continues with a review of data collection methods and outlines the research procedure. The discussion of this methodology also provides an account of the setting in which the research occurred and the sampling procedures that were implemented.

Ethical considerations form a central part of research methodology. This chapter provides a review of the pertinent ethical issues related to the present study as well as how these considerations were implemented in the research design. A review of data processing and analysis is also provided with specific reference to Tesch's (1990) content analysis as well as Lincoln and Guba's (1994) model of trustworthiness. The chapter concludes with a description of how these models were incorporated into the phenomenological research design.

4.2 Research Aims

The primary aims of this study were:

1. To explore and describe the perceptions of a sample of registered casualty unit nurses of the need for supplementary counselling skills training in their profession.
2. To explore and describe the willingness of a sample of registered casualty unit nurses to engage in supplementary counselling skills training within their profession.

4.3 Research Design

This study made use of the interpretivistic research paradigm in an attempt to understand and contextualise the data obtained. Interpretivism is a research paradigm that focuses on gaining an empathic understanding of how people feel inside, seeking to interpret the individual's everyday experiences, the deeper meanings and feelings as well as reasons for their behaviour (Rubin & Babbie, 1997). This paradigm views the nature of reality as a complex and dynamic interaction between the environment and the individuals in the environment (Guba & Lincoln, 1994). Individuals' constructions, interpretations and subjective experiences shape the reality that they experience. With regards to this study, the interpretivistic paradigm guided the study as it allowed for the phenomenological examination of the various subjective experiences of the participants. Phenomenological examinations do not rely on sequential methodological steps but allow the researcher to delve into the phenomenon without distorting the participants' accounts and in doing so, capture the essence of their lived experience (Moustakas, 1994). A benefit of the interpretivistic paradigm is that it allowed for the co-creation of the meaning of an experience and that it allows for a social and cultural context when considering theoretical models (Guba & Lincoln, 1994). Some of the disadvantages of this paradigm are that due to the subjective nature of the data gathered from the participants, there was limited generalisability and predictive power from the results obtained (Guba & Lincoln, 1994). This paradigm was employed as a means of understanding the data that was collected through the interview processes.

For the purposes of this study the researcher made use of the qualitative methodology in an effort to understand the perceptions and willingness of a sample of registered nurses within the casualty units to engage in supplementary counselling skills training. In qualitative research methods, the focus shifts from a traditional analysis of the cause-and-effect

relationship to the nature and texture of the experience (Willig, 2003). Qualitative research designs study human behaviour that cannot be approached with quantitative methodologies. Unlike quantitative research methods, qualitative research designs do not impose predetermined theoretical frameworks which have the potential to distort rather than to illuminate human behaviour, but aim to obtain comprehensive descriptions that can be used in a reflective process (Willig, 2003). This is achieved through the investigation and description of the meanings attached to an experience and not the measurement or explanation of its occurrence. Through this perspective, research participants are viewed as creative and compassionate beings and not objects of research interest. Consequently, such designs create an awareness of power or inequality and strive to acknowledge the role of an individual's perceptions within a given study (Neuman, 2003). Data obtained through qualitative research is essential in developing an integrated understanding of phenomena that can then be translated into evidence for further quantitative research (Moustakas, 1994). This study was qualitative and interpretive in nature and employed an exploratory-descriptive case study research design based on a multiple case study approach. Semi-structured in-depth interviews were conducted in order to obtain the necessary data.

Exploratory research refers to research that is conducted to gain insight into a situation, phenomenon, community or individual (de Vos, Strydom, Fouché, & Delpont, 2006). Exploratory research is primarily used when little or no information is available or no studies have been previously conducted in the field (Breakwell, Fife-Schaw, Smith, & Hammond, 2006). This form of research allowed the researcher to use the information gained from the semi-structured in-depth interviews to gain insight into the situation from the perspective of casualty nurses.

Descriptive research refers to research that is conducted in an attempt to present a picture of the specific details of a situation, social setting or relationship (de Vos, Strydom, Fouché,

& Delpont, 2006). This form of research aims to present a concise and well defined description of the phenomena or situation being studied. The aim of this format of research with regard to the proposed study is to attempt to describe the needs and perceptions of nurses in relation to supplementary counselling skills training.

The case study research design is a specific qualitative research design type in which there is an exploration or an in-depth analysis of a 'bounded system' (Henning, van Renburg, & Smit, 2004). The case study approach can be defined as an empirical inquiry that investigates a contemporary phenomenon within its real-life context, when the boundaries between phenomenon and context are not clearly evident and in which multiple sources of evidence are used (Rubin & Babbie, 1997). The case study research design was employed in this study to examine the information gained from the semi-structured in-depth interviews. This form of research design was chosen as it allowed the examiner to assess the real-life perceptions of nurses in a state hospital and the effects of these perceptions on their lives (Neuman, 2003). A multiple case study approach was employed in the study as each interview was seen as an individual case and the data from these studies were combined to form a multiple case study approach. The following section provides details on how the information was collected from the participants.

4.4 Data collection methods

The collection of data was completed through the use of a biographical questionnaire and a semi-structured interview schedule. The biographical questionnaire (Appendix A) was used to obtain relevant background information regarding the participants as well as to determine their relevance to the study. This relevance was ascertained through questions regarding the participants experience in casualty units as well as their qualification level in the field of nursing.

The data collection process was continued through the use of individual, semi-structured interviews. These interviews were used to obtain the relevant information regarding the goals of the study. Semi-structured interviews are defined as interviews organised around areas of particular interest, while still allowing considerable flexibility in scope and depth (de Vos, Strydom, Fouché, & Delpont, 2006). This type of data gathering technique is suitable where one is particularly interested in the complexity or process of the phenomena being studied or where an issue is controversial or personal (de Vos, Strydom, Fouché, & Delpont, 2006). As such it was appropriate for the proposed study as this study examined the willingness and perceived need of the registered casualty nurses to engage in supplementary counselling skills training. Semi-structured interviews make use of a set of predetermined questions on an interview schedule and are guided by rather than dictated by the schedule. A copy of the interview schedule that was employed in this study can be found in Appendix B. The interview schedule made use of open-ended questions which allowed the participants to provide as much or as little information as they chose (Breakwell, Fife-Schaw, Smith, & Hammond, 2006). The interview schedule was pilot studied and adjusted according to the feedback received from the participants and the problems that arose.

The benefit of the semi-structured interviews was that they provided both the researcher and the participant with flexibility. This flexibility allowed the researcher to follow up particularly interesting avenues of investigation that emerged through the interview. For the participants, this form of interview allowed the participant to provide a fuller picture of the phenomenon being studied by allowing them to include additional information (Cozby, 2007). This form of data collection allowed the participants to maintain a degree of control with regards to the focus of the interview and provided the participants with an opportunity to introduce additional topics for discussion (de Vos, Strydom, Fouché, & Delpont, 2006). The effectiveness of a semi-structured interview is dependent on the rapport that the researcher

establishes with the participant. This rapport was established by conducting the interviews in a neutral and comfortable environment and was established before the interviews commenced through general conversation between the researcher and the participant. This rapport was maintained during the interview by ensuring that the role of the researcher did not become prominent during the conversation (Willig, 2003).

4.4.1 Pilot study

Prior to the implementation of this study, the interview schedule was pilot studied. The pilot study was employed in order to ascertain whether participants understood the instructions of the study (Henning, van Renburg, & Smit, 2004). An advantage of conducting a pilot study is that it allows the researcher to ascertain whether the questions included in the interview schedule were accurately assessing the required fields. This process allowed the researcher to analyse the appropriateness of the items in the interview schedule and change them as necessary before commencing the actual study.

The process of pilot studying the interview schedule involved organising two participant registered casualty nurses. The research study was explained and described to the participants and their informed consent was gained to conduct the interview. The pilot study was audio recorded and then transcribed in order to determine the effectiveness of the semi-structured questions. The results from the pilot study indicated that the interview schedule elicited the relevant information and it was found that the participants could accurately ascertain the area that the question was aiming to assess. During the piloting process it was determined that an additional question should be included in the interview schedule. The question that was included was, "Which specific areas of counselling training do you feel would be most appropriate to include?" This question was included in the revised interview schedule as it allowed for the examination of the specific areas of counselling that registered casualty nurses feel the need for. The results from the pilot study indicated that the registered nurses

acknowledge the varied field of counselling and reported that specific types of counselling may be more relevant than others. The participants reported that the forms of counselling that they are familiar with may not always be appropriate for use in a casualty unit.

4.4.2 Research procedure

A proposal for this study was presented at a proposal meeting to the Psychology Department at the Nelson Mandela Metropolitan University before being submitted to the Faculty Research Technology and Innovations Committee (FRTI) for approval. The FRTI also granted ethical approval for the study to be conducted. Upon receiving approval from the FRTI, contact was made with the research participants by contacting the Medical Superintendent of one of the state hospitals located in the Nelson Mandela Metropolitan Municipality (NMMM), to gain their permission to contact the nurses working in that institution. Contact was established with the matron of the casualty unit of the hospital and the researcher described the study and requested that the matron identify relevant participants for the study. After the potential relevant participants had been contacted, the researcher determined whether they met the requirements for participation and if so, explained the purpose and aims of the study and requested their participation in the study. These registered nurses were provided with written documentation (Appendix C) explaining the aims and process of the study as well as the role of the participant in this process.

The participants who agreed to participate were each required to complete a copy of the informed consent form (Appendix D) so as to ensure that participation was voluntary. The signing of the consent form was accompanied by a detailed, personal explanation of what was required of the participants and at this point the prospective participants were able to ask any questions and voice any concerns or opinions regarding the research project. Once informed consent had been obtained from the participants, the interviewing process began. The researcher scheduled specific times for the face-to-face semi-structured interviews to be

conducted with each participant. The interviews were conducted on the hospital grounds and a request for a suitable area was made to the matron of the casualty unit. The interviews were scheduled and conducted at a time that did not affect the working hours of the relevant registered nurses. These interviews were audio-recorded and later the content from the interviews was transcribed by the researcher for analysis. The information obtained through the interviews was analysed using Tesch's (1990) model of content analysis firstly by the researcher and then by an independent psychologist with experience in qualitative research methods. The verification of the data by an independent coder ensured the integrity of the results obtained from the researcher's analysis. The trustworthiness and credibility of the data was determined using Guba's model of trustworthiness. On completion of the analysis, the participants were provided with written feedback on the study's findings. The feedback also provided an opportunity for each research participant to be contacted by the researcher during which they could reflect on their involvement in the study.

4.4.3 Setting

Each interview was conducted in an office at the hospital in which the registered casualty nurses worked. The venue was agreed upon by both the researcher and participant as the most convenient setting. In addition to this, using this venue allowed the researcher to eliminate variables that may have influenced the interview. One variable was the presence of other people that may have inhibited the participant and reduced the intensity of what the participant communicated. Other factors included external noise factors or disruptions as well as interruptions that may have been encountered in more public settings. Another advantage was that the use of this venue allowed the registered casualty nurses to be available had the need arisen.

The recording machine was only activated once the researcher was certain that a comfortable level of sharing had been reached by the participants. Once activated, the

recording device was only switched off once the interview had been concluded. All interviews were conducted in English, as all participants were fluent in this language. The total time of the interviews was 145 minutes, with an average interview time of approximately twenty four minutes. The total time for the follow-up phone calls was forty five minutes, with an average time of seven and a half minutes.

4.4.4 Participants and sampling

Qualitative research lends itself well to the use of non-probability sampling and this method was used to identify the participants for this study. Non-probability sampling focuses on the relevance of the sample in relation to the research as opposed to the degree of representation within the sample (Neuman, 2003). One of the advantages of this sampling method was that it allowed the researcher to select participants that have direct knowledge of the phenomena being studied, and as such they could provide relevant perceptions and opinions of it (Henning, van Renburg, & Smit, 2004). Another benefit of this sampling method was that it was relatively inexpensive and convenient to make contact with possible participants. A disadvantage of this sampling procedure, according to Cozby (2007), is that this method does not allow certain elements of the population to be a part of the study as they may not have any experience with the phenomena being assessed and as such, non-probability sampling does not lend itself to generalising the results to the population as a whole as it does not generate a group of participants that are representative of the population.

The researcher used a theoretical sample in which participants were selected based on their theoretical relevance to the study (Seal, Gobo, Gubrium, & Silverman, 2005). This theoretical sample was actualized through a purposive sampling technique in which participants were selected according to predetermined criteria. These criteria were that they have actively been involved or affected by the phenomena being studied and as such can provide specific and relevant information, using the most appropriate sampling methods

(Cozby, 2007; Neuman, 2003). The criteria used to select relevant participants for this study were that they were registered nurses with SANC. These registered nurses must have been working in a casualty unit in a hospital within the NMMM (in this study a state hospital was used) and must have had at least six months full time experience working in this unit. Participants must have been able to converse in English and be over the age of 21 years so as to provide informed consent and to volunteer legally.

This sampling technique focuses on selecting specific elements of the population to be a part of the sample in order to create a sample that is composed of elements that contain the most characteristic, representative or typical traits that are being studied (Henning, van Renburg, & Smit, 2004). This purposive sampling technique was primarily actualised by making contact with the matron of the denoted casualty unit. During this contact session, brief descriptions of the study as well as the goals of the research and the procedure were explained. The matron was then asked to identify appropriate registered nurses based upon the criteria as outlined in the participants section of this document. Once identified, each of these registered nurses were contacted and provided with a brief overview of the study and the possibility of participating in the study was discussed with the registered nurses. During this discussion, further information regarding the aim of the study as well as the role of the participants was provided. After this process individuals who were willing to participate in the study were screened again to ensure that they met the requirements for the study.

4.5 Data processing and analysis

During data processing the researcher set aside all previously acquired assumptions, judgements, ideas and knowledge so that the data obtained from the interviews could be viewed as fresh information that was not distorted by the researcher. The data obtained from the biographical questionnaire was compounded quantitatively in order to determine the ranges of experience and education of the participants in the professional nursing field.

The audio-recorded data from the semi-structured in-depth interviews was transcribed by the researcher and then submitted for independent transcription and coding by an independent coder. Both the researcher and the independent coder made use of Tesch's model of content analysis (Tesch, 1990). Initially the researcher aimed to get a sense of the whole by reading through all the transcripts and jotting down some ideas. The researcher then chose one specific interview with which to start the analysis, and wrote down thoughts as they occurred (Tesch, 1990). The researcher repeated this process with several of the transcribed interviews. At this point, a list of all found themes was compiled and the similar themes were clustered together. These were then formed into columns that were arranged according to major themes (Tesch, 1990). These themes were then abbreviated and coded with descriptive wording being associated with each theme; the researcher allocated the most appropriate descriptive wording for each of the themes. These themes were then turned into categories by grouping the themes that related to each other so as to reduce the total number of categories (Tesch, 1990). The researcher then made a final decision on the abbreviation for each category and then assembled them alphabetically; the data material that was found to belong to each category was then assembled and a preliminary analysis was then performed (Tesch, 1990). Finally, a consensus discussion was held by the researcher and the independent coder regarding the findings and a final decision on the major themes was then made (Tesch, 1990).

The validity and reliability of the data collected was assessed by using Guba's model of trustworthiness. The constructs were set out by Lincoln and Guba (1985) as referenced by De Vos, Strydom, Fouché and Delpont (2006) and deals with the soundness and validity of qualitative research. This construct works on the four principles of credibility, transferability, dependability and confirmability.

Credibility refers to the ability of the participants to accurately provide relevant information and to describe the phenomena being studied (de Vos, Strydom, Fouché, &

Delpport, 2006). With regards to this study, all participants had at least six months experience working in casualty units in state-based hospitals and all were registered nurses with SANC.

Transferability addresses the issues surrounding generalisability, specifically within small-scale qualitative studies. The principle of transferability aims to ensure that research is conducted in accordance with acceptable concepts and models that are obtained from previously reviewed theoretical frameworks (de Vos, Strydom, Fouché, & Delpport, 2006). This principle was incorporated in the present study through the discussion of the theoretical parameters of the study, including the models and concepts used in the collection and analysis of the data. Furthermore, data obtained from the participants was linked with the theoretical frameworks that were previously identified.

Dependability refers to efforts by the researcher to explain any changes that are observed in the phenomenon (de Vos, Strydom, Fouché, & Delpport, 2006). This principle is associated with the understanding that all experiences occur as part of the individual's social construction of reality and as such allows for the possibility of multiple realities. As a result of this perspective, the principle of dependability is integrated into qualitative studies to acknowledge changes in the social world that may make replication of the study difficult (Denscombe, 2002). With regards to this study, the methodology used for the completion of this research study allowed for adaptation as necessary with regards to the setting in order to retrieve the information from the interviews. Initially the researcher aimed to make use of an office away from the hospital grounds but due to the high pressure and workloads associated with casualty units, the registered nurses were requested to remain as close as possible in case their skills were needed.

Confirmability is related to the fact that the findings concluded from the study are based on the data obtained during the study and not on the subject characteristics, suspicions and opinions of the researcher (Guba & Lincoln, 1994). With regards to this research study, the

data was collected and then transcribed, as well as independently transcribed, and then collated under the supervision of the independent coder and the supervisors in order to maintain objectivity at all times. The semi-structured in-depth interview schedule that was used within this study was pilot studied on a small group of participants to ascertain whether the questions in the schedule were in line with Guba's model of trustworthiness and were measuring what the research study aimed to measure.

4.7 Ethical considerations

The process of ethical conduct in a research study initially occurs with ethical approval from a research ethics committee. Such approval is often obtained through a proposal presented by the researcher which is then reviewed to ascertain whether relevant ethical principles and procedures have been observed (Denscombe, 2002). Ethics approval for the study was obtained from the FRTI of the Faculty of Health Sciences at the Nelson Mandela Metropolitan University prior to conducting the research study.

A variety of ethical issues must be considered when conducting any research project. A primary concern of the researcher was the issue of obtaining voluntary informed consent from the participants. This consent was obtained in writing before the participant could take part in the research study. The purpose of this voluntary informed consent was to ensure that each participant in the research study was fully aware of the purpose and the topic of the research study. The issue of confidentiality was also considered in the planning of this research study. The data recorded from the participants was coded so as to ensure anonymity of the participants, and the data remained confidential and was not used for any other purpose than that described in the study.

The effectiveness of the interviewer in being able to administer the interviews without leading or affecting the responses of the participants was of great concern. This effectiveness was maintained by using an intern psychologist to administer the interviews and the

independent coder to examine the questions asked and the subsequent responses throughout the transcription process. During the transcription process, both personal and cultural biases were acknowledged and counteracted by the researcher through the process of external assessment of the transcribed material. Through the process of using the independent coder, the accuracy of the transcriptions was ascertained.

The researcher informed all participants of the objectives of the investigations including aspects that might reasonably be expected to influence their willingness to participate. The full disclosure was made prior to obtaining consent to protect the welfare and dignity of the participants. The essential principle was that the investigation should be considered from the standpoint of all participants. Strict measures were taken to ensure confidentiality and the data was stored safely at the end of the study. No potential psychological risks were identified by the researcher prior to conducting the interviews. However, during the interviews the researcher ensured that the discussion did not cause psychological discomfort or distress. This was achieved by observing nonverbal cues that indicated that the participant was experiencing increased levels of discomfort. When such nonverbal cues were observed, the researcher guided the conversation in such a manner to reduce and prevent this distress.

Non-maleficence is a significant ethical principle when conducting qualitative research and refers to the researcher's efforts to avoid harming participants (Flick, 2006). To actualise this principle, the researcher must at all times be aware of any potential harm that the participants may experience including physical, psychological, and legal harm (de Vos, Strydom, Fouché, & Delpont, 2006). A debriefing with the participants after the interview process was of vital importance in order to maintain that the participants had not been traumatised or suffered ill effects from the interview. This debriefing was conducted directly after the interview so as to be sure that the participant was still comfortable and to explain why certain questions were asked (Struwig & Stead, 2001). A secondary assessment of the

effects of the interview process was conducted after the participants had been contacted to verify the information obtained during the interview process.

4.8 Chapter Conclusion

Chapter Four reviewed the methodology of the present study and provided a discussion of the interpretivistic approach to research. The chapter explored the relevant aims, specific research design and data collection and analysis methods employed in this study. The description of the data collection methods and research procedure highlighted how the researcher integrated the principles elicited from the semi-structured in-depth interviews and the theoretical framework. Major ethical principles observed prior to conducting the research were identified. A discussion of the ethical considerations highlighted how they were implemented in the research design and methodology. The review of data processing and analysis procedures provided insight into how acceptable and reliable models were incorporated into the research methodology. Implementing these models ensured that the results that are discussed in Chapter Five were obtained through methods that enhanced the trustworthiness of the research.

CHAPTER 5

FINDINGS AND DISCUSSION

5.1 Chapter Overview

Interpretivistic research aims to understand and contextualise the data that has been obtained. The interpretivistic paradigm guided the study as it allowed for the phenomenological examination of the various subjective experiences of registered nurses working in a casualty unit regarding their perceived need and willingness to engage in supplementary counselling skills training. This chapter provides a summation of the findings of the present study as well as a discussion of these findings.

5.2 Operationalisation of the Current Research Study

The participants of the present study were selected according to the predetermined inclusion criteria as established through the use of the biographical questionnaire. Following the selection of the participants, each individual participated in a one-to-one semi-structured in-depth interview. These interviews were conducted in a separate office situated near the casualty unit so as to provide maximum available privacy and still allow the nurses to be available if necessary. All the interviews were conducted with English as the medium of communication and had an average duration of twenty four minutes. The interview guide consisted of six questions that were used to initiate explorations of the perceptions of registered nurses in casualty units. These questions provided guidance to the researcher but were not prescriptive as each participant was allowed to influence the flow of the dialogue.

All the interviews were audio recorded and later transcribed verbatim by the researcher. The process of transcription allowed the researcher to become absorbed in the data provided by each participant. Once all the transcriptions had been completed, the researcher used Tesch's (1990) eight steps to thematically analyse the data obtained from the interviews. Initially the researcher aimed to get a sense of the whole by reading through all the transcripts

and jotting down some ideas. The researcher then chose one specific interview with which to start the analysis and wrote down thoughts as they occurred. The researcher then repeated this process with all of the transcribed interviews. At this point, a list of all the found themes was compiled and the similar themes were clustered together. These were then formed into columns, with the columns being arranged according to major themes. These themes were then coded with appropriate descriptive wording for each theme and subtheme. The themes were then turned into categories by grouping the themes that relate to each other so as to reduce the total number of categories. The researcher then made some final decisions on the abbreviation for each category and data material that was found to belong to each category was assembled and a preliminary analysis was then performed (Tesch, 1990). Finally, a consensus discussion was held between the researcher and the independent coder regarding the themes that were obtained and a final decision on the themes was made.

Through this process, the themes were assembled into four main themes that emerged from the data analysis. The four themes were: (1) The perceived need of supplementary counselling skills for use with patients; (2) The perceived need of supplementary counselling skills training for nurses; (3) The factors influencing the willingness of staff to undergo supplementary counselling skills training; (4) Requirements for supplementary counselling skills training and implementation. Once the main themes had been established they were arranged into the most descriptive categories of meaning. These main themes were organised into sub-themes to provide structural and textural contextualisation of the data. A biographical description of the participants provides further contextualisation of the registered nurses working in casualty units.

5.3 Biographical description of the participants

The six participants selected for this study were all registered nurses who were working in a state based casualty unit within the NMMM; these six participants included the two participants from the pilot study. Each of these participants had had experience working in casualty units. The experience of the participants ranged from one year to over twenty-four years. The participants were all registered with the South African Nursing Council (SANC) as registered nurses with one of the participants registered as a chief professional nurse. The qualification levels of the participants ranged from Diploma in Nursing Science to Baccalaureus Curationis degrees with one of the participants also having achieved a Magister Curationis. The participants had received their training from various nursing training schools such as Lalitha Nursing College, the University of the Free State as well as the Nelson Mandela Metropolitan University, formerly the University of Port Elizabeth. All the participants in this study were female and their ages ranged from 26 to 58 years of age. All the participants were fluent in English and four of the participants were also fluent in Xhosa. This number of participants was selected as theoretical saturation of ideas occurred across their interviews. These interviews lasted for a total period of 145 minutes with an average of approximately twenty four minutes per interview.

The findings from the study are depicted in the following section in Table 1. This table displays the main themes from the findings and highlights the sub-themes that were elicited.

5.4 Findings and Discussion

Four main themes relating to the perceived need and willingness of registered nurses working in a casualty unit in the NMMM to engage in supplementary counselling skills training emerged from the data analysis. These main themes were: (1) The perceived need of supplementary counselling skills for use with patients; (2) The perceived need of supplementary counselling skills training for nurses; (3) The factors influencing the

willingness of staff to undergo supplementary counselling skills training; (4) Requirements for supplementary counselling skills training and implementation. These main themes provided a structural understanding of these nurses' perceived need and willingness to engage in supplementary counselling skills training. Further analysis of the data produced several sub-themes that allowed for greater illumination of the various facets of the main thematic findings. Each of the identified main themes and their subsequently extracted sub-themes are illustrated in Table 1. Furthermore, the findings of the present study are discussed according to the themes that emerged from the data collection process. The perceived need and willingness of registered casualty nurses to engage in supplementary counselling skills training is described through the integration and discussion of the themes that emerged from this data collection process.

Table 1: *Main themes and sub-themes*

Main theme	Sub-themes
The perceived need of supplementary counselling skills for use with patients	Containment and support of patients and families Coping skills Education
The perceived need of supplementary counselling skills training for nurses	Constant exposure to trauma Perceived shortfalls
Factors that influence the willingness of staff to undergo supplementary counselling skills training	Stress and burnout Workload Resources
Requirements for supplementary counselling skills training and implementation	Focus areas for training Methods for incorporation

5.4.1 The perceived need of supplementary counselling skills for use with patients

The first main theme that emerged from the data collection related to the participants' descriptions of their views on the patients' need for supplementary counselling skills. Within this main theme, three sub-themes emerged. The sub-themes that were identified were those of containment and support of patients and families, coping skills and education.

The information provided from the participants linked to this theme universally across all the interviews that were conducted. Each of the participants felt that there was a strong need for the inclusion of supplementary counselling skills training in order to better provide and effectively help the patients and their families. An example of this need was expressed by one of the participants as:

“No I feel there is a great need for that, because we are all human beings we all need to also remember that we, although we react from it in a different way it all effects us in a basic level that is the same”

Another participant reported this phenomenon as:

“You see they can become very emotional and break down and so nurses also have to play their parts when dealing with such types of patients”

Based on these statements, the participants perceive a need for the inclusion of a supplementary counselling skills training programme for use with the patients. The participants indicated that the patients are dealing with a great deal of problems, not only physical, but psychological and social in nature. These problems expressed that the patients are dealing with can be viewed in terms of the biopsychosocial model of health and illness (Taylor, 2003). Dombek and Wells-Moran (2006) reported that the biopsychosocial model of health and illness allows health practitioners to broadly assess the patient and the factors influencing the patient's conditions as opposed to merely viewing the biological factors influencing the condition.

5.4.1.1 Containment and support of patients and families

The participants reported that the containment of not only the patients but also their families was a key area that could be affected by the provision of supplementary counselling skills training. The participants reported that it was important to be able to calm the patients and their families as sometimes it was difficult to administer services to them due to the effects of the trauma suffered and the associated anxiety that the families were experiencing. These findings are related to the use of the nursing relationships with patients to affect the patients' subjective experiences of the care received and can have direct benefits for recovery and adherence (Horton, Tschudin, & Forget, 2007). Research reported in Larson (2004) also found that the inclusion of psychological skills have aided nurses in becoming more 'present' when dealing with patients. Nurses who have received these skills found that their patients were easier to deal with and reported fewer problems (Larson, 2004). An example of this was illustrated by one of the participants:

"You know, you talk to them and try to comfort them, you know, so that they can be calm"

Another participant stated:

"And even with the patients as well, it is the same thing, making things much easier and communicating better with them"

One of the participants reported that:

"Basically by talking to them and reassuring them that things, although that sometimes it could happen that the patient might not survive from you know the stuff that happened to them but just to say that they um must just be calm and not over exert themselves because sometimes they start crying and you have to be there just to give that support you know to say that you're there for them and you know"

The participants also reported that there was a need for the inclusion of supplementary counselling skills training for use with patients and their families as a method of identifying and intervening in the effects of the trauma situation on these individuals. The participants reported that initially it was important to contain and calm the families and the patient so that they could treat the patient as effectively as possible. The participants then reported that after the patient was no longer critical, the focus would be on providing support and guidance to these individuals. This support and guidance is crucial as there is the possibility for the individual and their families to develop secondary psychiatric or mental health concerns post exposure to the trauma or crisis (Benedek & Ursano, 2001). The inclusion of a supplementary counselling skills programme for the registered nurses could also allow them to better identify and recognise these early signs of possible mental illness (Frank, McDaniel, & Heldring, 2004). This approach of the participants is similar in structure and focus to the first order interventions described by Slaikou (1990) in his proposed crisis intervention model. The aim of first-order interventions in the crisis model is to give support, reduce lethality and to link the client to helping resources (Slaikou, 1990). These first-order interventions provide the necessary basis for the client to begin to re-establish themselves in terms of the crisis that they have experienced (Slaikou, 1990). This was expressed by one of the participants as:

“I mean they are stressed, they have different stressors, financially what what and then someone can come to the hospital not because she is sick she is feeling disturb but because she doesn't have finances she doesn't have food and all the patients who are HIV they are not working and they don't have someone to supply with food and whatever so with that thing we can reach each other and give them the talk and then treat them in casualty or refer them in different ways depending on what they need. We can assess what they need best”

These elements can also be viewed in terms of the biopsychosocial model of health and illness as well as the crisis intervention model. In terms of the biopsychosocial model of health and illness, the participants reported making use of a biopsychosocial assessment process when dealing with their patients. They report analysing the situations that the families and the patients are dealing with in terms of the biological, psychological and social factors that are affecting these individuals (Smith & Strain, 2002). With regards to the crisis intervention model, its use of the BASIC-ID modality to assess the individual and the system in which they reside is linked to this process that has been described by the participants (Corey 2005; Lazarus & Folkman, 1984). The participants report making use of a process that is similar in nature to the BASIC-ID modality and is linked closely to the multidisciplinary use of the biopsychosocial model of health and illness.

One of the participants reported this as:

“I mean these days it is needed especially with this economic recession and the problems that have come with it, the people are dealing with more than just injuries, they are having other stress too”

5.4.1.2 Coping skills

The second sub-theme that emerged was the importance of coping skills to be provided to the patients and their families. The participants reported that the patients that came into casualty generally also suffered from a variety of other problems at home. They stated that there is a possible need for these patients and their families to be provided with brief interventions and guidance that aim to increase their coping abilities. Some of the participants reported that the inclusion of a supplementary counselling skills training course could possibly reduce the number of admissions to the casualty unit as well as enable the patients and their families to better manage other aspects of their lives. This is represented by one of the participants as:

“If there can be people to help them and show them how to get themselves out of these problems. Because sometimes when a patient is discharged they didn’t want to go home because of poverty and at home they have nothing to eat, to do and they want to stay here. The counselling can show them how to get themselves out of the poverty and give them advice and develop their coping abilities fix the problems.”

Within the biopsychosocial model of health, this approach of giving credence to the various factors other than the biomedical or physical concerns of the patient is important as the inclusion of the various psychological and social factors affecting the patient has a direct impact on the health of the patient (Smith, 2002). This holistic approach examines the patients’ overall needs whilst still addressing the health issues that are affecting the patient at present (Smith, 2002). This theme also articulates the use of the nursing-therapeutic relationship in order to provide instruction to the patients when dealing with additional life issues (Carter, 1993). This factor is also related to the inter-disciplinary use of skills to provide an effective service to the patient.

5.4.1.3 Education

This sub-theme deals with the participants’ views on the need for education for the patients. The participants expressed a need for the patients to be educated about the various factors that are affecting their lives and also their admissions to the hospital. Some of the key areas related to the patients taking better care of themselves, the procedures within the casualty unit as well as the purpose of referrals. The participants in this study felt that the inclusion of a supplementary counselling skills programme could better aid them to impart this knowledge to the patients. One participant reported that:

“Educating the patients and the relatives is very very important”

An area of major concern for the participants was the presence of non-trauma patients in the casualty unit. These non-trauma patients have the potential to disrupt the unit as they have difficulty understanding why they are not seen as priority cases. The participants reported that this causes disruptions because both the patients and their families become upset when more critical cases are seen to before them even though they came in later. The participants also stated that having to treat these non-critical patients made it more difficult for them to provide services and spend adequate amounts of time with their patients. The inclusion of having to treat non-critical patients has the potential to overcrowd the casualty unit and impede its efficiency. This problem was illustrated by one of the participants as:

“there are the problems and challenges in the unit, like non-trauma patients, non-trauma patients they are one of the challenges in the unit, and if in the unit it can be only the trauma patients we can run the unit more effectively”

Another participant expressed this problem as:

“most of patients are not emergency patients only, there are lots of patients that are coming here that are very ill, they used, supposed to go to the our OPD [Out Patient Department] but first the clinics is closed and it makes the emergency unit full, that’s why it is so full like that, its not only emergency cases, all the cases from the community are coming here”

This problem is also expressed in literature in terms of the great demands on the available resources in South Africa due to the overcrowding of hospitals and clinics and the neglect of preventative and promotional programmes (Freeman, 2000). This factor is coupled with the general purpose of casualty units being focussed upon emergency trauma situations as opposed to general medical problems (Kearney, 2007) of a non-critical nature.

Another element that emerged within this theme was the need for patients to gain a better understanding of referral processes. The participants reported that it is important for patients

to better understand referral processes and for the nurses to make appropriate referrals for the patients. The majority of the participants stated that from within the casualty unit, many of the patients are referred to other appropriate services, both medical and psychological, based on their initial assessment of the patients' needs. This was expressed by one of the participants as:

“if we feel that the patient needs to be referred to either psychology or whatever then we do the necessary thing for the patient. And then you teach the patient and you make them aware of the places”

The integration of mental health services into the public health sector must be accompanied by the development of complementary services (Gatchel & Oordt, 2003) and these complementary services need to involve effective and clear referral and linkage systems (WONCA, 2008). These referral systems aim to better provide the appropriate psychological and mental health services to the community at large. Additionally these factors appear to be intrinsically linked to the biopsychosocial model of health and illness and also have implications for use within multidisciplinary teams. The biopsychosocial model of health and illness recognises the multifaceted nature of the problems that affect individuals and their families (Smith, 2002). Within this model, the use of multidisciplinary teams is important in providing treatment and dealing with these multifaceted problems that affect the individuals and their families. Through the use of effective referral systems, the participants indicated that they make the patients aware of the necessary structures to provide assistance to them.

5.4.2 Perceived need of supplementary counselling skills training for nurses

This theme is related to the descriptions that participants provided regarding their views on the need for supplementary counselling skills training for nurses themselves. Two sub-themes that emerged were identified as the constant exposure to trauma for the nurses and the perceived shortfalls from the viewpoint of the nurses.

This information indicated that there was a clear perceived need for the inclusion of supplementary counselling skills training for nurses. The participants all expressed that they felt that the supplementary counselling skills training would greatly benefit the nursing staff and provide them with much needed assistance to deal with the variety of problems that they are faced with. An example of this need was expressed by one of the participants as:

“we are working, as I told you, we are working under a lot of stress, counselling is very very important to us because we are working under lots of stress”

Another participant reported:

“it can be traumatic for the staff member as well to be exposed to a lot of different things and you get a lot of different types of situations in a trauma unit and it could be traumatic for you as well”

These statements indicate that the registered nurses are exposed to significant levels of stress in the casualty units. These stress levels could possibly impact on the effectiveness of the registered nurses and this is explored in a subsequent theme.

5.4.2.1 Constant exposure to trauma

The participants stated that working in the casualty unit can be a traumatic and chaotic experience at times. They attributed this to the aforementioned high workload that they have to deal with. The participants reported that this high workload combined with the traumatic events that they have to deal with when providing their services to the patients has led to a high level of stress for the nurses. The findings indicated that due to these high levels of stress there is a great need for debriefing to deal with this problem. The findings indicated that this expressed need for the inclusion of supplementary counselling skills training was related to this desire for debriefing as a means of dealing with other problems that were

expressed. The effects of this stress are discussed in a subsequent sub-theme. The participants expressed this exposure as:

“Mainly because of, we need to be counselled because it’s working us. These people are looking at us and saying that we didn’t help them, they didn’t know about the situation. I think it would be good for us, it will help us and each other”

Another participant represented this theme as:

“I think its debrief ja where people get debriefed and there’s nothing really available for nurses when they are exposed to traumatic events in the casualty unit”

Due to the nature of conditions and situations in the casualty unit, there is potential for the development of long term psychiatric problems for the registered nurses and other professionals that work in these units (Carter, 1993). The result of these stressful and chaotic situations has the potential to affect efficiency, work satisfaction, burnout and absenteeism (Kearney, 2007). This situation could have profound effects on the continuation of effective services and has the potential to worsen an already overburdened service and create a greater level of stress on the other nurses still in the unit (Horton, Tschudin, & Forget, 2007).

Another factor in this sub-theme is related to the effects of this exposure on the professionalism of the nurses. The participants reported that their professionalism is affected due to this exposure to stressful events. This exposure affects their ability to perform effectively and provide the necessary services. This was expressed by one of the participants as:

“You end up crying with the patient which is not really professional, you’re supposed to be there giving guidance and reassuring the patient instead of becoming emotionally attached like crying or that type of thing which is not really suitable for the profession”

Another participant reported this loss of professionalism in another form:

And then sometimes, you just, you just answer the patient without knowing that you are offending the patient you know and then after that you realise that you have done something wrong and then just you go to the patient and say “I’m sorry, it was not me, it was the pressure of the work”

These findings indicate that there are occurrences of a loss of professionalism for the registered nurses. This loss of professionalism affects the services provided to the patients and also their interactions with the families.

5.4.2.2 Perceived shortfalls

Some of the findings from this study demonstrated a perceived shortfall in the training that the participants received with regards to the counselling of patients. The participants reported that even though they received theoretical training in basic counselling skills they have had minimal practical exposure. Some of the participants reported that the majority of their training in terms of counselling skills was related to dealing with psychiatric patients as opposed to dealing with effects of traumatic situations. This was conveyed by one of the participants as:

“in our basic training we did learn, um, psychiatry and we had like exposure to how to deal with psychiatric patients and so forth. But here with trauma um at the home is a different set up than dealing with chronically mentally ill patients and so forth”

According to WONCA (2008), the integration of mental health services into public and primary health care aims to provide basic education on the epidemiological, identifying and treatment factors of the major psychiatric conditions. The majority of the training is focussed on the provision of services with regards to psychiatric patients as opposed to the provision of services dealing with other psychological problems (WONCA, 2008). The information provided by the participants is also related to SANC's regulations relating to the training for registered nurses (SANC, 1985). This regulation aims for the registered nurse to "understand him [the patient] as a psychological, physical and social being within this context" (SANC, 1985 p. 4) and this view is in line with the biopsychosocial model of health and illness. Another factor to consider is the focus of the nursing training provided by the various universities in South Africa. The training is predominantly focussed on the psychiatric spectrum as well as psychopathology, with only some attention spent on counselling skills training (University of Free State, 2009; University of Johannesburg, 2008; Department of Nursing Science, 2008; University of Witwatersrand, 2008).

5.4.3 Factors influencing the willingness of staff to undergo supplementary counselling skills training

This main theme is related to the willingness of the participants to engage in a supplementary counselling skills training course. This theme examines the various factors expressed by the participants that might affect their willingness to engage in the training. Three sub-themes were identified within this theme, namely stress and burnout, workload and resources.

Throughout the interviews the participants expressed a willingness to receive not only supplementary counselling skills training but also other forms of additional training. The participants also reported several factors that may influence the willingness of other nurses to

engage in this training process. One of the participants stated the following with regards to this willingness:

“The sisters are willing to further their education or whatever, to uplift themselves or whatever, there are people who are willing to do that”

This theme indicated that additional training is viewed as an important element in the professional development of registered nurses. Additionally this is associated with the use of preceptors in order to better orientate and improve the expertise of the nurses in training (Mee, 2007). This theme can also be viewed in terms of the practice of continuous professional development or CPD points that has been instituted by the HPCSA where registered professionals are required to engage in a certain amount of additional training each year.

5.4.3.1 Stress and burnout

This sub-theme highlights the effects of the stress brought on by exposure to trauma. Some of these effects were reported as registered nurses dealing with depression, burnout as well as problems at home. The participants reported that these problems have had a significant impact on the nurses in the casualty units. The effects of this exposure in the casualty unit are indicated by increased levels of absenteeism, turnover of staff, and nurses leaving the profession. Exposure to stressful events leads to staff shortages and increased workload for the nurses still in the unit and the participants stated that this increased workload further increases the stress that they are dealing with. Some of the participants reported feelings of being overwhelmed and demotivated by these increasing levels of stress and that this stress has been transferred into the homes of the nurses. The effects of this stress were expressed by one of the participants as:

“we are demotivated my dear, and burn out, and burn out, and burn out, people are burn out, people are burnout”

Another participant reported that:

“you take it home and end up bottling it up if you don’t have someone to talk to and that can also cause problems in your personal life, as well”

This was also expressed by another participant as:

“Sometimes you come in to work, like this morning, with your, with your stress from home”

Another participant reported:

“not only colleagues but friends as well that are in the profession, um they end up bottling it up so badly that they end up going through a state of depression where they had to be institutionalised, be put on medication and what do they call it, PTSD, I’ve seen quite a few of that”

These comments highlight emotional stressors that participants are dealing with. It is possible to see from the participants’ responses that they are suffering from high levels of stress and that this stress is affecting not only their professional performance, but also their motivation and home life. This is associated with information reported by Kearney (2007) that the effects of this stress can affect work efficiency and work satisfaction and increase the frequency of burnout and staff turnover. The management of the effects of this stress is important because if it is left unattended, there is the possibility for the development of secondary psychiatric or mental health concerns post exposure to these stressful incidents (Benedek & Ursano, 2001).

5.4.3.2 Workload

The participants reported that the workload and number of patients that they have to deal with also affect their willingness to engage in a supplementary counselling skills training course. The participants expressed that this workload is affected by the chaotic work environments and situations that they find themselves in. The problems posed by non-trauma patients within the casualty unit that was discussed above as well as the staff shortages that

were examined previously were reported to increase the workload that the participants are dealing with. This increased workload affects the participants' willingness to engage in a supplementary counselling skills training course. The participants reported that they are attempting to do the best they can in a difficult situation. This was expressed by one of the participants as:

“because this place is the busiest place in the hospital and as far as, the more it becomes busy, the more you make mistakes and then the management does not understand why so much mistakes can go wrong and as if people in that place are negligent, or if everybody in this place are negligent but it is not like that”

“You don't like, even you, you can't say you are happy when somebody says you are negligent whilst you know you are not. You do the best that you can in the situation.”

Another participant stated:

“the absenteeism rate is very very high because people they say no I'm not going to come on duty today because they're stressed out”

These findings indicate that the high levels of workload that the participants are faced with are affecting their ability to work effectively. The stress associated with dealing with multiple patients may have implications for the provision of services to these patients. It appears that this high workload is further exacerbated by the effects of the stress that the participants are working under. This stress is causing the registered nurses to stay absent. This absenteeism rate serves to further exacerbate the workload as there are now fewer nurses to provide services to the patients that are arriving at the unit. This problem is also associated with the views expressed by Kearney (2007) of the effects of this stressful work environment on the registered nurses.

5.4.3.3 Resources

This sub-theme relates to the various resources that the participants view as both positive and negative factors that may affect the willingness of the participants to engage in a supplementary counselling skills training course.

One of these positive resources is the participants' willingness to receive additional training. This desire for additional training affects their willingness to receive supplementary counselling skills training in a positive manner. Another positive resource from the findings was that some of the participants reported already having developed some skills through their experiences in dealing with patients. These participants reported that they had developed their own techniques which they employed in attempting to provide support and guidance to their patients. This was expressed by one of the participants as:

“The longer you are in the profession I suppose the more you can learn but you need also a bit of extra training to help you get over the problems”

The nursing profession makes use of preceptors, nurses with experience within the unit, to train and induct the newly graduated nurses into the profession (Mee, 2007). These preceptors provide guidance and advice for the nurses under their charge. The provision of guidance and advice to other nurses falls within the realm of Slaikeu's (1990) crisis intervention model's first order interventions. Although this use of the first order interventions is informal in nature, it still attempts to provide support and containment to the patient.

Some of the negative resources that may influence the participants' willingness to engage in a supplementary counselling skills training course are the staffing shortages, as were previously mentioned, as well as the effects of increased workload. The effects of these problems are that the registered nurses have limited time to spend with patients and due to this workload do not have time to provide additional services. These factors all affect the

willingness of registered nurses in casualty units to engage in supplementary counselling skills training. This was conveyed by one of the participants as:

“They just want us to do everything for these patients without them helping us or dealing with the problems”

Another participant expressed this as:

“We might not have the time to use the skills”

These views highlight the desire and willingness of the participants to engage in a supplementary counselling skills training programme. These views also highlight some of the difficulties that the participants foresee with the inclusion of such a training programme due to factors such as workload, unrealistic demands and limited time to spend with the patients.

5.4.4 Requirements for supplementary counselling skills training and implementation

This main theme relates to the perceived requirements that the implementation of a supplementary counselling skills training course would need to achieve. These requirements are related to the sub-themes of the specific areas that the nurses feel should be targeted in the training as well as their views of the most appropriate methods for incorporating this training.

This theme deals with the participants' perceptions of what specific areas of counselling a supplementary counselling skills training course should cover if it were to be provided to registered nurses. This theme also explores the participants' views on the most appropriate and least disruptive methods for the incorporation of a supplementary counselling skills training programme.

5.4.4.1 Focus areas for training

This sub-theme relates to the participants' perceptions of which key areas of focus should be included in a supplementary counselling skills programme. The participants reported that one of the areas for focus should be on the management of stress for both the nurses and patients. This was expressed by a participant as:

“Mainly the stress management, and then you can see most of the staff here are on the depression leave, why, because of the stress and this stress goes up then they couldn’t cope, they were depressed and they stayed at home. It is mainly those areas”

Another area that was elicited by the participants for focus was one of communication skills. The participants reported that these skills were greatly needed in order to facilitate patient-provider relations as well as develop efficient working relationships. One of the participants reported this as:

“the staff members towards the patients will be more empathetic instead of sympathetic, they can relate to the patients”

These identified areas indicate that the main focus of the supplementary counselling skills programme should be on dealing with the effects of stress as well as improved communication with patients. Dealing with stress is associated with Slaikeu’s (1990) crisis intervention model as a focus for first-order interventions where the aim is to begin re-establishing coping for the individual. Improved communication is associated with the biopsychosocial model of health and illness in its application and assessment of patients. This is achieved through the health professional engaging in in-depth background information in order to ascertain the various facets that are affecting the individual at this time (Smith & Strain, 2002).

5.4.4.2 Methods for incorporation

This sub-theme relates to the participants’ views on the most appropriate and least disruptive methods for the implementation of a supplementary counselling skills programme. The participants reported that for a training programme to be effectively implemented, in-service training with one or two of the nurses at a time would be most appropriate as this

would not affect the services provided in the casualty unit. One of the participants expressed this as:

“If you can get, a month or so of in-service training will be the best as that will motivate us”

Another participant reported:

“They can help us by taking a few nurses to go for that counselling, maybe two or one nurses, not all because we are short of staff, one by one for the training and then when one comes back the next one can go until they all get it”

The participants also expressed that there is a need for the inclusion of incentives for the registered nurses to engage in supplementary counselling skills training. This was reported by one of the participants as:

And if we can get money, money, money, money is our problem

Another of the participants reported:

“everyone after that receives certificates, and then the person putting into an action to show that the thing is fruitful to everyone and not to be neglected having a certificate without doing anything, we need to be involved”

These factors for the implementation of a supplementary counselling skills training programme are also linked to the guidelines for the integration of mental health services into public health care as provided by WONCA (2008). These guidelines state that for the effective implementation there should be adequate training provided to the participants as well as clearly defined roles on who is responsible for which factors and finally that integration is a process and not an event and that adequate time should be taken with the implementation of these skills (WONCA, 2008).

5.5 Chapter Conclusion

The interpretivistic approach to the present study revealed the various perceptions of the registered casualty nurses and the factors that are affecting them. The findings of this research provided a structured subjective view into the participants' experiences through the main themes that were identified. This chapter examined the registered casualty nurse's perceived need for supplementary counselling skills training in terms of both staff and patients and explored their willingness and the factors affecting their desire to engage in this training. This chapter also explored the registered casualty nurses' perceptions of what specific areas of supplementary counselling skills training they felt were important and their preferred methods of implementation should it occur. The outcomes and implications of the present study are discussed in Chapter Six.

CHAPTER 6

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

6.1 Chapter Overview

Chapter Six provides a summary of the present study and highlights the implications and outcomes of this research study. The outcomes of the study focus on the results obtained from data collected from the participants. The implications of this study for future research as well as the limitations of this study are examined and recommendations are made for further study.

6.2 Conclusions

The primary aims of this study were to explore and describe the perceptions of a sample of registered casualty unit nurses regarding the need for supplementary counselling skills training as well as to explore and describe their willingness to engage in supplementary counselling skills training. The actualisation of these aims occurred through the use of semi-structured in-depth interviews with the participants. These semi-structured in-depth interviews were then transcribed verbatim and analysed using Tesch's model of content analysis (Tesch, 1990). Several main themes were identified, each with several sub-themes that illustrated the various views expressed by the participants. These themes are represented in Table 1 on page 61.

The findings highlight that the registered nurses working in casualty units do perceive a need for the inclusion of supplementary counselling skills training. This perceived need is related to useful skills for dealing with patients and also as a means for the registered nurses to address their own concerns and traumas that they have experienced. The participants expressed that supplementary counselling skills training could provide assistance when dealing with patients and their families. This training could provide them with skills for containment and aid them in providing better support to these individuals. The participants

stated that there is a need to provide both coping skills and education for the patients within the casualty unit. The findings indicated that there is a need for supplementary counselling skills training for use with the registered nurses themselves. It was reported that this need is due to the constant exposure to trauma and the difficulties that this trauma causes for the registered nurses. The participants indicated that the supplementary counselling skills training may help them to deal with this trauma and its associated problems.

The data collected from the semi-structured interviews also pertained to the perceived willingness of the registered nurses to engage in supplementary counselling skills training. The findings expressed that there is a strong willingness to engage in the supplementary counselling skills training but there are numerous problems that inhibit this willingness. The participants stated that there are significant levels of stress and burnout as well as high workloads that they have to deal with. The participants expressed several positive as well as negative resources that affect their willingness to engage in supplementary counselling skills training. The findings indicated the specific areas that they reported the supplementary counselling skills training should deal with as well as their impressions of the most appropriate methods for the implementation of a supplementary counselling skills training programme.

6.3 Limitations of the study

There were limitations that may have influenced the results obtained from the study thus making generalisation difficult. One of these limitations was the use of only one state hospital in the selection of participants. This could potentially affect the results as it only allows for the inclusion of perceptions and opinions of the registered nurses working within this specific casualty unit.

Another limitation of this study relates to only sampling from state based hospitals. The inclusion of only state-based hospitals limited the study as the perceptions gained from the

data collection only reflect the opinions of registered nurses working within the public health sector and excludes those of the registered nurses in the private health sector.

6.4 Recommendations for future research

Based on the results obtained from this study a number of further research topics arose. To further establish the transferability of the results obtained in this study, it is recommended that the study is replicated in a number of different casualty units, in both state and private hospitals, to establish whether the results obtained in this study are an isolated experience or if this study will yield similar results in different settings.

Another possible indication for further research lay in the results obtained with regards to the willingness of the participants to engage in a supplementary counselling skills training programme. The findings of this study highlighted a number of external factors that may affect this willingness of the participants. A study into these external factors and their influence is recommended to better understand how they may affect the willingness of registered casualty nurses.

Another possible indication for future research lies in replicating the study using focus group discussions as opposed to interviews in order to collect the relevant data. The use of focus group discussions could allow for the gathering of additional information through the process of using the interactions of the group to generate different perspectives. The benefit of using a focus group is that the group format often enables the participants to discuss issues they consider to be important, thus eliciting key areas of focus for research.

6.5 Recommendations for practical application

Based on the findings obtained from this study, it is clear that the participants perceive a need for supplementary counselling skills training. These findings indicated several problems that the participants face. One of these problems is the loss of professionalism and communication difficulties that occur from the stressors and workload that they are faced

with. The biopsychosocial model of health and illness can positively influence this loss of professionalism in multiple ways. Its multifaceted, systemic approach allows for the development of improved communication skills and can enhance the patient-provider relationship (Smith & Strain, 2002). This is done through the collection of information from the patients in an attempt to gain information relating to not only the biological, but also these psychological and social factors relating to their illness. This approach and its information gathering lends itself well to the provision of more effective patient-provider relationships and has the tendency to increase the communication and professionalism of practitioners (Smith & Strain, 2002).

The inclusion of a supplementary counselling skills training programme can also affect the abilities of the registered nurses to overcome many of the stressors that they are faced with. These stressful events, and their effects, can be decreased through such a programme as it could allow the registered nurses to manage and affect the influence of trauma within their own lives and the lives of their colleagues (Carter, 1993).

Should a supplementary counselling skills programme be implemented with the registered casualty nurses, the results obtained from this study indicated that certain factors are necessary as reported by the participants. The participants indicated that for the successful implementation of a supplementary counselling skills training programme, the use of in-service training with only a few of the nurses at a time would be necessary. The participants also indicated that the use of incentives and the possibility of opportunities to make use of the skills would be beneficial.

6.6 Chapter Conclusion

This chapter examined the findings of the study and the conclusions that were drawn from these findings. It then outlined the limitations that influenced the study and made recommendations for future research. Recommendations for practical application of the

implementation of a supplementary counselling skills training course were also made based on these findings. These findings from this study reflected that there is a perceived need for supplementary counselling skills training by registered nurses in casualty units. This need was reported for use with both patients and staff. The findings also indicated that there is willingness from the registered casualty nurses to engage in a supplementary counselling skills training course but that this willingness is offset by a number of external and situational variables that make it perceivably difficult to engage in this skills training. Yet, this study has shown that the registered nurses do perceive a need for supplementary counselling skills training and are motivated and willing to receive this training despite the difficulties that they expressed.

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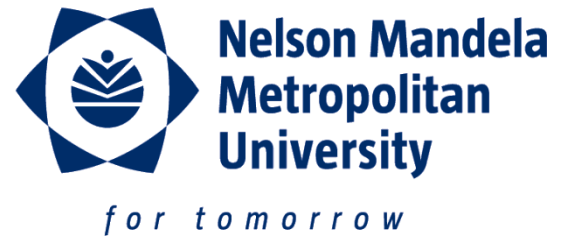
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APPENDICES

Appendix A: Biographical Questionnaire



SOUTH CAMPUS

FACULTY OF HEALTH SCIENCES / DEPARTMENT OF PSYCHOLOGY

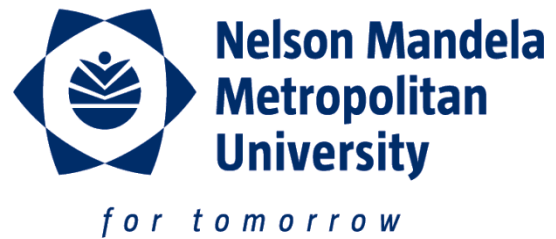
Tel. +27 (0)41 504-2354 Fax. +27 (0)504-2101

s204039150@nmmu.ac.za

Biographical Questionnaire for Participants

Surname	
First Name	
Telephone Number	
E-mail Address	
Birth date	
Home Language	
Gender	
Qualification Level	
Experience	
Nursing Registration Category	
Training Institute	

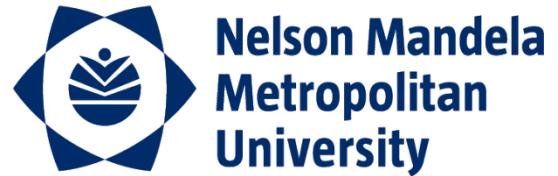
Appendix B: Interview Schedule



Perceived need and willingness of state based health care workers to engage in supplementary counselling skills training: Interview Schedule

1. What is your experience in supporting patients who had trauma?
2. What are, if any, your views of the need for supplementary counselling skills for patients and staff within the casualty unit in this hospital?
3. In what ways might the inclusion of supplementary counselling skills training for various staff members benefit the staff and patients of the casualty unit in this hospital?
4. What might some of the disadvantages, if any, for the patients and staff of the casualty unit in this hospital with the introduction of supplementary counselling skills training for various staff members?
5. Under what conditions would registered nurses be willing to receive supplementary counselling skills training?

Appendix C: Letter of Recruitment



for tomorrow

SOUTH CAMPUS

FACULTY OF HEALTH SCIENCES / DEPARTMENT OF PSYCHOLOGY

Tel. +27 (0)41 504-2354 Fax. +27 (0)504-2101

s204039150@nmmu.ac.za

Letter of Recruitment

Dear Sir or Madam,

Your participation is requested in a research study that aims to examine the perceived need and willingness of state based registered casualty unit nurses to engage in supplementary counselling skills training. This study was developed in order to address the question of the integration of mental health services into primary health care.

We are asking you to participate in an interview to discuss your perceptions and attitude towards the inclusion of supplementary counselling skills training within your field. With your permission, the interview will be audio-recorded. Your responses during the interview will be strictly confidential, and individual responses will not be shared with any outsiders. To ensure this confidentiality, after the interview, your responses will be transcribed from the audio recording and stored under an identification number that will be coded separately from your information. The audio recording will be deleted after the transcription has been verified. The interview will be followed by a debriefing in which any questions or queries that you have will be addressed and the final findings of the study will be made available to you if you so wish. Although your identity will, at all times remain confidential, the results of this research study may be presented at scientific conferences or in specialist publications.

Participation in this research study is completely voluntary and there is no obligation for you to do so. Should you choose to participate, you have the right to withdraw at any given time during the study.

Your participation in this research project is greatly appreciated.

Yours truly,

Warren Leonard
Intern Psychologist

Ms. O. Brown
Supervisor

Dr. L. Stroud
Co-Supervisor

NELSON MANDELA METROPOLITAN UNIVERSITY

INFORMATION AND INFORMED CONSENT FORM

Title of the research project	Perceived need and willingness of state based registered casualty nurses to engage in supplementary counselling skills training
Reference number	204039150 (Student number)
Principal investigator	Warren Leonard
Contact telephone number (private numbers not advisable)	041 583 1552

	Initial
A.1 I HEREBY CONFIRM AS FOLLOWS:	
<p>1. I, the participant, was invited to participate in the above-mentioned research project study that is</p> <p style="padding-left: 40px;">being undertaken by <input type="text" value="Warren Leonard"/></p> <p style="padding-left: 40px;">of the Department of <input type="text" value="Psychology"/></p> <p style="padding-left: 40px;">in the Faculty of <input type="text" value="Health Sciences"/></p> <p style="padding-left: 40px;">of the Nelson Mandela Metropolitan University</p>	

<p>2. The following aspects have been explained to me, the participant:</p> <p>2.1 Aim: The researcher is studying the perceived need and willingness of health care workers to engage in supplementary counselling skills training</p> <p>The information will be used to compile a treatise, publish an article and presented at a conference.</p>	
<p>2.2 Procedures: I understand that I will be participating in individual, face-to-face interviews and that these interviews will be audio-recorded</p>	
<p>2.3 Possible benefits: As a result of my participation in this study insight into the value and opportunities provided by supplementary counselling skills in my profession can be gained</p>	
<p>2.4 Confidentiality: My identity will not be revealed in any discussion, description or scientific publications by the researcher and I shall not disclose any information given by other participants to outsiders.</p>	
<p>2.5 Access to findings: Any new information/or benefit that develops during the course of the study will be shared with me by means of a report of the findings.</p>	
<p>2.6 Voluntary participation/refusal/discontinuation:</p> <p>My participation is voluntary.</p>	
<p>3. I was given the opportunity to ask questions and all these questions were answered satisfactorily.</p>	
<p>4. No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation.</p>	
<p>5. Participation in this study will not result in any additional cost to me.</p>	

A.2 I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT

Signed/confirmed at

	on		20
--	----	--	----

Signature or right thumb print of participant	Signature of witness
	Full name of witness

B. STATEMENT BY RESEARCHER

I, Warren Leonard declare that

- I have explained the information given in this document to

 and/or his/her representative
 - he/she was encouraged and given ample time to ask me any questions;
 - this conversation was conducted in

Afrikaans	<input type="checkbox"/>	English	<input checked="" type="checkbox"/>	Xhosa	<input type="checkbox"/>	Other	<input type="checkbox"/>
-----------	--------------------------	---------	-------------------------------------	-------	--------------------------	-------	--------------------------
 - and no translator was used
 I have detached Section D and handed it to the participant

	YES		NO
--	-----	--	----
- Signed/confirmed at
- | | | | |
|--|----|--|----|
| | on | | 20 |
|--|----|--|----|

Signature of interviewer	Signature of witness
	Full name of witness

C. IMPORTANT MESSAGE TO PARTICIPANT

Dear Participant,

Thank you for your participation in this study. Should, at any time during the study:

- an emergency arise as a result of the research, or
- you require any further information with regards to the study

Kindly contact me
at telephone number

041 379 3801

Warren Leonard
Researcher/Psychologist in Training