A MODEL TO FACILITATE A QUEST FOR EMOTIONAL MATURITY OF PSYCHIATRIC NURSES THROUGH CAPACITY DEVELOPMENT IN PROMOTING THEIR MENTAL HEALTH

by

DOROTHY SEKHUKHUNE

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of the

UNIVERSITY OF JOHANNESBURG

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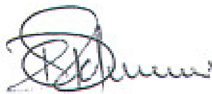
November 2005

I declare that:

A MODEL TO FACILITATE A QUEST FOR EMOTIONAL MATURITY OF PSYCHIATRIC NURSES THROUGH CAPACITY DEVELOPMENT IN PROMOTING THEIR MENTAL HEALTH

is my own work and that all the sources that I have used or quoted have been indicated or acknowledged by means of completed references



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I declare that:

This work has been passed by the Research Committee of the Faculty of Health Sciences of the University of Johannesburg and confirms that it complies with the approved Research Ethical Standards of the University of Johannesburg

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ABSTRACT

Lifecare, like any other corporate business, in the current environment, has to change all the time. Companies need new customers, innovative products, expanded market and cutting edge technologies. The Company has the potential to shape the behaviour, reinforce common beliefs, and encourage members to apply their efforts to accomplish important Company objectives of providing care for chronic mentally ill patients. The psychiatric nurses are therefore an essential requirement for the success of the Company in a competitive environment.

On the other side, psychiatric nurses face the difficult task of confronting the challenges involved in the nature of care required among chronic psychiatric patients. Whilst striving for quality patient care, they find themselves faced with some breakdowns within the environment in which they are interacting, resulting in their resorting to negative media publicity. This type of publicity can lead to damaging the Company's reputation and can retard the Company's growth strategy, which the psychiatric nurses might not seem to understand. There was also high staff turnover which hampered quality patient care. This could also affect the Company in terms of what affects the competitiveness of the quality care which the Company aims to deliver.

The researcher believes that for clinical care to take place, psychiatric nurses need to be in sound mental health and understand the dynamics within the Company in order to deal with it in an effective way. The following research questions posed were addressed in this research:

- What are the psychiatric nurses' experiences whilst being employed by the Company?
- In what way can the formulation of the model be of assistance in the promotion of the psychiatric nurses' mental health as an integral part of health?

The research objectives were:

- To explore and describe the experiences of the psychiatric nurses whilst employed by Lifecare.

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- To use the results to generate the concepts for the model that would serve as a framework for the psychiatric nursing specialist to facilitate the implementation of guidelines that would assist the psychiatric nurses to be in a sound mental state.
- To describe the guidelines that would serve as a framework for operationalising the model in nursing education, psychiatric nursing practice and nursing research.

Methods to ensure trustworthiness were ensured throughout this research. Ethical consideration as outlined in the Position Statements published by the Democratic Nursing Association of South Africa (1998: 2-21), was adopted. The researcher utilized the assumptions of the Theory for Health Promotion in Nursing in this research. This theory focuses on the whole person, that is, the mind, body and spirit as well as on the parameters of nursing and the beliefs about the person, health, illness and nursing. The emphasis in this theory is on mental health promotion of the psychiatric nurses within the Company.

This research consisted of three stages as follows:

In stage one a qualitative design was used to explore and describe the psychiatric nurses' inner world experiences of the Company's culture. In-depth semi-structured interviews were utilized to obtain data from these psychiatric nurses. These interviews were conducted by an independent interviewer, and were audio-taped. These were transcribed and were analysed by the researcher. Tesch (1990) in Cresswell (1994: 154) outlined eight steps, which are referred to as decontextualisation and contextualisation, which were adopted in analyzing the results. A description of the results was given. This was followed by literature control which highlighted the similarities to and contributions to this research. Themes that emerged highlighted the experiences that the psychiatric nurses had of the Company culture which affected their mental health.

In stage two the research design and theory generation was employed to formulate a model which could be used in nursing education, nursing research and nursing practice. The model formulated was based on the results

obtained on the inner world experiences of psychiatric nurses. A combination of stages of theory generation by Chinn and Kramer (1991:79-104) and Dickoff, James and Wiedenbach (1968: 431-434) were employed by the researcher to identify the central concepts that guided the identification of the main theme. A tentative model was formulated and was submitted to the independent experts for consultations and clarification. The model was named and presented in its final form to the independent experts.

In stage three the researcher formulated the guidelines for operationalising the implementation of the model in clinical practice, nursing education and recommendations were made for further research.

CHAPTER ONE

1 OVERVIEW AND RATIONALE

1.1 INTRODUCTION

Lifecare Group Holdings was established in the 1950s. This Company blazed the trail for the first genuine private/public partnership in healthcare in South Africa. The company contracted with the State to provide basic healthcare, specialising in long-term care for the chronically ill psychiatric patients, tuberculosis patients, frail and elderly patients – sectors of the market that had been seriously neglected. At this stage, Lifecare's business is conducted entirely through Provincial Government's contracts (Focus for Afrox and BOC Gases Employees in Africa June, 2001: 2).

The Government's National Health Act (Act 61 of 2003) stated that the focus of the services must be on primary health care and community-based care. Lifecare works effectively in tandem with the State, within the constrained public sector budgets. The public health budget accounts for between 10 to 11% of the overall budget of government (Department of Health, Health Sector Strategic Framework 1999-2004: 9). Lifecare, unlike other private healthcare sectors catering for medical aid and private patients, offers long-term chronic care and acute care services in level one facilities such as District Hospitals, specialising in care for all sectors of the community who are unable to pay for their health care services and are dependent on the state and rely on social funding to access health care facilities.

Lifecare has the experience of caring for chronic mentally ill patients and at the same time is developing workable models of community-based care for patients with chronic illnesses as envisaged with the implementation of the new Mental Health Care Act (Act 17 of 2002) and the Mental Health Care Act 2002 General Regulations (General Regulations of 15 December, 2004). In this model of care a multidisciplinary team approach consists of the following members: social workers, occupational therapists, physiotherapists, psychiatric nurses, medical practitioners/psychiatrists who are all important components in every facility for an integrated holistic approach to patient

care. Lifecare has pioneered true public-private partnerships in South Africa, including four build-operate-transfer (BOT) health facilities, which means that the company would build a facility then operate it for a stipulated number of years as agreed in the contract that Lifecare and the Government agreed on. At the end of the contract the company would then transfer the facility to government. This is a classic Public Private Partnership arrangement that Lifecare had with the Government. (Focus for Afrox and BOC Gasses Employees: June 2001:2) Lifecare is the largest provider of psychiatric services in the country.

In 1999 the Company went through major transformation in the ownership of Lifecare Group Holdings. Afrox acquired 55% shareholding in Lifecare and the remaining 45% of Lifecare is held by the empowerment group, Real Africa Holdings (Focus for Afrox and BOC Gases Employees in Africa June, 2001: 2).

A fair amount of restructuring took place whereby synergies were identified, merged and/or worked together to share the best operational practices, for example, the communication and information technology department, human resource functions, financial management, and procurement, to name just a few synergies, and the company is now settled into the Afrox Healthcare Group.

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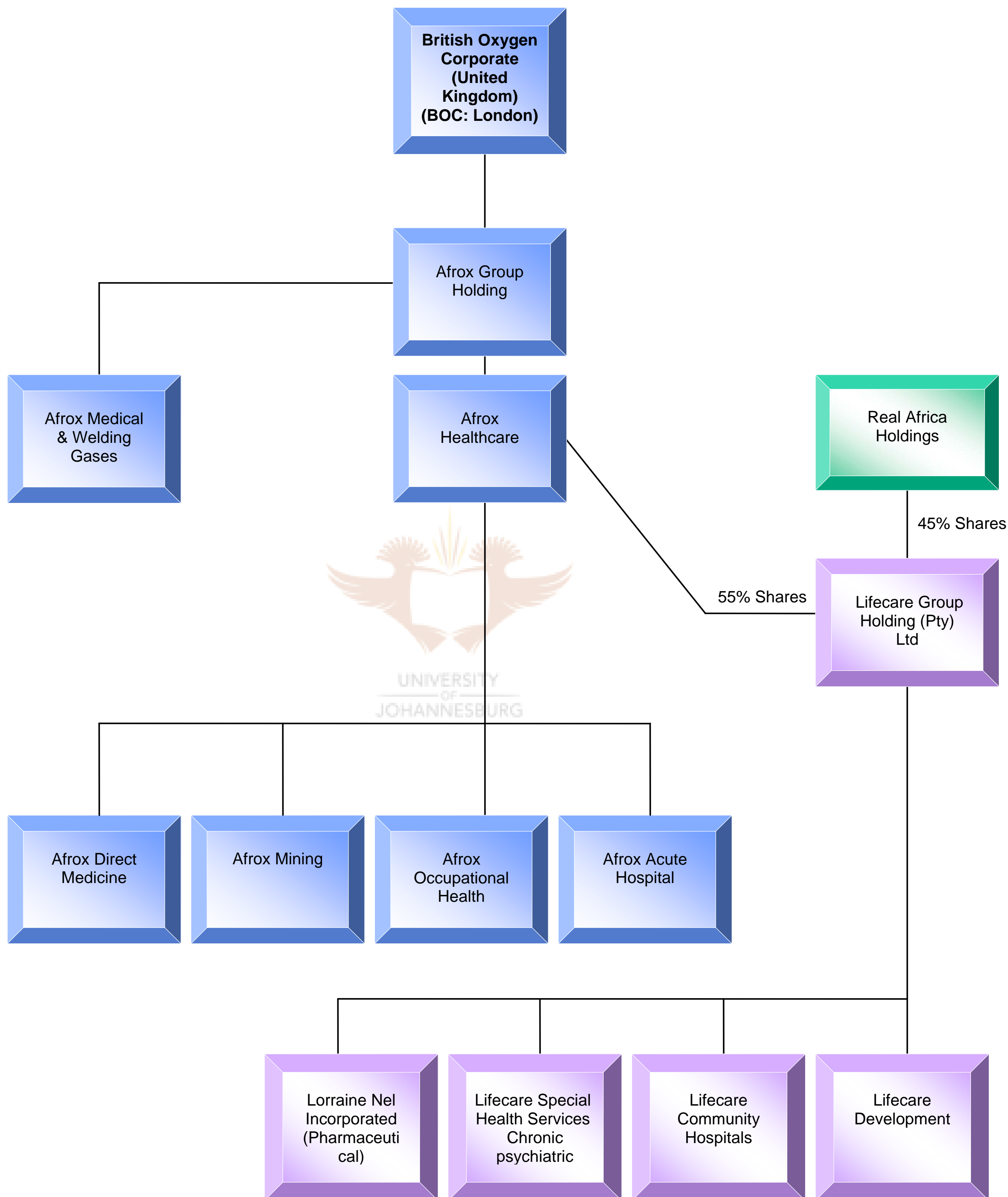
Figure 1.1 on the following page depicts the organisational structure of Afrox and where Lifecare has been positioned.

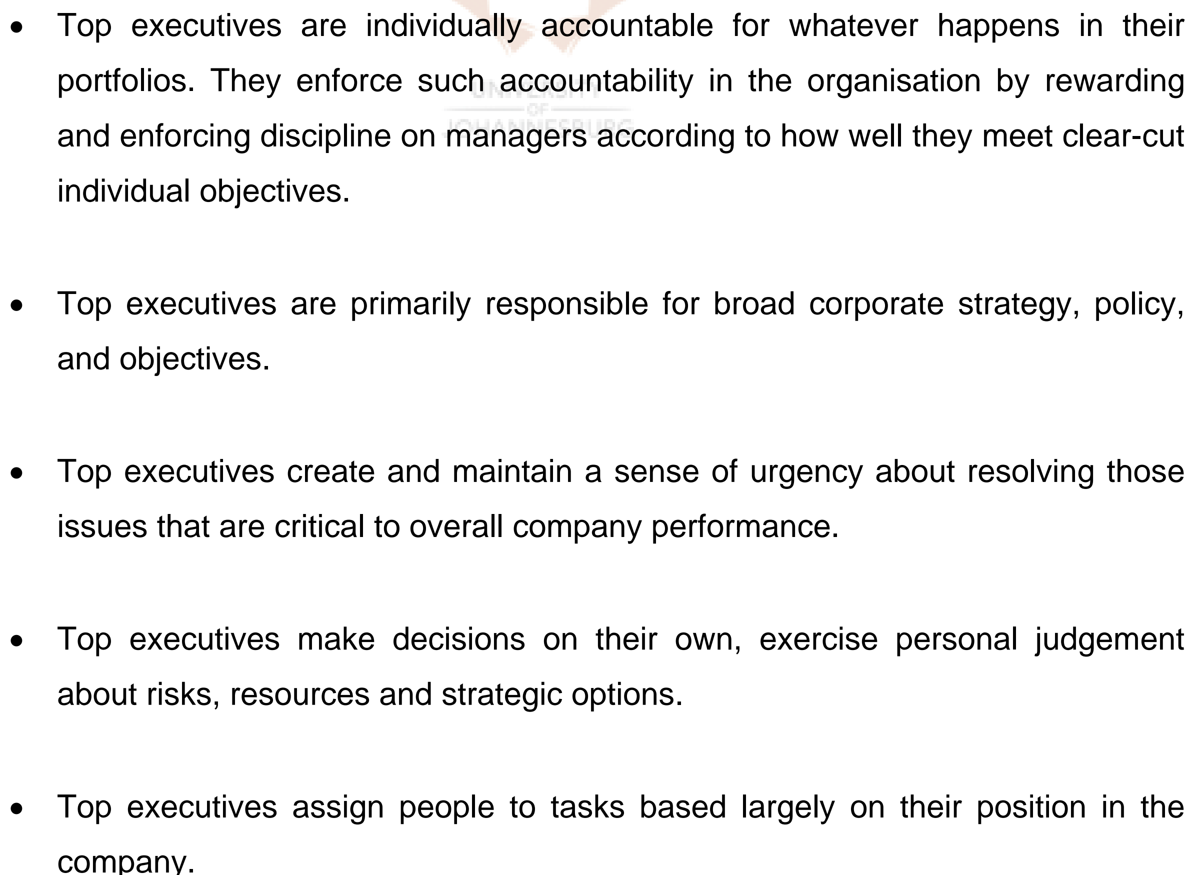
Figure 1.1
THE ORGANISATIONAL STRUCTURE OF LIFECARE/AFROX



(Adapted from Lifecare Information brochure,1997)

1.2 ORGANISATIONAL STRUCTURE

Lifecare's organisational structure consists of the executive team comprising of the Managing Director and the Executive Directors. Lifecare's team has a pattern of behaviour typical in the top leadership group that is familiar in all companies. (Katzenbach,1997: 84). The Managing Director designates his Directors as an executive management. The executive's primary purpose is to shape strategic priorities, enforce operating standards, establish corporate policy, and develop management talents of its members and direct them to the company's vision, mission, values and policies. The group meet regularly to discuss operating matters, and meet periodically to discuss major strategic and policy matters. In short, the executive management functions as an efficient, effective working group with a single leader. The team is therefore deeply committed to a purpose that not only provides a sense of direction to its members, but also justifies and clarifies the extra collective efforts required for the team to achieve its performance potential. The executive team roles can best be described as follows:



- Top executives are individually accountable for whatever happens in their portfolios. They enforce such accountability in the organisation by rewarding and enforcing discipline on managers according to how well they meet clear-cut individual objectives.

- Top executives are primarily responsible for broad corporate strategy, policy, and objectives.

- Top executives create and maintain a sense of urgency about resolving those issues that are critical to overall company performance.

- Top executives make decisions on their own, exercise personal judgement about risks, resources and strategic options.

- Top executives assign people to tasks based largely on their position in the company.

- Top executives leverage their time and experience by means of efficient organisational and managerial processes. As executives become more efficient and thus more valuable, they are given responsibility for more people and greater assets.

For this team to be effective, it has frontline managers who are responsible for articulating a meaning and purpose of improving the company's performance. They are responsible for the implementation of company strategy and focus on mutual accountability that is necessary for the company's achievement.

The goals of frontline managers are clear and specific, recurring and measurable. They cover the company's downtime, changeover speeds, yields, costs and outputs. The extra performance capability that the executive put on the frontline managers is largely from complementary mixing of its members' skills. As a result, team members are selected primarily on the basis of set skills they will bring to the group.

Each manager and their team need to shape a working approach that takes into account their members' available time, as well as different skills and roles. The members must become as committed to that approach as they are to the team's overall purpose and goals.

Another aspect that the executives require from the frontline managers is mutual accountability and individual accountability. The executives believe that individual accountability is essential to maintain control over performance, and they can point to results over time to back up that belief. Mutual accountability by contrast, is much harder to develop (Katzenbach, 1997: 85).

In this company the same happens. As stated above the executives of Lifecare require some form of team time commitment. Each management team needs to shape a working approach that takes into account its members' available time, as well as their different skills and roles.

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The executives believe that a working facility with a single leader can energise and align the group relatively well. A good leader of the facility usually knows what the group's goals and basic working approach should be. As a result, it can rely on the experience and formal position of its facility's unit leader to make individual assignments clearly and wisely, to protect them from unfriendly outside elements, and to keep its members on track. The facility's unit group is likely to make few mistakes, because of the manager's knowledge and experience regarding the task at hand. Moreover, the members seek out and rely on the formal manager's know-how. Based on the above the executive team recognised the inherent value of both behaviours, and the fundamentally different disciplines of the multidisciplinary team required for the execution of its strategy.

The roles of the front line managers can be summarised as follows:

- Managers hold their members mutually accountable for collective results.

- The managers' purpose and goals are tightly focused on specific performance results.

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- Managers mobilise around a meaningful purpose and a commitment to specific, common goals.

- Managers make collective judgement by means of open dialogue, conflict resolution and collective real work.

- Managers and the team are assigned on the basis of the specific skills required by the task at hand, regardless of their formal role in the company.

- Managers engage the team in the most efficient way of getting the work done.

These contrasting multidisciplinary team members produce conflicts that are difficult to resolve. The fundamental point, however, is that each has its place in the senior management and leadership of any performance-oriented company like Lifecare.

Lifecare now caters for approximately 8 000 patients a day with a capacity of 11 000 beds. Twenty-four (24) Lifecare facilities operate under contract to Provincial Health Authorities. Two (2) of these facilities are district hospitals providing medical, surgical, maternity and paediatric care services in the remote rural areas. These hospitals also provide a full range of Out-Patient Department services such as dental, chronic medical care services, tuberculosis services, psychiatric services, ophthalmic services, antenatal services, post-natal care, reproductive services and the well-baby clinic for immunisation and monitoring of the under five year old children. Five (5) facilities cater for tuberculosis patients, five (5) facilities cater for the frail and elderly patients and the remaining twelve (12) facilities cater for chronic psychiatric patients.

Lifecare facilities are geographically situated in most Provinces except the North-West, Northern Cape and Free State. Five (5) facilities were built by Lifecare on a build, operate and transfer (BOT) basis in a classic private/public partnership arrangement (Focus for Afrox and BOC Gases Employees: June 2001: 2).

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The core business is enhancing the standard of care in the public sector while understanding the nature and category of the patients and their psychological, social, biological as well as their spiritual needs. Lifecare look up to their nursing staff and rely on them as a large component of health care providers in their employment to meet the needs of the patients in Lifecare facilities, and to care for these patients in order to do business with government. Lifecare therefore regards the patients, their families and the communities in which the hospitals are based, as their customers. They also take cognisance of the referral public hospitals and community-based clinics as their customers.

With a dramatic increase in HIV/AIDS related illness, the demand for services provided by Lifecare is increasing. The HIV/AIDS epidemic is the most important challenge facing South Africa since the birth of our new democracy. The challenge comes at the time when the country is faced with many other competing needs:

redressing the imbalance of the past, transformation of the society, as well as integrating the country into the global economy, are some of the many challenges that the health department is faced with (Department of Health, HIV/AIDS & STD: Strategic Plan for South Africa 2000-2005). As a company, this is shared with the Department of Health. Lifecare management as a partner to the Department of Health is therefore constantly exploring innovative and affordable ways to alleviate the suffering of these patients. This approach has been part of Lifecare strategy to grow its business and to remain competitive in the business environment.

Like any other corporate business, the company has its own corporate culture. In the current environment, companies have to change all the time. Companies like Lifecare need new customers, innovative products, expanded market and cutting edge technology. This aspect of a company can give important meaning and direction to the day-to-day behaviour of its members serving as a background force. It has the potential to shape the behaviour, reinforce common beliefs, and encourage members to apply their efforts to accomplish important company objectives and through company practices, the values of managers and other members of the staff are shaped and pointed in the same direction.

Lifecare as a company is dependent on the nursing staff to deliver quality patient care in the 24 facilities that they are managing. The majority of the nursing staff is in the psychiatric facilities. The researcher thought that by targeting psychiatric nurses employed by this company, the researcher would be in the best position to identify these unconscious assumptions or own values as understood by the psychiatric nurses that they find upsetting or even threatening to them. It was also important to narrow this population of nursing staff in the psychiatric facilities and focus only on the psychiatric nurses who are mainly the caregivers within their psychiatric units.

In addition, psychiatric nurses are faced with demands to provide a service which is efficient, effective, and economic, which is what the company expects in order to achieve its goals

Therefore the role of the psychiatric nurses can best be described as follows:

- **Psychiatric Nurses as Professionals:**

Psychiatric nurses have to be registered as Registered Psychiatric Nurses with the South African Nursing Council after having completed nursing education and training as prescribed by the South African Nursing Council (South African Nursing Council, Directives for Psychiatric Nursing, 1985:13).

They then function within the relevant health care legislations and the scope of practice as outlined below:

- Creation of a therapeutic environment and the psychiatric nurses' function within this environment is to apply the psychiatric nursing skills and therapy with regard to psychiatric condition
- Physical treatment including promoting activities of daily living
- Prevention and rehabilitative aspects
- Function within the ambit of the legislation
- Administration of prescribed medication and observing the side-effects thereof
- Facilitation of nutrition of the patients
- Dental and oral hygiene of the patients
- Application of the therapeutic methods in psychiatry, that is, group methods in psychiatry, psychotherapy, physical methods of treatment, recreation, the use of leisure time for patients, music and art in therapy (South African Nursing Council, Regulations R2551 of 1985: 13).

- **Psychiatric Nurses as Unit Managers:**

- They have to be skilled in ward management and clinical teaching

- They have to plan and organise the nursing unit for effective clinical nursing to take place

- They have to plan for the utilisation of human and material resources for effective psychiatric nursing care to take place

- They control the resources allocated to them (Booyens, 2002: 228-229).

- **Psychiatric Nurses as Members of the Multidisciplinary Team:**

Psychiatric nurses as members of the multidisciplinary team are the leaders of the psychiatric nursing units and function within the multidisciplinary team approach. This means that they have to liaise with the team members on matters pertaining to patient care, that is: observe that the medication prescribed is effectual, ensure that medication prescribed is being issued by the pharmacist, that the patient is participating in occupational therapy activities, and that the social worker does make family contact for the patient.

Whilst being ultimately accountable for quality of care as prescribed in the rules set out in the Acts or Omissions Regulations (Regulations No 2490: 1990), by the South African Nursing Council, psychiatric nurses provide their services in an area characterised by change and uncertainty associated with the move from institutional to a community-based location, as demanded by the present primary health care structure, as envisaged by the Government of South Africa, for the care of this population within this specific company (Department of Health, Health sector strategic framework 1999-2004: 5).

Thus psychiatric nurses are an essential component for the success of the company in a competitive health environment. On the other hand, the demand for services provided by the company is increasing.

1.3 PROBLEM STATEMENT

Lifecare operate twelve (12) psychiatric facilities in South Africa of which eight (8) are in Gauteng Province where the research will be undertaken. Most of the staff involved are the psychiatric nurses. Sullivan (1953: 591) said psychiatric nursing is invariably assumed to be a stressful area of nursing practice. Sullivan (1953: 591) further stated that empirical evidence to support this proposition is limited.

It was also documented by Sullivan (1953: 591) that psychiatric nursing is a specialised area of nursing practice that involves dealing with the psychological distress and suffering of the mentally disordered on a daily basis. He further stated that the work is demanding and its essence is an intimate and often intense interaction with a disturbed client group, an interaction that includes the confrontation of difficult and challenging behaviours on a regular basis.

It was also documented by Stein-Parbury (1993: 26) who said that feelings are bound to be part of the nurses' responses to patients. Personal emotions are aspects of self-awareness that often pose dilemmas for nurses because they are taught, implicitly or explicitly, to keep their emotions under control. Many nurses interpret the need to maintain control over their emotions to mean that they should be void of emotions. While a lack of emotional display in the presence of embarrassing situations assists nurses in managing such situations, a total lack of emotions prevents nurses from establishing interpersonal contact with patients.

Psychiatric nurses have to be in a sound mental health state for them to contribute meaningfully to the growth agenda that the company is envisaging because executive management constantly explores innovative and affordable ways to alleviate the quiet suffering of these patients, thereby growing their business. Psychiatric nurses seem not to comprehend this. This was seen when these employees resort to labour unrest activities which led to the publication of an article in the Sowetan titled "No easy job being psychiatric nurse" (Bhengu, 2000: 6) This article was written following the interview that the journalist had with these nurses. This type of publication can lead to damaging the company's reputation and can retard the company's growth strategy which the psychiatric nurses might not seem to understand.

There is also nursing staff turnover which hampers quality patient care. This can also affect the company in terms of what affects the competitiveness of the quality care the company needs to deliver. Nursing staff mentioned to this journalist that part of their concern is high staff resignation. This is what has led to them to say "it is not easy to be a psychiatric nurse" (Bhengu, 2000: 6). In order to understand the psychiatric nurses' concern, the researcher collected the nursing staff turnover statistics from the psychiatric facilities in the Gauteng Province where the research was done, for a period of three years from year 2001 to year 2003 as a way of trying to identify the problem areas among the nursing staff as a starting point.

When the statistics were analysed, it was noted that there had been a high staff turnover among the nursing staff in this company. Nursing staff statistics are shown on the next page.

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Table 1.1 TOTAL NURSING STAFF ESTABLISHMENT FOR THE THREE YEARS 2001/2002/2003

	2001	**2002**	**2003**
Chief Professional Nurses	27	28	21
Senior Professional Nurses	91	91	69
Professional Nurses	408	413	415
Enrolled Nursing Auxiliaries	1580	1581	1461
Residential Health Workers	297	299	311
Grand Total	**2403**	**2412**	**2277**

Table 1.2 NURSING STAFF RESIGNATIONS FOR A PERIOD OF THREE YEARS

	2001	**2002**	**2003**	**Total**
Chief Professional Nurses	1	2	5	8
Senior Professional Nurses	16	27	15	58
Professional Nurses	120	162	226	508
Enrolled Nursing Auxiliaries	128	332	261	721
Residential Health Workers	29	16	13	58
Grand Total	**294**	**539**	**520**	**1353**

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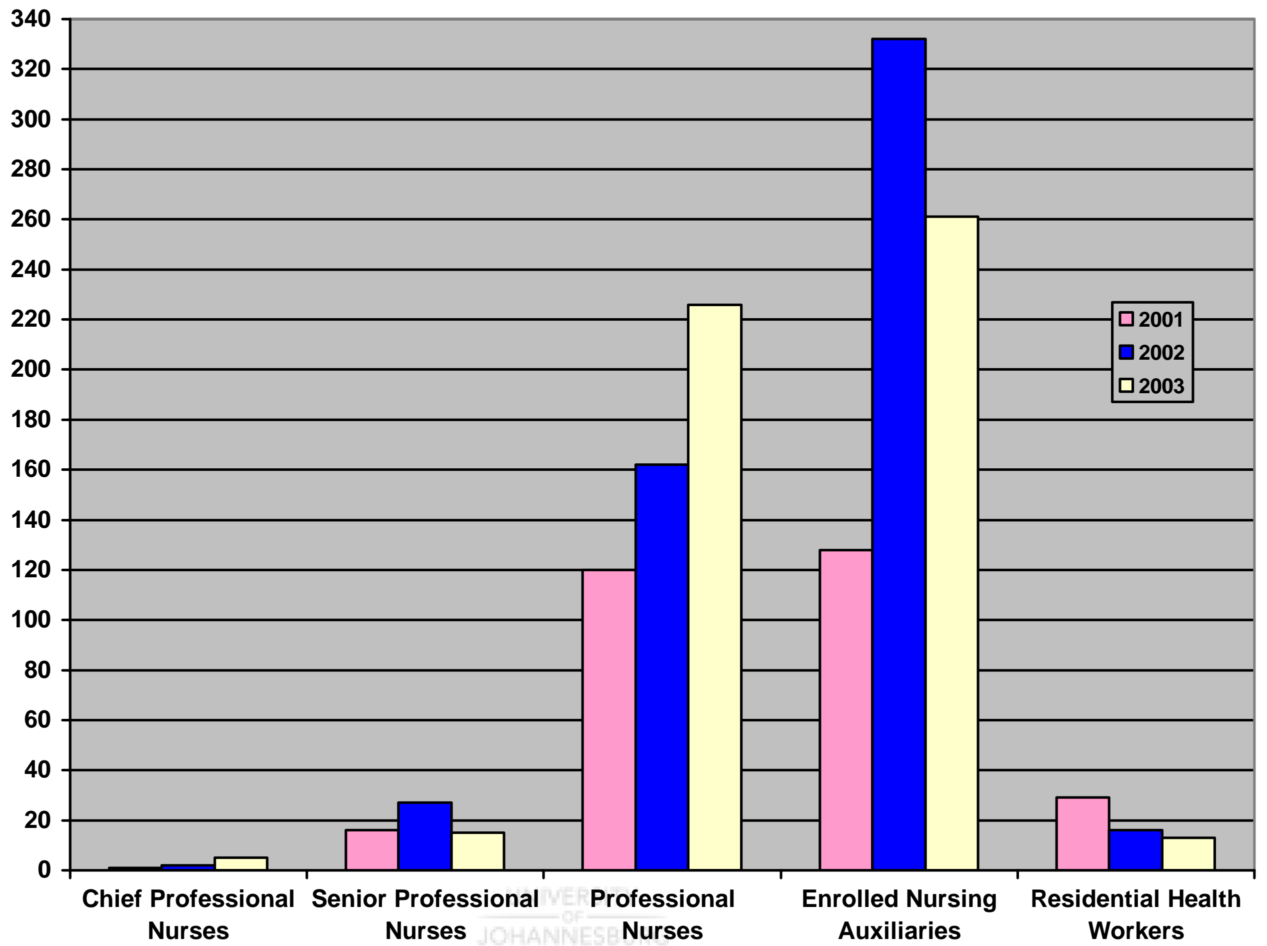
Figure 1.2 NURSING STAFF TURNOVER FOR 2001, 2002, AND 2003



Reasons for leaving are summarised as follows:

Table 1.3 REASONS GIVEN FOR LEAVING THE COMPANY DURING YEAR 2001

	Chief Professional Nurses	Senior Professional Nurses	Professional Nurses	Enrolled Nursing Auxiliaries	Residential Health Workers
	2001	**2001**	**2001**	**2001**	**2001**
Absconded			1	2	4
Contract Complete			50	36	3
Death			3	10	3
Disciplinary		1		5	1
Dissatisfaction (work environment)			3	3	2
Early Retirement			1	3	1
Further Studies		1	4	7	
Ill Health			3	7	
Job Opportunity	1	5	13	15	
No reason given		5	19	15	1
Normal retirement			2	3	
Personal reason		2	12	9	1
Relocation		2	7	6	1
Retrenched - involuntary			2	7	12
Grand Total	**1**	**16**	**120**	**128**	**29**

Table 1.4 REASONS GIVEN FOR LEAVING THE COMPANY DURING YEAR 2002

	Chief Professional Nurses	Senior Professional Nurses	Professional Nurses	Enrolled Nursing Auxiliaries	Residential Health Workers
	2002	**2002**	**2002**	**2002**	**2002**
Absconded			2	7	
Contract Complete			62	102	
Death			5	13	2
Disciplinary			1	9	4
Dissatisfaction (work environment)		4	10	11	1
Early Retirement			1	8	
Further Studies			5	41	2
Ill Health		2	10	11	1
Ill health retirement			1	8	
Job Opportunity	1	7	18	38	
No reason given		8	21	31	1
Normal retirement	1	1		13	
Personal reason		5	26	32	
Relocation				8	4
Resignation on company request					1
Grand Total	**2**	**27**	**162**	**332**	**16**

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Table 1.5 REASONS GIVEN FOR LEAVING THE COMPANY DURING YEAR 2003

	Chief Professional Nurses	Senior Professional Nurses	Professional Nurses	Enrolled Nursing Auxiliaries	Residential Health Workers
	2003	2003	2003	2003	2003
Absconded			4	6	2
Contract Complete			85	53	
Death		1	4	13	4
Disciplinary			4	12	
Dissatisfaction (work environment)		5	7	1	
Early Retirement		1	1	17	1
Further Studies		1	4	19	1
Ill Health			2	11	
Ill health retirement			1	1	
Job Opportunity	2	4	43	53	1
No reason given			30	31	2
Normal retirement	1		6	19	
Personal reason	2	2	29	19	
Relocation		1	5	4	2
Resignation on company request				2	
Retrenched - involuntary					
Grand Total	**5**	**15**	**226**	**261**	**13**

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The pattern of reasons given by these professional nurses, was depicted in these three years. When analysing the above reasons given for leaving, the most reasons for leaving were as follows among the professional nurses in particular:

- When contract ended the professional nurses did not want to renew the contract
- Job opportunities
- Personal reasons
- Reasons not given

The researcher as a psychiatric nursing specialist believes that for clinical care to take place, psychiatric nurses need to be in sound mental health and understand the dynamics within the company in order to deal with it in an effective way. This can ultimately assist the psychiatric nurses and enable them to address issues of concern and thereafter contribute meaningfully to the business by being productive and delivering quality patient care which is what the company's client wants to see happening.

It is therefore a belief by the researcher that once the psychiatric nurses are able to exercise their responsibilities as professionals, it will improve the quality of psychiatric nursing care.

1.4 THE RESEARCH QUESTIONS POSED:

- What are the psychiatric nurses' experiences whilst being employed by the company?

- In what way can the formulation of a model be of assistance in the promotion of the psychiatric nurses' mental health as an integral part of health?

1.5 PURPOSE OF THE STUDY

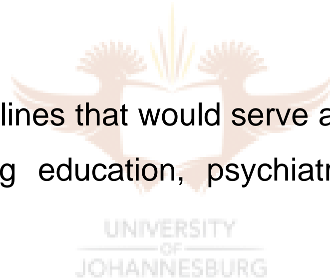
The overall purpose of this research was to formulate and describe a model as framework for the psychiatric nursing specialist to promote the mental health of the psychiatric nurses in psychiatric facilities managed by Lifecare.

The objectives are:

- To explore and describe the experiences of the psychiatric nurses whilst being employed by Lifecare.

- To use the results to generate the concepts for the model that would serve as a framework for the psychiatric nursing specialist to facilitate the implementation of guidelines that would assist the psychiatric nurses to be in a sound mental state.

- To describe the guidelines that would serve as a framework for operationalising the model in nursing education, psychiatric nursing practice and nursing research.



What follows are the discussions on the paradigmatic perspectives that the researcher has chosen.

1.6 PARADIGMATIC PERSPECTIVE

A paradigmatic perspective is an internalised way of looking at reality. It is also a collection of logically connected concepts and propositions that provide a theoretical orientation that frequently guides research approaches towards a topic (Field and Morse, 1995: 138).

Based on the above statement, the researcher chose to incorporate the assumptions about the research domain as described by Mouton and Marais (1990: 24) in that it is the specific framework or model, a specific research model and the resultant methodological preferences. Therefore the researcher utilised the assumptions of the

Theory for Health Promotion in Nursing (Rand Afrikaans University, Department of Nursing, 2001: 4-8) in this research. This theory focuses on the whole person, that is, the mind, body and spirit, as well as on the parameters of nursing and the beliefs about the person, health, illness and nursing. The emphasis in this theory is on the health promotion of the individual, the family, the group and the community.

This research focuses on the promotion of mental health of psychiatric nurses within this company.

The Theory for Health Promotion in Nursing is depicted in Figure 1.2 on the next page.

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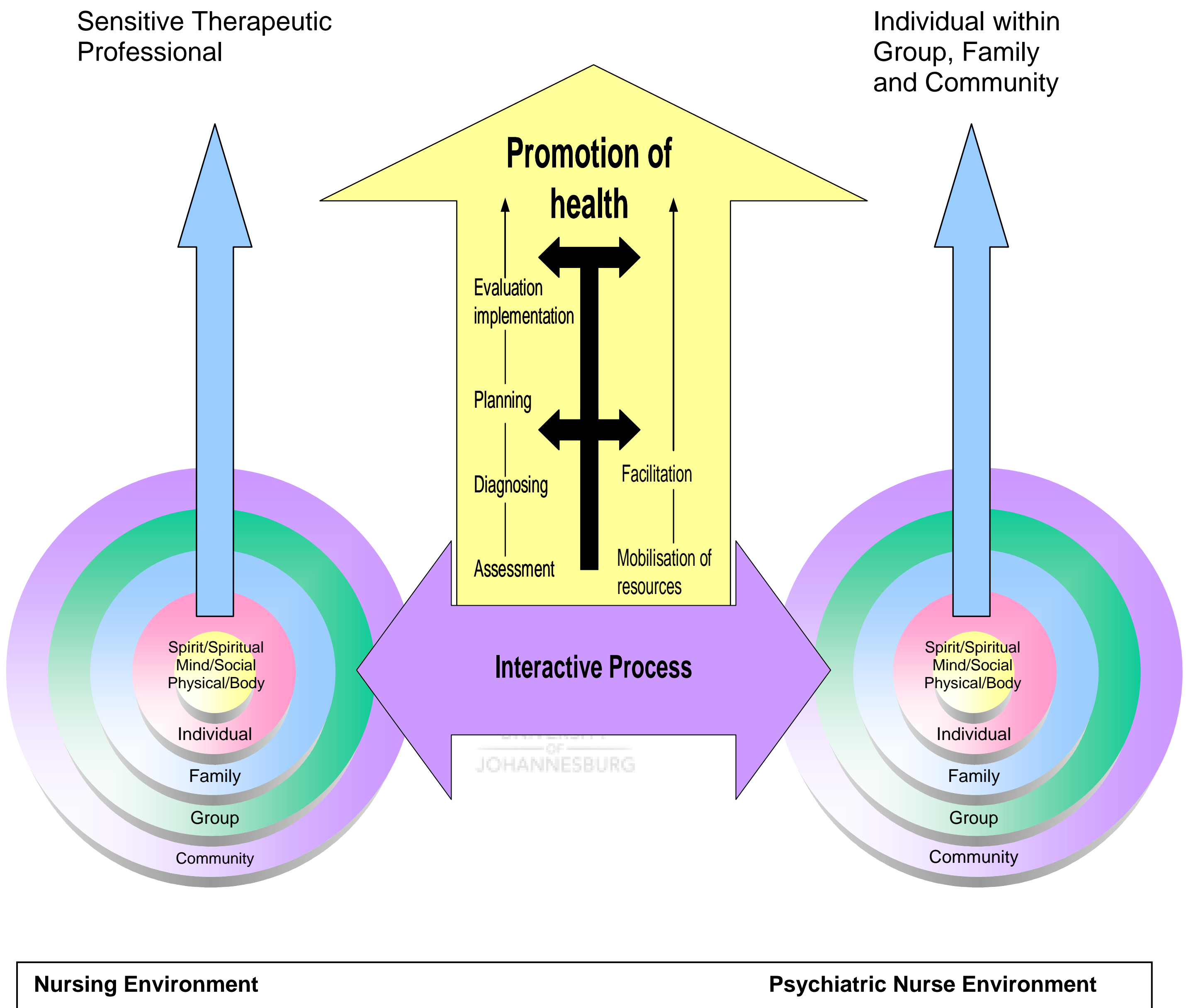
Figure 1.3 THEORY FOR HEALTH PROMOTION IN NURSING



Adapted from Rand Afrikaans University (2001:3)

Within this theory framework, the emphasis is on the health promotion of the individual, their family, the group, and the community.

Therefore, in line with this theoretical framework, the following key concepts were adopted in this research:

1.6.1 Meta-Theoretical Assumptions

Meta-theoretical assumptions have their origin in philosophy. They are not meant to be tested but are merely value convictions, which offer a framework of congruency (Mouton & Marais, 1990: 19-20).

These assumptions were highlighted by Botes (1989: 5) who said a meta-theoretical component does not make any epistemic judgement but directs thoughts and actions and thus the underlying rationale why there is a specific way of thinking and doing. Although the assumptions are not epistemic pronouncements, they do influence the research decisions throughout the study.

The theoretical component makes epistemic judgements and these were generated by this research.

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In this research, the word, person, referred to all the mental health care practitioners who are the psychiatric nurses, social workers, occupational therapists, physiotherapists, psychiatrists, medical practitioners, and colleagues employed by the company in all the psychiatric care facilities. Each of these is a multidimensional person with mind, body and spirit and functions holistically whilst interacting with the environment (Rand Afrikaans University, 2001: 5). For practical purposes the focus will be on psychiatric nurses in this research.

The environment includes an internal and external environment. The internal environment of the psychiatric nurses includes the three dimensions, namely the body, mind and spirit (Rand Afrikaans University, 2001: 5).

The first dimension is the body**.** This includes the anatomical structures and the physiological functions. These structures and functions are compromised by the demands from their external environment.

Emotionally disturbed persons require the services of psychiatric nurses all the time. Equally demanding are their families as these psychiatric nurses are removed from their families to be with the patients (Rand Afrikaans University, 2001: 6).

The second dimension, which is the mind, includes emotions, volition and intellect. Emotions refer to affective desire and feeling. Volition is the ability to make decisions. Intellect is the capacity and the quality of the psychological processes of thinking, judgement, being able to associate and to be analytical and to understand and this demonstrates the capacity of an individual (Rand Afrikaans University, 2001: 6).

Psychiatric nurses need a healthy mind and a healthy body to make a judgement call pertaining to the patients and personal issues. Because the psychiatric nurses are a whole, their mind will be influenced by their body and spirit and vice versa (Poggenpoel, 1994: 8). Although psychiatric nurses have received training in handling challenging issues they still need support for professional growth so that they can function independently. They also need to interact professionally with fellow members of the multidisciplinary team and their colleagues.

The third dimension is the spirit, which is the relationship that psychiatric nurses have with God. Spirit has two interrelated components, namely the conscience and relationships which have an integrated function (Rand Afrikaans University, 2001: 6). Psychiatric nurses interact with patients from different religions. The relationship that they formulate with God is therefore important and they can therefore understand the patients' needs in this regard.

This touches on their conscience whilst trying to understand the patients' spiritual aspect. The majority of the psychiatric nurses are believers because the researcher has often observed them starting their day with a prayer and their active involvement in Christian activities whilst at the psychiatric facilities.

For psychiatric nurses to function effectively, they need a healthy body. This will result in a healthy mind and ultimately they will have the capacity to act and think rationally, exercise good judgement and be able to make informed decisions. The psychiatric nurses need to be able to cope in the external environment in which they function.

Psychiatric nurses need to use themselves therapeutically as part of the psychiatric nursing methods and skill, have self knowledge and a sound knowledge based on attitudes, values, philosophies and interpersonal skills required in a therapeutic milieu (Poggenpoel, 1985: 2-24). They need to be able to interact positively and to remain professional when interacting with fellow colleagues.

The external environment consists of the three dimensions namely; physical, social and spiritual dimensions (Rand Afrikaans University, 200l: 6).

The first dimension in the external environment is the physical dimension which refers to the physical and chemical structures and this includes aspects such as the availability of resources, which can facilitate and influence psychiatric nurses to be effective in taking full responsibility and professional accountability in looking after the psychiatric patients. The availability of the resources and the quality of these resources inside and outside the psychiatric facilities can influence whether psychiatric nurses are able to take full responsibility for the patients in their care.

The second dimension is the social dimension which refers to the human resources in the external environment of the individual (Rand Afrikaans University, 2001: 7). In the case of psychiatric nurses, it refers to their colleagues, management in their therapeutic milieu as well as the patients in the psychiatric facility.

Psychiatric nurses interact with these individuals, for example; the psychiatric nurse is a parent biologically and socially. They are in a profession that still need to be recognised by other mental health care professionals who still believe that psychiatric nurses have to take orders from them. This may have implications on their feelings of self-worth and self-esteem.

The third dimension is the spiritual dimension which refers to norms, beliefs, values and religious aspects in the external environment of psychiatric nurses and includes the relationship these nurses have with their fellowmen. This can indicate whether they feel supported or not.

The next step is to deal with the theoretical assumptions as it is this aspect that would be guiding this research.

1.6.2 Theoretical Assumptions

The Theory for Health Promotion in Nursing (Rand Afrikaans University, 2001) was utilised to guide this research.

A psychiatric nurse within the Theory for Health Promotion in Nursing (Rand Afrikaans University, 2001: 4) assumes that the psychiatric nurse functions within the nursing environment as a bio-psycho-social being with mind, body and spirit and is constantly interacting holistically in their quest for wholeness. Psychiatric nurses are also members of a family unit which is part of the society. These psychiatric nurses' biological family needs are as important as the biological needs of the patients with whom they are interacting to promote their mental health. These psychiatric nurses are also members of the community that is, the psychiatric facility in which they function. Whilst in this community they mobilise the resources at their disposal utilising the nursing process for mental health promotion. Psychiatric nursing is part of nursing and it is seen as an interactive process which facilitates the promotion of mental health (Rand Afrikaans University, 2001: 4).

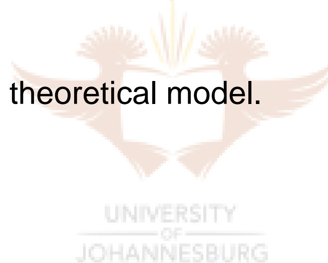
Advanced psychiatric nursing is an area of specialisation in the practice of psychiatric nursing. The main activities in this area of specialisation involve promotion, maintenance and restoration of mental health and prevention of mental illness in a person. The psychiatric nursing specialist therefore engages in these activities by adopting the various roles of a competent practitioner, researcher, educator and consultant (Tshotsho, 1998: 8).

The researcher is a psychiatric nursing specialist whose main activities in psychiatric services is the promotion, maintenance and restoration of mental health of psychiatric patients by involving psychiatric nurses to render such services.

The researcher is sensitive to needs of the psychiatric nurses, and understands the pressure that psychiatric nurses have because of responsibilities that may affect their mental health and therefore realises that there is a need to facilitate the promotion of their mental health.

Mental health is viewed as an integral part of health, which is a dynamic process in the psychiatric nurses' environment. The interactions in the psychiatric nurses' environment reflect their relative mental health status. This interaction contributes or interferes with the promotion of their mental health and whether they can take full responsibility for the patients entrusted in their care. The promotion of mental health implicates the mobilisation of resources (Rand Afrikaans University, 2001:5).

The next step to follow is the theoretical model.



1.6.3 Theoretical Model

The researcher's approach to this research was that of open-mindedness and applied "intuition and bracketing" techniques. A literature review was executed only after the analysis of data to avoid any influence during theory formation. It was only then that the researcher contextualised the results within the principles of Theory for Health Promotion in Nursing.

The key concepts utilised in this research are now defined below.

1.6.4 Definition of Concepts Used In This Research

Quest is defined as in search of something or an act of seeking (Readers Digest Complete Wordfinder, 1993: 1251).

Emotional maturity: Holmer (1993: 3) defined the word **emotional** and says it is a challenge as any real or perceived threat to an individual's security or self-concept that stimulates their instinctive self-protective tendencies to withdrawal or aggression. **Maturity** is when the individual has the capacity for skilful responses to emotional challenges and has the ability to neutralise instinctive or habitual self-proactive tendencies to denial, defensiveness, or withdrawal that may be involved in generating such responses (Holmer, 1993:3). Therefore **emotional maturity** is a developed or skilful response to an emotional challenge in which the individual recognises and engages directly with the challenge, consciously choosing behavioural responses rather than reacting out of instinct or habit (Holmer, 1993: 3).

Psychiatric nurse is a sensitive therapeutic professional who demonstrates knowledge, skills and values to facilitate the promotion of mental health (Rand Afrikaans University, 2001: 7).

Mobilisation of resources is a mutual, purposeful activity between nurses and patients where opportunities for the promotion of health are utilised. It also includes the identification and bridging of obstacles in the promotion of mental health (Rand Afrikaans University, 2001: 7).

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Facilitation is a dynamic, interactive process for the promotion of mental health through the creation of a positive environment, mobilisation of resources as well as the identification and bridging of obstacles in the promotion of mental health (Rand Afrikaans University, 2001: 7).

Mental health refers to the ability of people, couples, families, and the communities to respond adaptively to external stressors (Antai-Otong, 1995: 120). Mental health is viewed as an integral part of health, which is a dynamic process in the psychiatric nurses' environment. These interactions in the psychiatric nurses' environment reflect their relative mental health status. This interaction contributes or interferes with the promotion of their mental health (Adapted – Rand Afrikaans University, 2001: 5).

Health promotion is the science and art of helping people change their lifestyle to move toward a state of optimal health. Optimal health is defined as a balance of

physical, emotional, social, spiritual and intellectual health (Karch, 2000: 3-5). Health promotion includes the promotion, maintenance and restoration of health and is aimed at the facilitation of an individual, family, group and community's mobilisation of resources (Rand Afrikaans University, 2001: 5).

Having defined the main concepts, the next step was to describe the methodological assumptions that governed this research.

1.6.5 Methodological Assumptions

A psychiatric facility is a dynamic therapeutic milieu and it is part of a larger structure that promotes the psycho-social rehabilitation of the psychiatric patients. Its principles are based on the quest to facilitate psycho-social rehabilitation and it is unique in its approach towards psychiatric care. As a result, the researcher could utilise the outcome of this research to facilitate policy- and decision-making on how psychiatric nurses could be mobilised and utilised to facilitate a sustainable psycho-social rehabilitation of psychiatric patients in the company. The result of this research was used to develop a model that would facilitate the mental health promotion of psychiatric nurses, whilst caring for psychiatric patients and develop them into autonomous independent practitioners, who are able to interact positively with fellow colleagues and management. The model would offer a framework that would clearly demonstrate a clear relationship between the three orders of nursing, which are:

- Nursing research
- Nursing education
- Nursing practice

The researcher would like to see her research work being applied in practice in these three areas.

The next step was to describe the research design and method that was adopted in this research.

1.7 RESEARCH DESIGN AND METHOD

In this research, a theory generative design was adopted. This design is qualitative, exploratory, descriptive and contextual in nature (Merriam, 1991:19). Such a design will try to assist the researcher in understanding the phenomenon under investigation, that is, the experiences of psychiatric nurses whilst being employed by the company to care for psychiatric patients. A full description will be done in Chapter Two.

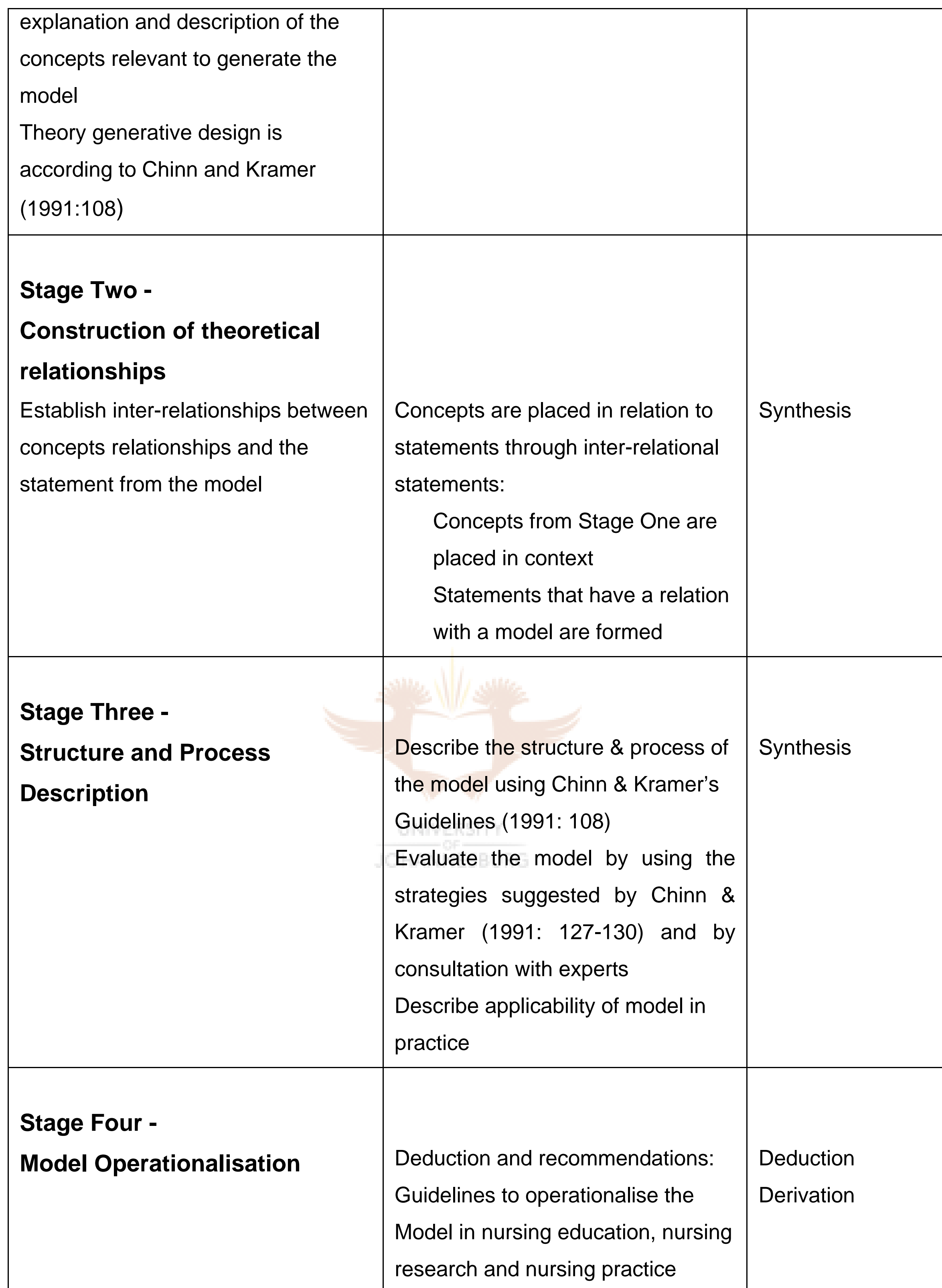
What follows is the research plan.

1.8 RESEARCH PLAN

The researcher followed the research plan that incorporate theory generative stages and made use of Chinn and Kramer's method of theory generative design which has been summarised as indicated below (Chinn and Kramer, 1991: 79-105).

Table 1.6 THEORY GENERATIVE DESIGN

Theory Generative Level	Research Methods	Reasoning Strategies
Stage One - Concept Analysis		
1.1 Concept identification	Sampling Technique: Purposive Data Collection Method: In-depth semi-structured interviews Data Analysis Method: Tesch's in Cresswell (1994: 154) Method in conjunction with Giorgi (1985: 10-19)	Induction Analysis Bracketing and Intuition Synthesis
1.2 Concept definition Literature control, selection of concepts, conclusions and recommendations Use two of the three step method to get the dictionary definitions and subject definitions to facilitate the	Use result of research from in-depth interviews to identify themes	Induction, Deductive derivation and induction



explanation and description of the concepts relevant to generate the model Theory generative design is according to Chinn and Kramer (1991:108)		
Stage Two - **Construction of theoretical relationships** Establish inter-relationships between concepts relationships and the statement from the model	Concepts are placed in relation to statements through inter-relational statements: Concepts from Stage One are placed in context Statements that have a relation with a model are formed	Synthesis
Stage Three - **Structure and Process Description**	Describe the structure & process of the model using Chinn & Kramer's Guidelines (1991: 108) Evaluate the model by using the strategies suggested by Chinn & Kramer (1991: 127-130) and by consultation with experts Describe applicability of model in practice	Synthesis
Stage Four - **Model Operationalisation**	Deduction and recommendations: Guidelines to operationalise the Model in nursing education, nursing research and nursing practice	Deduction Derivation

A full description will be provided in Chapter Two

1.9 TRUSTWORTHINESS

Lincoln and Guba (1985: 289-331) outlined strategies of trustworthiness which were utilised to ensure trustworthiness.

The following strategies were followed:

1.9.1 Truth Value:

Credibility was ensured by utilising an independent interviewer and an independent coder. This interviewer had been an expert in the field of psychiatric nursing with psychiatric interpersonal skills.

1.9.2 Applicability:

Transferability was ensured by dense description through the complete description of the methodology.

1.9.3 Dependability:

Consistency was ensured by dependability audit through the external coder of data gathered in this phase.

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1.9.4 Neutrality:

Confirmability was ensured by consensus discussion between the researcher, the independent coder and the research experts.

1.10 ETHICAL CONSIDERATION

The guidelines for nurse researchers as outlined in the Position Statements of the Democratic Nursing Organisation of South Africa (1998: 2-21) were adopted. A full description of this will be given in Chapter Two.

1.11 FEEDBACK

The executives of the company and the participants were given the outcome of the research prior to the finalisation of the research thesis so that trustworthiness of the findings was ensured.

The criteria for ensuring the above research standards will be explained in detail in Chapter Two.

To uphold the standards of qualitative research, this research upheld the standards of trustworthiness which are outlined above.

The application of these criteria will be discussed fully in Chapter Two.

1.12 CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

A conclusion was formulated, limitations were discussed and recommendations were made on the basis of the research findings in relation to nursing research, nursing education and nursing clinical practice.

1.13 CONCLUSION

The main task in this thesis was to acquire a deeper understanding of the experiences of the psychiatric nurses whilst being employed by the company. Chapter One therefore focused on laying the foundation of understanding the rationale for such a research, given the overall background of the company's executives' roles, its management roles and the roles of the psychiatric nurses. This chapter also highlighted the problems that have led to the research being undertaken. It was stated that psychiatric nursing is a specialised area of nursing practice that involves dealing with the psychological distress and suffering of the mentally disordered on a daily basis. Some of the problems that were stated in this chapter were the high staff turnover of psychiatric nurses that is being experienced by this company.

The problems identified are related to the burden that the psychiatric nurses have to bear caring for the psychiatric patients within the company where the research was undertaken. The psychiatric nurses are therefore an essential component for the success of the company in a competitive health environment. At the same time the care of psychiatric patients puts the onus on the psychiatric nurses to deliver quality patient care. These psychiatric nurses have to be in a sound mental health status for them to contribute meaningfully to the growth agenda that the company is envisaging.

The problem statement as indicated in this chapter caused the researcher to decide to explore and describe the experiences that these psychiatric nurses have whilst caring for the psychiatric patients. The results of their experiences were used to formulate a model that would serve as a framework for the psychiatric nursing specialist to facilitate the promotion of mental health amongst these psychiatric nurses.

The next chapter will deal with the research design and method.

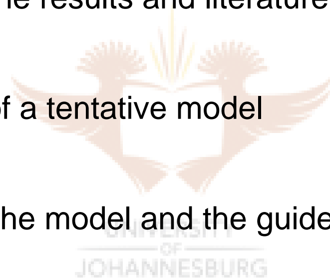
1.14 STRUCTURE OF THE THESIS

Chapter 1 Rationale and background

Chapter 2 Research design and method

Chapter 3 Discussion of the results and literature control

Chapter 4 Development of a tentative model



Chapter 5 Description of the model and the guidelines for implementation

Chapter 6 Justification, evaluation, recommendations and conclusion

CHAPTER TWO

2 RESEARCH DESIGN AND METHOD

2.1 INTRODUCTION

The previous chapter dealt with the overview and rationale and the background of Lifecare and why this research had to be conducted. A problem statement highlighting the reasons why this research was undertaken, was discussed. An explanation that the research would be conducted in four stages, was given, that is, stage one - concept analysis, stage two - formulation of the theoretical relationships, stage three - description of the model and stage four - the operationalisation of the model.

In this chapter the researcher will discuss the rationale for adopting the research design and method. The chapter will also discuss broadly the qualitative, descriptive, exploratory and contextual approach to be used in this research. This chapter will also cover the concept analysis, theory generation, how the model will be structured and the brief description of the guidelines to operationalise the model. Methods of sampling, data gathering and data analysis will be discussed as well. The chapter will conclude with the discussions on how trustworthiness as outlined by Lincoln and Guba (1985: 209-307), will be dealt with.

2.2 PURPOSE OF THE RESEARCH

- The overall purpose of this research was to describe and formulate a model as a framework for the psychiatric nursing specialist to promote the mental health of the psychiatric nurses in psychiatric facilities managed by Lifecare. In order to achieve the abovestated purpose, the researcher had the following objectives:

- To explore and describe the experiences of the psychiatric nurses whilst being employed by Lifecare.

- To use the results to generate the concepts for the model that would serve as a framework for the psychiatric nursing specialist to facilitate the implementation of guidelines that would assist the psychiatric nurses to be in a sound mental state.

- To describe the guidelines that would serve as a framework for operationalising the model in nursing education, psychiatric nursing practice and nursing research.

2.3 RESEARCH DESIGN

The researcher adopted the qualitative theory generative design, which is descriptive, exploratory and contextual in nature.

Theory generative design will now be discussed below.

2.3.1 Theory Generative

The purpose of this research was to describe and formulate a model as a framework for the psychiatric nursing specialist to promote the mental health of the psychiatric nurses in psychiatric facilities managed by the company under study. The process of developing such a model has an element of theorising the exercise, as indicated below.

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2.3.2 Definition of a Theory

Chinn and Kramer (1991: 79) define theory as a systematic abstraction of reality which implies an organisation of words that represent perceptual experiences of objects, properties or events. However Meleis (1991: 12) says theory is an organised, coherent and systematic articulation of a set of statements that are related to significant questions in a discipline, and are communicated in a meaningful whole.

Both Chinn and Kramer (1991: 79) and Meleis (1991: 12) are implying that, at the end, there is a product which demonstrates a creative structuring of the idea that projects a tentative view of a phenomenon. This research was about generating a model that would symbolise a representation of an empirical experience. Chinn and

Kramer (1991: 72-75) say, seeing that it is a representation, not of a thing, it is a form of theory and its description just like theory development it must follow logical reasoning. Therefore the reasoning strategies adopted in generating the model were analysis, synthesis, derivation, inductive reasoning and deductive reasoning. These strategies are outlined below.

2.3.3 Analysis

According to Walker and Avant (1995: 28) this type of reasoning engages in activities of dissecting, that is breaking down, and the reduction of a complex whole into component parts for the purpose of clarifying, refining, and mostly better understanding, followed by sharpening of concepts, statements or theories, and then examining the relationship of each of the parts to each other and to the whole.

In this research, the strategy of analysis was used in data analysis for the purpose of identification of concepts and searching for relationships between statements which formed the basis for the development of the model for facilitating the promotion of mental health of the psychiatric nurses.

The researcher applied the steps of concept analysis according to Walker and Avant (1995: 39) as follows:

- Selection of a concept

  This was done in such a way as to avoid the broad terms that might confuse the analysis.
- Determination of the aims and purpose of the analysis

  This helped to focus attention on what the researcher intended to gain from the results.
- Identification of use of the term, to be found in the dictionaries and literature.

  This was used to clarify the definition of the terms used.
- Determination of defining attributes

  From a list of provisional criteria, a decision was made regarding which of those would be most useful in relation to the aims of the analysis.

- Development of a model case

  This was a pure case example of concept, with no attributes of any other concept.

2.3.4 Synthesis

The strategy of synthesis involved merging, joining together, and combining seemingly isolated pieces of information together in a new light. This was useful in theory building in that it helped to construct a new concept, a new statement or even a new theory (Walker and Avant, 1995: 28-29).

In this research, synthesis alternated with analysis when used during data analysis so as to aid in arriving at the conclusion and recommendations based on the findings from the field work and the exploration and description of the concepts relevant to the model for facilitating the promotion of the mental health of the psychiatric nurses.

2.3.5 Derivation

Walker and Avant (1995: 29) stated that the strategy of derivation requires the researcher firstly to conduct an intensive literature review on the topic of interest. These authors say this is mostly applied to areas in which no theory base exists or to modernise an old theory. However in this research the procedure for conducting concept derivation adopted the suggestion by Walker and Avant (1995: 70) as follows:

- At the end of the fieldwork, the researcher conducted an intensive literature review control to familiarise herself with the existing literature on the topic that facilitated the promotion of the mental health of psychiatric nurses within their profession.
- Other fields were researched for new ways of looking at the topic for promoting these psychiatric nurses' mental health in order to deal with challenges facing the psychiatric nurses as stated earlier in the problem statement.

2.3.6 Induction

Streubert and Carpenter (1995: 316) describe induction as a form of logical reasoning that involves making a conclusion through a process of moving from specific observation to generalisation. However Mouton and Marais (1990: 103) say that in induction, the researcher enters into the field without a clear conceptual framework. After the data has been generated, relationships or patterns are formed resulting in a systematic explanation or a conceptual framework.

In this research inductive reasoning was used to obtain and analyse data from the interviews and field notes. This was through the interviews conducted with the psychiatric nurses on their in-depth description of their experiences whilst being employed by the company. Data collected were used to generate concepts that would be used as a framework for the model.

2.3.7 Deduction

Chinn and Kramer (1991: 63) say deductive reasoning is a system of reasoning in which propositions are interrelated in a consistent way, whilst Streubert and Carpenter (1995: 61) mentioned that in deductive reasoning two or more premises are used to draw a conclusion. Chinn and Kramer (1991: 63) reason that this type of reasoning allows the researcher to use an abstract theoretical relationship to derive a specific question or a hypothesis. However Mouton and Marais (1990: 112) say that in a deductive reasoning, true premises does not necessarily lead to true conclusions. That is why Bandman and Bandman (1988: 187) said that the truth of the conclusion is already either implicitly or explicitly contained in the truth of the premises.

In this research, deductive reasoning was therefore useful in the following instances:

- when doing literature control
- in the conclusion and recommendations drawn from the data analysis
- in the development of the model once constructs have been identified
- in the development of the guidelines for the implementation of the model

This research was therefore conducted with the aim of generating a model that would serve as a framework for the psychiatric nursing specialist to facilitate the promotion of the mental health of the psychiatric nurses.

Walker and Avant (1995: 26) came up with four stages of theorising namely; description, explanation, prediction, and control. These are comparable to the theory development of Dickoff et al (1968: 431- 434) and are:

Level One Factor Isolating
Level Two Factor Relating
Level Three Situation Relating
Level Four Situation Producing

Table 2.1 illustrates the comparability of Dickoff et al (1968: 431-434) and Chinn and Kramer (1991: 79 -104) and how it was applied in this research.

Table 2.1 A COMBINATION OF STAGES OF THEORY GENERATION BY CHINN AND KRAMER (1991: 79-104) AND DICKOFF et al (1968: 431-434)

Chinn and Kramer	Dickoff, James and Wiedenbach	Stages used in this Research
First Level: • Creating conceptual meaning • Identification and definition of concepts	**Factor isolating theory or naming theory** • Conceptual ideas – descriptive in nature	**Concept analysis**: • Identify concepts and define them
Second Level: • The meaning created is structured and conceptualised • Multiple concepts are linked in a loose structure.	**Factor relating theory depicting situation** • Concept are no longer in isolation • Higher level of complexity	**Theoretical relationships are constructed**
Third Level: Generation of theoretic relations and the testing thereof: • empirical and grounding • emerging relationships • empiric indicators • validating relationships	**Situation relating theory**. • Prediction of theory with the aim of allowing the prediction of relationships between situations that are predictable.	**Prediction of relationships:** • Description of structure and process
Fourth Level: • Deliberate application of theory in clinical setting • Outcome variable is determined for practice method of study is implemented	**Situation producing theory:** • prescriptive in nature • goal content specified as aim of activity • prescriptions for activity to realise goal content • survey list as supplement	**Description of guidelines for operationalising the model**

The application of Table 2.1 above will be used in the generation of a model that will be described in this research.

2.4. THEORY GENERATIVE DESIGN

The researcher adopted a theory generative design. Theory generative design in itself is qualitative and it is descriptive, exploratory and contextual in nature.
These are discussed below.

2.4.1. Qualitative

The qualitative method was employed because the researcher sought to describe and interpret the subjective, meaningful world of people and in this case it was that of the psychiatric nurses (Muller, 1993: 19). Mouton (1986: 2) stated that the aim of qualitative research is not to explain human behaviour in terms of universally valid laws or generalizations, but rather to understand and interpret the meanings and intentions that underlie everyday human action.

In a qualitative approach, the researcher obtained an explanation of what experiences psychiatric nurses had in the company. Qualitative results provided the researcher with the critical information for addressing the problems being experienced (Morse, 1994: 28-29).

The reasons behind adopting the qualitative approach were because it was concerned with processes rather than outcomes. It is about how these psychiatric nurses make sense of their lives and how they structure their social world.

The researcher described the descriptive, exploratory and contextual as follows:

2.4.1.1. Descriptive

The researcher was more interested in the in-depth description of the lived experiences of the psychiatric nurses. The lived experiences of the psychiatric nurses enabled the researcher to describe the followings at several levels as part of this research:

- The experiences of the psychiatric nurses and how it affected them whilst working in nursing units

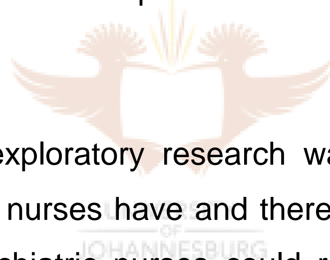
- The relationships of the identified concepts

- A model that served as a framework for the psychiatric nursing specialist to facilitate the promotion of the mental health of psychiatric nurses

- The guidelines for operationalising the model in practice

2.4.1.2 Exploratory

The researcher's intention was to explore the psychiatric nurses' inner world of their experiences of the company and to ascertain the meanings that are engendered by such encounters. This involves the exploration of a relatively unknown research area (Cresswell, 1994: 60).



The rationale behind this exploratory research was to gain new insights into the experiences that psychiatric nurses have and thereafter form the basis of what state of mental health these psychiatric nurses could reach, and what model would be suitable to be developed to facilitate the promotion of their mental health.

2.4.1.3. Contextual

This research was contextual in that it focused on the psychiatric nurses working in psychiatric facilities in a company in the Gauteng Province. Moloto (1999: 41) stated that, what make the research contextual are the situations, instances, and life events or lived through experiences, with particular meanings that are known to people in their specific environment under study. The context would be used to emphasise that which is unique or regarding viewpoints on the company and how it is being experienced and understood in this company and what impact these experiences have on service delivery. The context would thus be unique (Morse, 1994: 106). This approach is used to emphasise that which is unique to this specific company within the psychiatric facilities in the Gauteng Province.

What follows is the description of the research method.

2.5. RESEARCH METHOD

The overall purpose of this research was to generate and describe a model that would serve as a framework for the psychiatric nursing specialist to promote the mental health of psychiatric nurses by facilitating the implementation of the model that would achieve this goal whilst they are employed by the company.

For the researcher to develop such a model it was imperative to understand what these psychiatric nurses were experiencing whilst being employed by this company. The focus was on the psychiatric nurses and what their experiences were whilst interacting with management, members of the multidisciplinary team and colleagues whilst caring for psychiatric patients, which is the function of this company's business. This research followed the strategy of theory generation using the following steps: concept analysis, construction of theoretical relationships, structure and process description, and the model operationalisation. These steps for theory generation are described below.

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2.5.1 Stage One - Concept Analysis

The concepts that would be used for the generation of the model were identified from the results obtained following the interviews. These were incorporated from the population, sampling, data collection, the role of the independent interviewer and the researcher, field notes kept, data analysis, ethical rigor, literature control, and methods used to ensure trustworthiness.

2.5.1.1 Population

The participants were drawn from the eight (8) psychiatric facilities managed by this specific company in the Gauteng Province. Participants selected met the criteria for inclusion in this research as described earlier. The participants were selected through an open invitation by the area senior nursing services managers on the basis that

these participants might be able to verbalise their experiences and concerns without feeling intimidated by the independent interviewer. These senior nursing service managers were not directly linked to the day-to-day management in these facilities.

2.5.1.2 Sampling method

The researcher adopted purposive sampling which is based on the assumption that the researcher wanted to discover, understand and gain insight, so that the researcher can learn the most (Merriam, 1991: 48). Silverman (2000: 104) states that choosing a sample allows one to select participants because they pose a feature or process in which the researcher is interested and that they meet the sampling criteria for inclusion.

The logic and power of purposive sampling lies in selecting rich information cases from which one can learn a great deal about issues that are important to the purpose of the research (Patton, 1990:169). It became important for the researcher to determine the sampling criteria before approaching the participants. This was one of the essential characteristics from the list that qualified participants for selection in the research (Burns and Grove, 1993: 246). The researcher approached the area senior nursing managers with this in mind as they were tasked to assist the independent interviewer in determining whether the participants she invited and who were willing to take part in the research, met the criteria outlined below.

2.5.1.3 ***Sampling criteria***

Participants who would be selected were based on the criteria as outlined below:

- They had to be registered as registered psychiatric nurses with the South African Nursing Council.
- They had to be employed by the company and had to be in permanent positions in a psychiatric facility. The company appoint their nurses as permanent staff after their completing the six months' probation period.
- Psychiatric nurses in the ranks of professional nurse, senior professional nurse and chief professional nurse qualified to participate in this research. These

nurses were directly involved with the day-to-day clinical care of the psychiatric patients.

- They had to be able to communicate in English. The understanding of the language by the independent interviewer and participants is very important in studies that are descriptive.

2.5.1.4 Sample size

The size of the sample was determined by the saturation of data. Morse (1994: 147-149) defines data saturation as data that is adequate and operationalised when collecting data until no new information is obtained. The repetition of themes or information is an indication that data is now saturated (Streubert and Carpenter, 1995: 44). In-depth phenomenological interviews are not about the numbers of participants, but about the inner world experiences as described by the participants.

The area senior nursing services managers at the selected facilities assisted the independent interviewer by arranging the preparatory sessions in order to invite those participants who wished to engage in the research and who met the criteria as outlined. Thereafter the participants met individually and voluntarily with the independent interviewer at the place arranged for the interviews. In this research, the participants were interviewed until no new information came forth.

2.5.1.5 Data collection

The phenomenological approach to research is a systematic investigation of a phenomenon. The goal of phenomenology is to describe a particular phenomenon as a lived experience (Streubert and Carpenter, 1995: 30-36). All forms of in-depth interviews were therefore used as modes of theory building. The main method of data collection was therefore in-depth phenomenological interviews with the participants. This was done in order for them to describe their inner world views with regard to their experiences whilst being employed by the company. Data collected during field work were also used to supplement data already collected. In this research, the phenomenon under investigation was the lived experiences of psychiatric nurses whilst being employed by the company to care for chronic psychiatric patients.

Therefore building the theory from exploring and describing their lived experiences was very important for this research. The interviews were conducted in private during the working time as arranged with management. The place of interview was easily accessible for the participants to attend. The interviews were conducted in English and were audio-taped in order to capture the rich points as described by the participants. As discussed earlier (see section on ethical rigor for details) in this research the audio tape would only be accessible to the independent interviewer and the independent coder. This was explained to the participants so that they could feel free to describe their experiences. All participants were asked the same open-ended question at the beginning, thereafter utilising the interview techniques employed to get more information until data was saturated. The research question asked was: "What are your experiences whilst being employed by this company?" In phenomenological research the use of an open-ended question is crucial because the researcher seeks to understand the experience as it is being described as having been experienced and the manner in which this experience is presented (Streubert and Carpenter, 1995: 35).

To avoid coercion, as the researcher is in the executive management team of the company, the independent interviewer who is a doctorally prepared expert in qualitative research was brought in to do fieldwork. The independent interviewer was also not employed by the company. Discussions were held with the independent interviewer on what was expected of her in this research. The role as discussed with the independent interviewer is outlined below.

2.5.1.6 The role of the independent interviewer in this research

The role of the interviewer in this research was to establish rapport, and to act as the data collector and to listen to the participants as they described their lived experiences (Streubert and Carpenter, 1995: 37). It was also important to keep a close observation during interviews so that the independent interviewer could describe her observations as to what transpired during the interviews apart from the audio-taped information. The interviewer had to ensure that the participants understood the question posed to them, and to utilise the interviewing techniques to get further information. It was also important that the interviewer assisted the

participants to stay within the research question so as to be able to describe their experiences fully.

2.5.1.7 Interviews and qualitative research

The proponents of qualitative research methodology advocate the use of an informal, unstructured or semi-structured interview that is flexible and dynamic. Such interviews are mainly open-ended, in-depth and qualitative by nature, and typically employ a set of themes or topics in the course of conversation (Schurink, 1989a: 5; Abdellah and Levine, 1979: 339).

The researcher's intention was to utilise the interview method as outlined in Muller (1993: 25). Muller (1993: 25) says by in-depth interviewing we mean face-to-face encounters between the researcher and informants (participants), directed towards understanding informants' perspectives on their lived experiences, or situations as expressed in their own words. The in-depth interview is modelled after a conversation between equals, rather than a formal question-and-answer exchange. The interviewer, not an interview schedule or protocol, is the research tool.

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Use was made of the techniques of bracketing, that is, detachment from the phenomenon of everyday experience from the context of natural living, while preserving the content as fully as possible and intuiting, that is, a means of investigating the phenomenon, whilst being as free as possible from preconceived expectations. (Omery,1983:51-53). These methods are common to phenomenological interpretation.

2.5.1.8 The interview process

The interviews were conducted in two phases:

Phase 1 was exploratory and phenomenological in that a single central question was posed concerning the nature of the participants' experiences of the company which employs them. The question was phrased as follows: "What are your experiences whilst being employed by this company?"

Phase 2 was more probing for further experiences, based on the data elicited in the first phase. This phase was thus more descriptive in nature and probing was from the perspective of the internal environment as described in Theory for Health Promotion in Nursing (Rand Afrikaans University, Department of Nursing, 2001: 4-8). If Phase 1 did not elicit the participant's inner world experiences in terms of mind, body and spirit, the interviewer probed further to gain those experiences.

Field notes were gathered during the interviews and these were part of the data gathering. The recording of these field notes was as described by Wilson (1985: 382) and is explained below:

- Observational notes are the descriptions of events experienced through the watching and listening by the independent interviewer. They include the who, what, where and how of a situation and contain as little interpretation as possible.

- Theoretical notes are purposeful attempts to derive meaning from the observational notes. The researcher interprets, infers and hypothesizes in order to ultimately build an analytical scheme.

- Methodological notes are instructions to the independent interviewer, critiques of one's tactics, and reminders about approaches that may be fruitful.

- Personal notes are notes about the independent interviewer's own reactions, reflections and experiences which are useful (Wilson, 1985: 382).

All these notes were recorded and put together to become the basis for analysis.

During the interview a range of interpersonal and communication skills was used by the independent interviewer to facilitate the successful course of the interview.

These interpersonal and communication skills are now discussed:

- Open-ended questions are questions which offer the participants a wide range of options as to how and what to respond to, rather than just yes or no answers. Examples of such questions are:

  How did you respond to that situation?

  What makes you say they are not there for you?

- Reflection conveyed to the participants their expressed thoughts and related feelings, and indicated that the interviewer was listening to, and interested in, their internal world experience.

  Examples of such reflections are:

  You sound sad.

  You say you gave a thought to this.

- Active listening is the ability to pay attention to the communicator and to be objective and requires the listener to be accurate in interpreting the information received. The interviewer must guard against being defensive or selective in her listening. This can cause the interviewer to miss the important information that needed to be probed further and can lead to misinterpretation of the information received.

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- In clarification the interviewer attempted to find meaning of a communicated message which she had not clearly understood.

  Example:

  I am not sure if I am understanding you. Can you rephrase it in another way?

  What do you mean by this?

- Validation is used to confirm one's observations and interpretations in order to arrive at mutual understanding.

  Examples are:

  It must be difficult to deal with this situation.

  It is hard to work under such conditions.

- In observation the interviewer used her training and experience to observe and interpret correctly all important matters concerning the interactive process of the interview that is both verbal and non-verbal (content and process).

- Probing is any question used to get more details about an issue under discussion. This is the area where the interviewer had to exercise caution because that might be perceived as invasion of the private environment of the individual.

  Examples of probing are:

  How do you feel now?

  Uh..hum…….

- Conflict may arise during the interview because of increased pressure that is experienced by the participant's personal experiences of the situation. In this instant the interviewer would engage with the conflict in an attempt to resolve it effectively in order to facilitate the resolution of the conflict amicably, in order to continue with the interview.

- The interviewer had to be able to analyse and interpret the information obtained in order to use it to elicit more information. In this instance the interviewer had to bracket the information and use it to facilitate logical thinking.

  Example:

  > *During your discussion about your experiences, I heard you mentioning your kids; I wonder how is this connected?*

- Terminating the interview was done in an effective way as the interviewer was an experienced qualitative researcher and had extensive experience in this regard. (Beck et al, 1988: 250-254; Perko and Kreigh, 1988: 231-240; 250-254).

2.5.1.9 Data analysis

Data analysis was done using the eight steps outlined by Tesch (1990) in Cresswell (1994:154) which are referred to as decontextualisation and contextualisation. The analysis process according to Tesch (1990) in (Cresswell,1994: 154) consists of "taking apart" into smaller pieces and the final goal will be the emergence of a larger consolidated picture.

The researcher applied the following steps in this research:

- The researcher got a sense of the whole picture by reading through the transcript. Information was recorded carefully and systematically as it came to mind.

- The researcher picked one interview document at a time and went through it. As the researcher read through the document she asked herself what was this about. The researcher did not think about the meaning. Thoughts were written down for later reference.

- When the task was completed, all concepts were listed.

- Similar concepts were clustered together, and were arranged as major concepts, unique concepts and left-over concepts.

- The researcher returned to the data. Topics were abbreviated as codes next to the appropriate segment of the text.

- A preliminary organising scheme followed to see whether new categories and codes emerged.

- The researcher then found the most descriptive wording for the concepts and turned them into categories. The categories were reduced by grouping together concepts that related to each other.

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- The researcher then tried to show inter-relationships of these concepts.

- The researcher then made the final decision on the abbreviation for each category and put them into the codes.

- In the end the researcher assembled the data material belonging to each category and preliminary analysis was done according to Tesch (1990) in (Cresswell, 1994: 155).

The researcher also employed the services of an independent coder who is an experienced psychiatric nursing specialist to assist her. Clean transcripts with a protocol to analyse the data were provided to the independent coder. The independent coder analysed the data separately from the researcher. Thereafter they met for consensus discussions.

2.5.1.10 Literature control

Literature control was conducted for the purpose of re-contextualising. Literature control examined trends and similarities in the phenomenon under study and this was conducted in Phase One to support the evidence. This was through the identification of similarities and differences and also the significant unique contributions made in this research with the existing literature relevant to this research. It was also useful to look at implications of the findings in terms of future application (Field and Morse,1985: 106-107).

The results of the research were discussed on the basis of studies related to the subject of this research. A summary of the identified central and associated concepts was highlighted.

2.5.2 Stage One - Developing the Model

Building a theory entails the following elements; concepts, statements and theories (Walker and Avant,1995: 23). In order to articulate a theory, the researcher needed to

go through well-defined theory generative steps according to Chinn and Kramer (1991:106). These included the following elements: identification of the purpose of a theory, analysing, classifying and defining concepts, identifying relationships between concepts, describing the model in terms of structure, process and how the model would be operationalised in practice. These elements are now discussed.

2.5.2.1 Concept identification and definition

Concept is defined as a mental image of a phenomenon. It is an idea or a construct in the mind about a thing or an action (Walker and Avant, 1995: 24). This research was about searching for words that represented which objects, properties or events within the phenomenon that identified the concepts related to the development of a model that would facilitate the promotion of the mental health of the psychiatric nurses as an integral part of their overall health.

Concepts were identified and put into single group of categories. This was followed by further steps in theory building, starting with the identification of the main concept and other related concepts. Chinn and Kramer (1991: 78-79) says the foundation for developing theory is built by creating conceptual meaning and considering all sources of experience related to that concept. The three categories forming the sources of this experience were, word or symbol, the thing itself which could be an object, property or event, and lastly the associated feelings, values, and attitudes.

In order to facilitate the foundational stage of theory building the survey list of Dickoff et al (1968:437) was utilised. This list allocates the following six aspects of activity to certain dimensions, knowledge or other resources relevant to the activity:

- agency (who or what performs the activity)
- recipient (who or what is the recipient of the activity)
- framework (in what context is the activity performed)
- procedure (what is the guiding procedure, technique or protocol of the activity)
- dynamics (what is the energy source for the activity whether chemical, physical, biological, mechanical, or physiological)
- terminus (what is the end point of the activity)

Conceptual meaning was created by describing the phenomenon of patterns of experiences of the psychiatric nurses of the company. The results of the analysis were used to identify, classify and categorise the important themes or factors concerning the phenomenon which created conceptual meaning regarding the reality of psychiatric nurses.

The main concept of facilitating the promotion of mental health of psychiatric nurses within the psychiatric facility was identified. The reason for selecting a concept was to move closer to the goal of developing a model for the psychiatric nursing specialist to facilitate mental health promotion to the psychiatric nurses within the psychiatric facilities managed by the company. The identified main concept and related concepts were based on the research and are defined in the following section:

2.5.2.2 Definition of concepts

The important activity in theory generation is the definition of concepts. Meleis (1991: 203) says this activity helps to delineate sub-concepts and dimensions of the concept, it clarifies ambiguities, and it enhances precision and relates concepts to some empirical referents. The concepts identified in this research were defined in order to create meaning and show their representation of the empirical reality of facilitating the promotion of the mental health of the psychiatric nurses as the integral part of health. In this research concepts were defined using the three-step method described by Wandelt and Stewart (1975: 64-69). The three steps are to:

- write the dictionary definition and the synonyms for each concept
- convey the accepted ways in which they are used
- write a handbook or other source definitions

The definitions adhered to the rules proposed by Copi and Cohen (1994: 192-196) and Kim (1993: 82-83) which are as follows:

- a definition must state the essential attributes of a species
- a definition must not be circular
- a definition must not be too broad or too narrow

- a definition must not be expressed in an ambiguous or a figurative language
- a definition must not be negative when it can be affirmative

The attributes of the major concept were then identified, analysed and synthesised by the researcher to form its definition following the above rules (Copi and Cohen,1994: 192-196; Kim,1993: 82-83).

2.5.3. Stage Two - Construction of Relationship Statement

The relationship within theories creates meaning and imparts understanding. A relationship statement shows the connection of some kind between two or more concepts (Chinn and Kramer,1991: 111). Burns and Grove (1993: 175) say the relational statements are sometimes referred to as propositions and constitute the core of the theory.

2.5.4 Stage Three - Model Description and Evaluation

Chinn and Kramer (1991: 117) say the theoretic components of the model can be defined, described and organised by asking critical questions related to the model, and when the questions are being answered, that is when the understanding of theory begins to form.

The following questions as stated by Chinn and Kramer (1991: 117-135) were utilised to facilitate the description of the model:

- What is the purpose of the model?

  This question explains why the model was generated and reflects the context and situations, to which the model could be applied.

- What are the concepts of the model?

  These are the descriptions of the ideas that are structured and related within the model, which would then be identified and described.

- How are the concepts defined?

The response to this question would clarify the meaning of concepts within the model.

- What is the nature of the relationships?

This demonstrates how concepts are linked together.

- What is the structure of the model?

This would show whether the model had the partial structures or had the basic form.

- On what assumptions does the model build?

This would address the basic truth that underlines theoretical reasoning.

When the model has been fully described utilising the criteria as listed above, it would be critically evaluated further by engaging the experts in theory generation. Critical reflection on how well the model relates to research, education and clinical practice, would be employed.

Questions related to critical reflection according to Chinn and Kramer, (1991: 127-134) are as follows:

- How clear is the model?

  This question seeks to address issues of clarity and consistency.

- How simple is the model?

  This question seeks to address the issue around the number of structural components and relationships within the model. Simplicity implies fewer relational statements, whereas complexity implies numerous relational components within the model.

- How general is the model?

  This is about the scope which is covered by the model. Specificity implies the narrow scope which is covered by the model whereas generality implies a wider scope of the phenomenon.

- How accessible is the model?
  This question addresses the extent to which the concepts within the model are grounded in empirically identifiable phenomena.

- How important is the model?
  This addresses the extent to which the model leads to valued nursing goals in research, nursing education and clinical practice (Chinn and Kramer, 1991: 127-134).

Strauss and Corbin (1990: 160) provided additional criteria of generality and understanding for evaluating the model. Generality is achieved when the data on which the model is based are comprehensive and the interpretations are conceptual and broad. A model is said to be understandable if it is comprehensive enough to make sense to the practitioners in the service and researchers. The model has to be abstract to include sufficient variation to make it applicable to a variety of contexts related to the phenomenon being researched (Strauss and Corbin, 1990:160).

2.5.5 Stage Four - Guidelines for Operationalising the Model

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At this stage, evidence was generated to demonstrate how the clinical setting becomes important for theory development. It is upon this that guidelines for the implementation of the model were developed. Once the model had been developed and critically evaluated, the application of this model in clinical setting becomes important towards theory development. It is at this stage that evidence is generated to demonstrate how the clinical setting is affected by the application of the theory (Chinn and Kramer, 1991: 101).

There are two important reasoning strategies which are inductive and deductive reasoning in theorising. Inductive reasoning is used to make a transition from the empirical level to the theoretical, whilst deductive reasoning is used to move from theoretical level to empirical. These types of reasoning are seen as very important reasoning strategies in theorising (Chinn and Kramer, 1991:99).

Guidelines for application in practical setting were described for the purpose of this research.

What follows is the discussion on how ethical rigors were dealt with in this research.

2.6 ETHICAL RIGOR

In qualitative research, ethical dilemmas are likely to occur during data gathering and during dissemination of findings (Moloto, 1999: 47). Merriam (1991: 178) states that the right to privacy and protection from harm must be ensured. To avoid coercion, as the researcher is in the executive management team, the independent interviewer who is a doctorally prepared expert in qualitative research was brought in to do fieldwork. She was also not employed by the company.

The participants were protected from their rights being violated and ensured that their privacy and dignity would be assured throughout the interviews. Anonymity would be ensured throughout the interviews so that the participants could freely participate and volunteer relevant information (Mouton and Marais, 1990: 22).

It was emphasised to the participants that the independent interviewer would maintain confidentiality and anonymity and that only the experts in research and the independent coder would have access to the audio-taped material. The recorded material would be destroyed after the transcription had been done.

In order to maintain confidentiality, privacy and dignity of the participants, the independent interviewer conducted interviews in private and encouraged the participants to give relevant information and the independent interviewer continuously emphasised that anonymity would be maintained throughout the research.

The independent interviewer made it impossible for anybody to link data with a specific facility, group or individuals. If the participants felt uncomfortable during the research they were informed that they could drop out of the research.

Permission to conduct the study had been sought from the company's Managing Director and the right to reserve the facilities' identity would be maintained.

Individual permission from the participants was sought before starting to conduct the interview (Democratic Nursing Organization of South Africa 1998: 1-7).

Methods of ensuring trustworthiness adopted in this research are described below.

2.7 METHODS TO ENSURE TRUSTWORTHINESS

Lincoln and Guba's (1985: 209-307) model of trustworthiness was utilised to ensure the validity and reliability of this research. They state that according to science, justification in qualitative research regarding the validity and reliability of the research had to be ensured (Lincoln and Guba, 1985: 209-307). This model is used extensively in qualitative research because it is conceptually well developed. (Krefting, 1991: 215).

The four criteria for trustworthiness in terms of truth-value, applicability, consistency and neutrality are described below.

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- Truth-value using strategies of credibility
- Applicability using strategies of transferability
- Consistency using strategies of dependability
- Neutrality using strategies of confirmability.

2.7.1 Truth-value

The criteria that were used to establish the extent to which the findings of this research were a true representation of the world of the research participants as described and experienced by the psychiatric nurses.

The strategy of establishing the truth-value is **credibility.**

The activities involved in achieving credibility are prolonged engagement, varied field experience, reflexive diary, in-depth interviews, triangulation, peer review, and member checking (Lincoln and Guba, 1985: 294-296).

Below is the description of the strategies as applied:

2.7.1.1 Prolonged engagement

The independent interviewer is a doctorally prepared expert in qualitative research. As an expert, her prolonged engagement with the particular participants during the interviews gave her the time to identify recurring patterns, themes and to check the perspectives.

2.7.1.2 In-depth interview

The independent interviewer engaged her skill and knowledge to gain understanding of the psychiatric nurses' inner world experiences. She engaged the participants until data was saturated. This was reflected in the transcripts of the audio recordings that were done following the interviews.

2.7.1.3 Peer review

The discussions held with the independent coder increased the credibility of the independent interviewer's findings. The two promoters are experts in qualitative research and in the development of facilitative models and guidelines, and by engaging them the credibility of this research has been enhanced.

2.7.1.4 Varied field experience

Observations done during field work and time spent yielded the findings. Participants were given time to describe their lived experience.

2.7.1.5 Reflective diary

The independent interviewer kept the reflective diary of her experiences whilst interacting with the participants. Her reflective diary came across as "tell it as experienced" which further increased the credibility of the research. The independent interviewer kept extensive field notes which further increased credibility as they reflected the descriptions of the experiences disclosed by the participants.

2.7.1.6 Triangulation

Other sources of data collection were from the discussions with the members of the multidisciplinary team during the presentation at the workshops.

2.7.1.7 Member checking

Engaging the experts in the field of qualitative research was done during the model presentation at the two doctoral seminars and the evaluation thereof.

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2.7.2 Applicability

This refers to the degree to which the findings can be applied to other settings within the entire company or with other organisations.

Lincoln and Guba (1985: 296-298) refer to the techniques used which involve using a nominated sample with demographic data, time sample and dense descriptions.

The strategy adopted is **transferability**

The techniques applied are discussed below:

2.7.2.1 *Nominated sample with demographic data*

A purposive sample was used where the participants participated voluntarily. The study sample included the registered psychiatric nurses who have been with the

company from eight (8) months up to twenty-three (23) years of service. These psychiatric nurses ranged from professional nurses, senior professional nurses and chief professional nurses. A total of seventeen participants of which five (5) were males and twelve (12) were females participated in the study. They were all Africans from a variety of cultural and ethnic backgrounds. None of them had English as their first language. All were in full-time employment with the company.

2.7.2.2 Dense description of the results

The interview results demonstrated the time spent by the interviewer with the participants. The interviewer used minimal verbal responses to extract more in-depth description of the psychiatric nurses lived experiences.

Statements below are a direct verbatim transcript depicting such engagements with the participants:

Interviewer: *Mm..mm*

Participant: *"….. and when the other departments don't want to do what they are supposed to do, then at the end of the day it's left to the nursing staff to do it. Others don't worry and you are in charge, but others support and protect their staff so it adds heavy on the load of nurses. Like if you want things from the laundry and then they are not there or they just say, we have no clothing and then the matron comes to you why are these patients not dressed, why do they look like this, you say the laundry has not helped, they say, did you go to the laundry. So you must just leave your work and go to the laundry, or the OT department or what, to look for whatever"*

Another verbatim extract from the transcript:

Interviewer: "*So in this way you have been failed"*

Participant: *"……ja, they are not. Because at the end of the day it is left with you, you who are the person in charge of the ward. Ja.., you've got to see how to go about. Then even when the food doesn't come in time, you must be a dietician, you've got to phone the kitchen, and uh, we do a lot of things, for our own life to go on."*

A full description of the results will be discussed in Chapter Three.

2.7.3 Consistency

This refers to the extent to which replication of the research with the same subjects or in a similar setting will yield similar results. The strategy for achieving this criterion is referred to as dependability. The techniques applied here are a dependability audit, giving a dense description of the research methods, stepwise replication, triangulation, peer examinations, and the code-recode procedure (Lincohn and Guba, 1985: 298-299).

The strategy is **dependability**

The techniques for consistency were applied as follows:

2.7.3.1 Dependability audit

Dense description of the research method was done. The engagement of peer examination of the model was also organised. The guidelines were developed and these went through the peer examination. Two doctoral seminar presentations and dialogue with the doctoral committee continued to take place throughout this research.

2.7.3.2 Triangulation

The research employed different data collection methods, such as semi-structured interviews, field notes and observations done by the independent interviewer. Several sources for defining concepts were utilised, for example, the use of the dictionaries from different versions and the subject definition of the concepts from the literature reviewed. Throughout this research the researcher engaged the research promoters who are experts in the field of qualitative research.

2.7.3.3 Peer examination

The involvement of the independent coder was used to code the raw data. Peer examination was done during doctoral seminars.

2.7.4 Neutrality

This refers to the degree to which the extent of the study is free from bias. This was achieved by adopting the strategy called confirmability. The techniques applied are audit, triangulation, and reflexivity (Lincoln and Guba,1985: 299-300).

The strategy adopted is **confirmability**

The techniques as applied are discussed below:

2.7.4.1 Confirmability audit

A panel of experts were selected to examine the whole process. Two doctoral seminars were conducted where the committee were involved in the auditing.

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2.7.4.2 Triangulation

Different data gathering methods as described earlier in this chapter were used.

2.7.4.3 Reflexivity

A field journal was kept by the independent interviewer during the interviews for the purpose of reflection. Some of the most general outcomes were those that are reflected in nursing standards of quality care.

The method to ensure trustworthiness has been extensively discussed above.

Table 2.2 below is the summary of the methods to ensure trustworthiness as applied in this research.

Table 2.2 SUMMARY OF THE METHODS TO ENSURE TRUSTWORTHINESS AS APPLIED IN THIS RESEARCH

Criteria to ensure Trustworth-iness	**Strategy**	**Technique**	**Application**
Truth-value	Credibility	Prolonged engagement	The independent interviewer is a doctorally prepared expert in qualitative research. As an expert, her prolonged engagement with the particular participants during the interviews gave her the time to identify recurring patterns, themes and to check the perspectives.
		In-depth interviews	The independent interviewer engaged her skills and knowledge to gain understanding of the participants' inner world experiences. She engaged the participants until data were saturated. This was reflected in the transcript of the audio recordings that were done following the interviews
		Peer review	The discussions held with the independent coder increased the credibility of the independent interviewer's findings. The two promoters are experts in qualitative research and the development of facilitative models and guidelines, and by engaging them the credibility of this research was enhanced.
		Varied Observation	Observations done during field work and time spent yielded the findings. Participants were given time to describe their lived experience.

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Criteria to ensure Trustworth-iness	Strategy	Technique	Application
		Reflective diary	The independent interviewer kept the reflective diary of her experiences whilst interacting with the participants. Her reflective diary came across as “tell it as experienced” which further increased the credibility of the study. The independent interviewer kept extensive field notes which further increased credibility as they reflected the description as experienced by the participants.
		Triangulation	Other sources of data collection were from the discussions with the members of the multidisciplinary team during the presentation at the workshop.
		Member checking	Engaging the experts in the field of qualitative research was done during the model presentation at the doctoral seminar evaluation.
Applicability	Transferability	Dense description	The interview results demonstrated the time spent by the interviewer with the participants. The interviewer used minimal verbal response to extract more in-depth description of the participants’ lived experiences. A complete description of methodology was used.
		Nominated sample	A purposive sample where the participants participated voluntarily was used. The sampling method as discussed, was adhered to.

Criteria to ensure Trustworth-iness	Strategy	Technique	Application
Consistency	Dependability	Dependability audit Triangulation Peer examination	Engagement of peer examination of the model was done Guidelines were developed and went through peer examination. Two doctoral seminar presentations and dialogue with the doctoral committee continued throughout the research. The researcher employed different data collection methods such as the semi-structured interviews conducted by the independent interviewer. Field notes and observations were done by the independent interviewer during the interviews Throughout the research the researcher engaged with the study promoters who are experts in the field of qualitative research. An independent coder to code the raw data was organised. Peer examination was done during doctoral seminars.
Neutrality	Confirmability	Confirmability audit Triangulation Reflexibility	A panel of experts was selected to examine the whole process. Two doctoral seminars where a committee was involved in the auditing were conducted. Different data-gathering methods were used as described in the research. A field journal was kept for the purpose of reflection.

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2.8 CONCLUSION

This chapter broadly discussed the research design which entailed a theory generative design. It was followed with the discussion on the descriptive, exploratory and contextual approach to be used in this research. Research methods such as concept analysis, sampling, and data gathering have been outlined. The manner in which interviews were conducted and data analysis performed have also been discussed. The chapter also covered how the model would be developed. Ethical rigor was discussed and lastly methods of trustworthiness according to Lincoln and Guba (1985: 209-307) were discussed.

The next chapter will discuss the results and the literature control.

CHAPTER THREE

3 DISCUSSION OF RESULTS

3.1 INTRODUCTION

The previous chapter broadly discussed the qualitative research method used in this research. Methods of sampling, data gathering and how data were analysed, were also discussed.

This chapter discusses the results obtained from the analysis of the transcriptions of the participants' inner world experiences of company culture and the meanings that are engendered by such encounters.

This discussion also encompasses the phenomena encountered in operationalising the field research that is, the results themselves, the field notes of the interviewer and the experiences shared with the researcher. Literature control will form part of the discussion.

3.2 OPERATIONALISING THE FIELD RESEARCH

Permission to conduct the research was obtained from the company's Managing Director (Appendix 3). The independent interviewer took time to explain to the participants the purpose of the interviews prior to conducting the interviews and also to seek their permission to conduct the interviews. Verbal permission was obtained from each participant. This was to protect the identity of the participants.

To avoid coercion, as the researcher is in the executive management team in the company, the independent interviewer who is a doctorally prepared expert in qualitative research, was brought in to do fieldwork. She was furthermore not employed by the company. The independent interviewer also reassured the participants that the rights to privacy and protection from harm were ensured and that confidentiality would be maintained and also assured the participants that anonymity would be ensured through the interviews.

It was crucial to this research that the participants' inner world experiences of the company culture, be obtained. All participants who participated in the research did so voluntarily. Interviews were conducted during April to June 2003.

The Gauteng Province was chosen on the basis that it had more psychiatric facilities than other Provinces. There are altogether twelve (12) psychiatric facilities managed by this company of which eight (8) facilities are in the Gauteng Province.

The participants were all registered psychiatric nurses from the rank of professional nurses, senior professional nurses and chief professional nurses who are in the permanent employment of the company's Gauteng Province psychiatric facilities. All participants who participated in the interviews were in the employment of the company and had between eight (8) months and twenty-three (23) years of service. All participants were Africans from a variety of cultural and ethnic backgrounds. There were five (5) males and twelve (12) females who participated in the study. None of them has English as their first language.

The interviews were conducted in English as this was the most accessible language between interviewer and participants. The interviewer was satisfied that all participants were able to relate their experiences in English. It did occur occasionally that the participants had difficulty in adequately expressing themselves verbally. This might have led to a less rich description of their experience.

Interviews were conducted with individual participants until data were saturated. These interviews lasted up to forty-five minutes or more depending on the participants' response to the interview. A total of seventeen (17) interviews were conducted.

3.3 PROCESS OF ANALYSIS

Data analysis was done using the eight steps of decontextualisation and contextualisation outlined by Tesch (1990) in Cresswell (1994:154-155). This process has already been described in Chapter Two.

The researcher commenced with analysis by writing words and phrases representing the participants' internal world of experience of company culture.

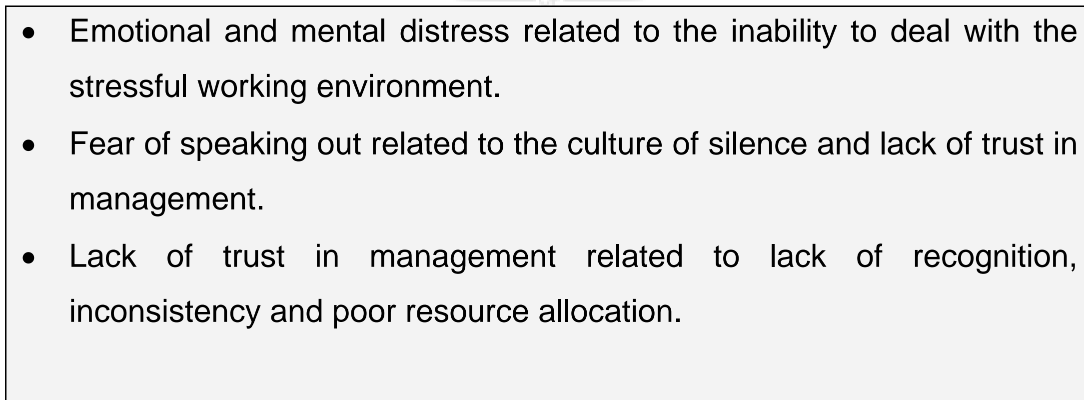
Further sub-categories were developed as the analysis proceeded within the framework of the universal categories. In this way new categories which had not been previously identified, were developed.

Refining the definition of newly developed categories then occurred in order that the criteria of homogeneity, inclusiveness, usefulness, mutual exclusiveness, clarity and specificity would be met.

3.4 FINDINGS FROM THE INTERVIEWS

The following themes (see Table 3.1) were identified by the participants in this company as experiences that hampered their meaningful contribution to total quality patient care and thus affecting their mental health.

Table 3.1 THEMES IDENTIFIED



- Emotional and mental distress related to the inability to deal with the stressful working environment.
- Fear of speaking out related to the culture of silence and lack of trust in management.
- Lack of trust in management related to lack of recognition, inconsistency and poor resource allocation.

Theme One: Emotional and mental distress related to the inability to deal with stressful working environment

Emotional and mental distress was identified as a common theme experienced by the participants. These participants experienced frustration, unhappiness, wanting to run

away, being tearful, absenteeism and high staff turnover as they related their inner world experiences.

Frustration was experienced when they felt that they were on their own, faced with the challenges of caring for difficult psychiatric patients who were dependent on these nurses for their total care in an environment that was not conducive to quality patient care. The following statement supports the participants' experience:

> *"it has deteriorated in a sense that, when I started here you know, management had time to a worker's problem or if there was anything, like a problem that arises during working or interacting with the patients or staff, then they would listen or be objective and be supportive. But up to this stage its you are on your own, you are at fault, you get hammered left, right and centre. You , you actually do not get any support from anyone"*

The statement above depicted the frustration that these nurses were experiencing. In some instances these participants stated that the company had set patient care standards, which the nurses acknowledge, and were aiming to strive for quality patient care; however there were no resources to implement the standards set. Statements like the following support their experience:

> "*…Ok well, I think they,..uh, they have values, they have their mission statement, they have their beliefs. They are beautifully written, you know. You stand there, you feel like implementing them. There are those that are impossible to implement, you know,, you lack the resources. You lack human resources to implement those, you know……….But now lately the buzzword is budget, budget you know , and there are such constraints….."*

This resulted in mental distress because they did not have the support and guidance from management to give them the human and material resources necessary to attain the goal of quality patient care. The following excerpt shows the distress that these participants experience:

> *"……we don't have the means. We don't have human means, human resources. Having shortages, others, even the very material to use onto patients………"*

Unhappiness occurred when these participants did not get the support from management. Instead management blamed them whenever there was a problem.

Statements such as the following support the above:

> *"…..Ja, you know that the people who are your seniors, who are supposed to be supporting you, they just tear you up………. to shreds,…….. you know…."*

> *"it has, definitely,……. it has…, even at the time, what I am trying to say, it was not necessarily that when you got through management, whatever they take, send it over to take action, but they would be there to say let's work together and see how we can make the best out of the situation or whatever. That is gone……."*

Such statements attributed to the unhappiness that was being experienced by these participants whilst interacting with management.

Participants also stated that they often felt tearful and wanted to run away from the situation of being faced with psychiatric patients and having nothing to offer them. The participants said patients relied on them to render quality care, but they felt helpless because of the stressful situation they found themselves in. The following statement below shows these experiences:

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> *" I've been asking myself and lately I'm asking myself every day, why am I here. And then I think, when I think about it, I nearly come to tears. Now, at the end, I always, I always blame myself. I should have got out of this before now. Because now, you've got to consider yourself, how old are you, what extra skill are you bringing for them to say even at this age. But if I can get a job anywhere today I would leave. I would leave today. Even if it's not the same job and salary I am getting. I'm not happy" (* quite tearful).

As a result they found themselves fluctuating between feeling good at one time and the other time feeling uncertain about themselves. An excerpt like this substantiates the participant's experience:

> *" …….If , if you fluctuate between the feeling that you could be good, at other times you are not so certain, you wonder, I don't know………."*

These experiences resulted in a high staff turnover which was attributed to the lack of human resources, absenteeism, sick leave taken by the nursing staff from time to

time, and the nursing positions that were not being filled timeously, thus leaving them overworked. This is manifested in a statement such as:

> "*……..because they are so over worked, some actually don't even feel like coming to work, they just stay absent or just take leave because of stress'"*

Some of the experiences as expressed above could affect their mental health if not adequately addressed.

Another experience was the role ambiguity occurring because of lack of clear consistent information about the activities, which had to be performed or goals that had to be pursued in the environment in which they were functioning.

These participants said that what compounds the mental stress was that they frequently encountered difficulties in making the system work for the patients. For example, when psychiatric nurses had to convince the kitchen to deliver appropriate food for the patients, or for the laundry to supply clean linen and clothing for patients. The statement below describes the experience:

> *"Ja, they are not. Because at the end of the day, it is left with you who are the person in charge of the ward. Ja, you've got to see how to go about. Then, even when the food doesn't come in time, you must be a dietician, you've got to phone the kitchen, and uh, we do a lot of things, for our own life to go on"*

Such routine frustration became overwhelming over time, and whilst striving for quality patient care, management was either absent or blaming them for any problems encountered. This was depicted in such a statement as the following:

> *"…………It's not what you wanted to happen, be there to say this is wrong what has happened is wrong, but you tried this and during your working and now you are so stressed out because of the results. Because you really get stressed out. Just to be there at that point, and not try and point more fingers, and more fingers, and all other stuff that actually makes more stress"*

The participants mentioned that sometimes management harassed them and that management did not treat them with respect, leaving them tearful and wanting to run away. A supporting statement is as follows:

> *" ………then along the line when you need to get this and this and this. Then along the line it's too expensive, and this is the budget. Then at the end of the day you've got to compromise here, and compromise there. Then things go wrong all the fingers point you, you are wrong here, you are wrong there, haai (sighs) And when you think of coming on duty, if you can scream on top of your voice and just I don't know"*

What compounded the mental stress were the roles that they found themselves in. They had to make quick role shifts from working as professional psychiatric nurses in a psychiatric facility and then coming home and playing the role of the wife, parent and housekeeper. These inner world experiences can affect the wellbeing of the psychiatric nurses if not attended to. Psychiatric nurses need to be in a sound mental health state for them to function optimally to care for patients with a mental disability. This was evident in the following statements as these participants express their inner world experiences as follows:

> *'….. it actually affects, it influences how to interact, even, it affects your whole life because when you get home you haven't got time for anybody, you can't even listen to your kids coming with their homework and stuff, ja, I think so"*

another statement is as follows:

> "*……….. ja, I've been here ever since. This is my life but I don't know how long for the future. You know, its really stressful, you know, you feel when you go off, your brain cannot switch off, when you want to take a nap, you just think of the w, w ,w, (referring to the hospital). All the time, just going through your head, the whole situation. When you go off at weekends, come Sunday morning, oh! I'm going back to that tomorrow again'"*

In tying up this section, Sullivan (1953: 591) stated that psychiatric nursing is invariably assumed to be a stressful area of nursing practice. This author further said that the work was demanding and in its essence was an intimate and often intense interaction with a disturbed client group, an interaction that included the confrontation of difficult and challenging behaviours on a regular basis. Sullivan (1953: 591) went

on to say psychiatric nursing was a specialised area of nursing practice that involved dealing with the psychological distress and the suffering of the mentally disordered on a daily basis.

Whilst the psychiatric nurses were faced with such a challenge, they found themselves also having to function in an environment which was stressful and with management that was not supportive. This could compound the frustration experienced by these psychiatric nurses and could affect their mental health.

This was supported by Booyens (1999: 135) who stated that the behaviour of a supervisor who has an authoritarian, punitive and closely controlling style of supervision, creates much stress in a working environment. Booyens (1999:135) further says, chronic work-related stresses include having too much to do in too little time, stress resulting from interpersonal factors, nurses frequently encountering difficulty in making the system work for the patients, for example, trying to persuade the medical practitioner to take the patient's symptoms seriously, trying to get the kitchen to deliver a late tray of food. Such routine frustrations can become rather overwhelming over time.

Sullivan and Decker (1992: 205) added that role ambiguity could also affect the individual especially where there was a lack of clear consistent information on what was expected of the individual. Psychiatric nurses experienced the absence of management to give guidance and support whilst they are working with patients. Such stressors affect the mental health of individuals. Psychiatric nurses need to be in a sound mental health state for them to interact meaningfully with psychiatric patients.

It was also stated by Bailey et al (1987:17) that once persons are exposed to chronic work-related stress factors, they manifest symptoms such as frustration, unhappiness, feeling of insecurity, fearfulness, anger, and anxiety.

This was supported by Minnaar (2001: 39) in the study that was conducted on the view of nurses regarding caring in the workplace. It revealed that nurses felt that they do not work in environments which facilitate support and caring for nurses. Minnaar (2001: 39) also found that the lack of support and reassurance could be particularly

painful for nurses, who were expected to deliver care to patients themselves. The fact that psychiatric nurses did not receive the support made it difficult for them to render quality patient care.

Schaeffer (2002: 43) says autocracy causes pain and arouses antagonism and there is simply no way for managers to escape the resentment and blame that will be directed at them. The statement above is supported by Ibarra (2000: 154) who said managers had to provide support to professionals at the most difficult moments instead of blaming them. Hallowell (1999: 59) came up with the concept of the human moment and that it has two requisites: people's physical presence and their emotional and intellectual attention. This author said, when human moments are few and far between, oversensitivity, self doubt, and even boorishness and abrasive curtness can be observed in the best people. Productive employees will begin to feel lousy and that, in turn, will lead them to under-perform or think of looking elsewhere for work. Hallowell (1999:59) said further the irony was that this kind of alienation in the work place derived not from lack of communication but from a surplus of the wrong kind of managers. Eventually such people make up the majority. The organisational environment turns unfriendly and unforgiving. Good people leave. Those who remain are unhappy. Mental health concerns aside, such conditions are not good for business and indeed, they can be downright corrosive. Employees end up feeling lonely or isolated at work.

Participants interviewed expressed similar factors. In order for them to function at optimal level, they had to be in sound mental state. Hallowell (1999: 60) says employees need human contact in order to survive. They need it to maintain their mental acuity and their emotional wellbeing. What happens to the psychology of the mind when the human moment vanishes or at least fades? In the worst case, paranoia fills the vacuum. More often the human moment is replaced by worry. This results in toxic worry. It is anxiety that immobilises the sufferer and leads to indecision or destructive action. Hallowell (1999: 60) says people feel worn out by the non-human interactions that fill their days. The author described an encounter with his client who said:

"*I feel like I'm going brain dead'*.

The client felt like she was losing her memory. She said that whilst in a meeting with management, words were not coming as quickly as she wanted. She said she felt like as if her head was swallowed by fog. She said she ended up talking and seeing people less and less because of the absence of human moments (Hallowell, 1999: 58-60).

The following statement as expressed by the participant interviewed, was very much similar to the one stated by Hallowell (1999: 59) above, who said people feel worn out by the non-human interactions that fill their days.

> *"…..Ja, you know that the people who are your seniors, who are supposed to be supporting you, they just tear you up………. to shreds,…….. you know…."*

Participants interviewed shared similar experiences as described by this participant above. The environment in which they were interacting appeared not to be promoting such human moments as depicted on the absence of management to support them in times of need.

It was also documented by Buckingham (2005: 74) who said it takes time and effort to gain the full appreciation of employees. This author further said great managers spent a good deal of time outside the office walking around, watching each person's reactions to events, listening and taking mental notes about what each individual was drawn to and what each person struggled with. Buckingham (2005: 75) said there was no substitute for this kind of observation, but you could obtain a lot of information about a person by asking a few simple open-ended questions and listening carefully to the answers given. However, in this research, participants said management never listened to their plight but capitalised on their mistakes and weaknesses and were not available to support these nurses.

In summary, the description of their inner world indicated that these participants were experiencing emotional and mental distress related to the work environment in which they were involved. As a result of these experiences, the nurses' mental health became affected.

Theme Two: Fear of speaking out related to the culture of silence and lack of trust in management

What emerged in this theme was that participants were faced with interpersonal problems with management. The participants stated that they often decide not to speak up because of fear of victimisation.

The following statement depict this:

> *" the problem is that if you tried to speak, I can say, you are not going to end up in the good relationship. They are not going to talk to you any longer and that has happened to many people. I am sure of that"*

The participants stated that the virtues of their silence were reinforced by their survival instincts. These participants said that if they verbalised their feelings they could end up losing their jobs. They said that they had experienced their colleagues who expressed their concerns and were marginalised and made to feel irrelevant. This created fear and anger feelings among the psychiatric nurses. A statement such as this supported their views:

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> *"yes (giggles) Um, you know I think because even the meetings we have, you know, when you try to voice your unhappiness, or dissatisfaction or whatever, you've got this, you know, it is taken negatively. As if they fail to know why are things not done as they should have been done. And then tell them it's because I was alone in the ward, and there was nobody, and they tell you never to tell us that again………"*

Participants also said that the tendency to remain silent rather than express a difference kept them on the safe side. The pressure of silence resulted in suppressing the feeling of anger. Participants said by silencing these nurses, management failed to create a compelling vision, and the company continued with no clear direction. Hence these participants experienced the absence of management. This is supported by the following statement:

> *"Ja, you pick up problems. You can't, you are not democratic, but you can't say what you want because they are in the corridor. Sometimes you want to think, and then you ah, I am going to be treated very badly. You know, sometimes if you want to voice your anger, like for instance,*

just now according to the requirements of a psychiatric nurse, if you are a night shift or a SPN you must have psychiatry"

Participants also described fear as forcing them to be silent. They said that if they began to raise uncomfortable issues of concern and maybe knowing that what they said was factual, they were ridiculed and told that they had to stop being inquisitive. Below is a supporting statement:

"*When I raised that, they got too negative because they said that….what did they say, eh…. It is my inquisitiveness to look into someone's salary because it is confidential"*

It might also be that management also felt uncomfortable expressing their differences with subordinates and thus kept a distance. As a result, these participants said that management did not listen to their problems and this resulted in strained relationships between management and psychiatric nurses. This is depicted in the following statement:

" You know, I think within the first few months I was here, I had a problem with, with the management. They admit it, talk to them to try and resolve the problem, but after talking the problem, there was another problems which cropped up. That time. Others he could not solve them, even most of them we could not solve them"

Every time they kept silent about their experiences, they experienced negative emotions like anger and resentment. When these negative emotions were repressed it resulted in a feeling of disconnection in their relationships, which in turn caused them to become increasingly defensive and self-protective. The following excerpt depicts this:

"Ja, because I was, there was a time where I was not speaking to them at all. Not me, actually I would go to the office, morning, noon, and at that time, they would keep quiet, the others. It was not me at all, actually. Now the problems are many, there is too many. They did not want to talk to us, but it does not mean that I want to stay here for a long time. The, problems like others , I did not get earlier, I would have left the company last year, so you go, and September 11- we could not go. I don't see my future at this company, I would think it will be all right if I don't have this problem here. Ja, most of the people, maybe they should, they wouldn't leave the company if there was no problems of the management "

Once caught up in such a "spiral of silence" it ended up with a high staff turnover, which is what the participants interviewed experienced. The inner world experience of negative emotions if not handled, could result in their mental health being affected. The following excerpt highlights this:

> *"'….. there is a problem of people who are resigning, because we are having a lot of people who are resigning in our institution because of our managers"*

There is also the lack of trust that the participants have experienced. These participants said they did not trust other employees as well, because these employees act as informers for management. They said if you start raising uncomfortable issues of concern they are told that they must stay out of other people's affairs. This was another way of silencing the psychiatric nurses.

The following comment supports this statement:

> *"There is a cross there. There is us, between professional nurses and senior professional nurses. Ja, this one you don't talk. Because if I talk to you, that other one is going to tell. So you always rather keep quiet".*

The literature reviewed provided the supporting evidence. Some of the above experiences have been reported by Perlow and Williams (2003: 52) who said that silence is reinforced by our survival instincts. These authors said many organisations send the message verbally and non-verbally, that falling into line is the safest way for employees to hold on to their jobs and further their careers. The study that they conducted in a corporate environment came up with the findings that silence can exact a high psychological price on individuals, generating feelings of humiliation, pernicious anger, resentment, and if unexpressed, contaminate every interaction, shut down creativity, and undermine productivity. Perlow and Williams (2003: 52) stated that more familiar to many is the pressure to keep silent as a result of differences in rank. How easy it is for the boss to send a powerful signal that a worker should be quiet. As a result many members of the organisations silence themselves before the boss has the slightest inkling of what they're thinking. Basically if you start raising uncomfortable questions and being "holier-than-thou" you may be absolutely right, but you shoot yourself in the foot. It is not just subordinates who feel the pressure to keep

silent, but it is the managers themselves. Managers also feel uncomfortable expressing their differences with subordinates. Even if the employee decides to keep quiet about an issue, that issue does not go away, instead, the individual experiences anger. In an attempt to release these negative feelings, the individual will complain bitterly to peers and others. In this study these experiences were expressed in various ways by the participants.

Perlow and Williams (2003: 53) said that the more the individual represses the feelings, these feelings remained potent and colour the way the individual relates to other people. There was also an experience of disconnection in the psychiatric nurses' relationships which, in turn, caused them to become increasingly self-protective. Every time these psychiatric nurses kept silent they experienced negative emotions like anger, anxiety, and resentment.

Many nurses interpret the need to maintain control over their emotions to mean that they should be void of emotions. While the lack of emotional display in the presence of embarrassing situations assist nurses in managing such situations, a total lack of emotions prevents nurses from establishing interpersonal contact with other people. In the interviews conducted, the participants described their inner world experiences resembling the similar experiences of being silent and they ended up being angry with management and themselves. Rather than deny that emotional responses are present, it is better for nurses to be aware of and reflect on such reactions. Nurses who keep in tune with their emotional responses have a greater chance of maintaining control than those who try to deny the presence of emotional response. By revealing their emotions these nurses might minimize the risk of blaming the person for what is probably an interactive phenomenon (Stein-Parbury, 1993: 27).

It was documented that the troubled employees' decline generally does not stem from a single factor; it results from an accumulation of decisions, actions, and commitments that became entangled in self-perpetuating workplace dynamics. Secrecy, blame, isolation, avoidance, lack of respect, and feelings of helplessness create a culture that makes an already bad situation worse. Once the employees are caught up in this spiral, it is hard to simply stop and reverse the direction.

The dynamics boil down to the managers beginning to point fingers and deriding colleagues in another part of the company, in this instance the psychiatric nurses. The resulting tensions curtailed collaboration and degenerated quickly into turf protection. Increasing levels of isolation engender secrecy. The employees find themselves less and less able to render their services as required, and eventually they came to believe that they were helpless. Passivity sets in. Finally the ultimate pathology of troubled employees takes hold of collective denial, and they enter into a collective pretence to ignore what they individually know (Kanter, 2003: 60-61).

What has been documented by Kanter (2003: 60-61) above is no different from what the participants stated as their experiences.

Based on what is stated above it is therefore important to address the mental health of the psychiatric nurses so that they can function optimally, because by being silent they might be withholding important information from colleagues and management that could enhance the quality of their work and that of the company.

Theme Three: Lack of trust in management related to lack of recognition, inconsistency and poor resource allocation

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Participants interviewed stated that they did not trust management. These participants said that managers did not uphold what they said they would do and that the psychiatric nurses were not allowed to make decisions on how to manage their wards. Managers did not "allow them" to make mistakes. Instead the psychiatric nurses were ridiculed and were criticized about whatever mistakes they have committed.

The following excerpt justifies this:

> *"……… Then I believe nursing managers they do interfere in the wards. Their professional nurses are not autonomous. You know, you have autonomy. They as professionals are not allowed to make their own decisions, even a little thing, you have to be checked. Then the difficult is professionals are not working as professionals they cannot decide anything for example in our institution, we have a duty schedule as a professional nurse. I have to do off duties, and adhere to all the principles of duty, duties, balance it the way it should balance.*

Then you take the off duties to the office for approval, they have to approve. But sometimes the off duties would come back to the wards after a long time with everything's being changed. When you are trying to check what off duties is changed, it is still the same thing – she doesn't like me work Monday,………if you do query that, then you could do something then give to me to do"……

Another statement is as follows:

" The office does not trust the professional nurses"

Participants said that psychiatric nurses ended up being afraid to make mistakes, because they could land in trouble. The participants said they did not trust the managers to support them when a mistake had been committed. As a result these participants felt that as psychiatric nurses their mental health was affected because they were constantly preoccupied and fearful to commit mistakes whilst executing their activities. This is seen in the following statement:

"This company there are many disciplinary hearings are necessary because there are people saying always giving their seniors problems so she has taken them for disciplinary hearing. Ja, most of them are not really reasons to take them for a hearing, but the chances of those reasons, even if you would come with a tangible reasons, as in that hearing you are going to be punished. There is no way you can without……one can say this, they are given a penalty or advice to penalise that person in this way by the management"

Another reason for the lack of trust in management is that the participants have experienced that management often communicated inconsistent messages and priorities to various parts of the company. These participants said top management came up with the company strategy, which was communicated, to them in the Vision, Mission and Values that the company upheld. Top management developed these documents which they said were hanging on the walls emphasising that the company was quality driven. This was however not supported by management at the facility. A statement such as this highlighted the experience:

" yes, look at these things on the wall (pointing at the vision, mission and values document*) and the absolute understanding of nursing to be a stressful job, the bulk of the*

company employment is nurses and that's why I say for this company to achieve its objectives it needs to keep its nurses in good health. These are the things we would say if it was possible"

This was seen when resources were not allocated for the psychiatric nurses to carry out their work in order to achieve the company's goal, which was optimal patient care. Instead the participants said psychiatric nurses found themselves struggling to find resources such as human resources and material resources to fulfil the obligation of striving for optimal patient care. The following statement supports these experiences:

*" …..You lack human resources to implement those (*meaning mission statements and values*). You cannot please the customer, the patient, because there are such shortcomings. You know, I mean a simple thing, when you go for a ward round you are looking for no gaps, and there are such constraints, and I feel we are not doing much for the patients"*

As a result of this, the participants said they were experiencing a high turnover of nursing staff due to shortages of human and material resources. Those remaining were experiencing pressure of working under such conditions which affected their mental health. The following statement highlighted the experiences :

" You know, your loyalty to the patients. isn't it like, you know the company has got its policies and the like, by virtue of me being here, it indicates that I am abiding and I am working my best to that. You know, but you are like a squeezed out orange"

Another experience of mistrust of management was the inconsistent standards whereby the managers did not apply the policies in a fair manner. The participants said their trust of management has been eroded by this inconsistency. They also mentioned that when it came to leave allocation (compassionate leave) psychiatric nurses were not treated the same. These participants said that the company had criteria on policy implementation however; management did not implement it fairly. They said some employees are allocated more days, up to seven days, whilst others would be allocated two to three days. This behaviour further damaged the trust that psychiatric nurses had with their managers.

The statement below depicts such an experience:

> *"….. you don't get your leave like you want it for instance they work according to policy. So if you want one day's leave they will tell you, no, due to operational matters – you cannot get that day. There are not always good choice.. like personal matter when you have serious problems like the compassionate leave they give us, The others might get many days, the other person might get four days, the other one day, two days….."*

Lack of trust leads to strained or a break in relationships. Once this happened it affected the psychiatric nurses' mental health. What also came up during the interviews was that psychiatric nurses have the experience that managers did not honour their promises when it came to their remuneration. The participants said irrespective of the years of experience working as psychiatric nurses, they are remunerated the same as the newly qualified psychiatric nurses. Statements such as this below demonstrate their experience:

> *" There are salary increases, uhm, the salary increases are general, but if maybe another PN uhm a new PN they are going to get the same. So they are superior"*

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Participants interviewed were of the opinion that management did not recognise them as experienced professionals. When the experienced psychiatric nurses raise the issue of remuneration, managers said the matter was receiving attention, but nothing got addressed.

The following excerpt reflects some of the experiences:

> *"…..when I ask about the salary, management say the company is busy updating this, but I do not see anything that is being updated ….."*

In some instances management would say that top management was looking into the matter, or the psychiatric nurses would be told that they were too inquisitive to be checking other people's remuneration, because salaries are a private matter for individuals. An excerpt like this depicts such an experience:

"…when I raised that, they got too negative because they said that……..,what did they say, eh….it is my inquisitiveness to look into someone's salary because it is confidential"

Participants also said that managers did not reward them for the work done, instead the incentives that some of the psychiatric nurses used to get were stopped without discussing it with those nurses concerned. A statement such as this highlighted this concern:

" There was, uh, when I started in this post there was incentive which also covered the CPNs, which was just decided from nowhere, somewhere, that let it be stopped for the CPNs, and the CPN's in this place are actually the people who do the spade work for you to come in and say, oh well done. It was just abruptly stopped, you know"

Some of the experiences were that management did not share information with the psychiatric nurses or that if information was shared it was like "an hour-glass" in which information filtered through. Further to this experience was that management was either unavailable for support or for guidance. The following excerpt highlighted their experiences:

'….. information is like the 'hour glass thing' when it gets to management. Even if you would,…… even if you would dream of having that information, about what is here, it will never go through. There is a block. A filtering of concerns or plans or whatever they do……….. You can't go further than that'

This kind of behaviour by management such as not keeping their word, not sharing pertinent information or even not allocating resources or not respecting the psychiatric nurses' own judgement were everyday examples of the lack of trust that management was displaying. These participants said the more their commitment towards involvement in their work and their company, the greater they experienced this mistrust of management. This behaviour has led to the interpersonal trust with management being damaged.

The above excerpts indicate that participants have shared experiences that indicate their lack of trust in the company in their workplace.

In the literature reviewed, Galford and Drapeau (2003: 89) mentioned that trust within the company was far more fragile that trust between a consultant and a client. They also said that the client and the consultant could control the communication and be able to build trust. Whilst in an organisation, there were different groups with conflicting goals.

It came out in this research that the participants' experiences was the lack of trust of management because they believe that it is expected of the psychiatric nurses to deliver optimal patient care and they expected management to supply them with the necessary resources to achieve this goal. Management on the other side was not seen as being supportive in this regard. This resulted in trust being eroded.

It is on this basis that Galford and Drapeau (2003: 90) said that if things are not working out, employees think that the organisation has acted in bad faith and as a result the employees will rarely forgive and will not forget. As a result of this break in trust, psychiatric nurses' mental health became affected. Psychiatric nurses felt management has betrayed them.

Reina and Reina (1999: 5) said that some form of betrayal leads to more serious hurts and accounts for more pain towards management and the company. That is why these psychiatric nurses are experiencing a high staff turnover. Galford and Drapeau (2003: 90) support these authors and said that employees have to have personal trust in their own management. Each time an individual manager violates the personal trust of their subordinates' direct reports, for example, the organisation trust would be damaged. Once trust is damaged it affects the relationship the psychiatric nurses have with their managers and this results in their mental health being affected.

Some of the literature reviewed also supported the above statements and it was stated that employees' trust in their superiors was seen as pivotal for the leader-effectiveness and work unit productivity. It was also mentioned that the supervisor's behaviour is fundamental in determining the level of interpersonal trust in a work unit and listed managerial behaviour such as sharing of appropriate information, recognising and rewarding good performance and not abusing the vulnerability of others.

However Manville and Ober (2003: 51) said when the shape of a modern company reflects a fundamental distrust of its members it could easily give rise to a malignant arrogance. Tightly-scripted planning, budgeting and approval processes deter rather than encourage free thinking and honest debate. In most companies today, by way of contrast, there is a tension between an employee's individual will and the will of the organisation. Management is forever arbitrating the bounds between personal freedom and the corporate interest.

What is stated above is supported by Joni (2004: 82-84) who said that the most successful leaders understand that trust is a function of relationships as well as integrity and expertise, and they know that relationships based on trust depended on where people stand on the organisational map. Personal trust develops in a workplace through shared experiences and knowledge. It is tempting to believe that trust derives from affinity and esteem and therefore the employees would trust those whose characters makes them trustworthy. However, there are times when trust is eroded, for example when those managers cannot give straight forward answers to questions asked by the employees.

This was what the participants experienced when they said that managers did not give them honest answers to the questions that they posed to management; instead management became arrogant when responding to the questions asked.

Galford and Drapeau (2003: 91) said most break-downs in trust could be traced back to one of the following problems:

- Inconsistent messages - one of the fastest moving destroyers of trust; inconsistent messages can occur anywhere in an organisation from senior managers downwards. These have significant repercussions on the employees. Senior managers often communicate inconsistent messages and priorities to various parts of the organisation. Senior managers tell people what they want to hear and often all senior managers across the company have widely disparate world views which they communicate to their constituencies.

Galford and Drapeau (2003: 91) mentioned that the antidotes to inconsistent messages are straightforward though not easy to implement.

- The next are the inconsistent standards which are another cause of breakdown in trust from this type of inconsistency. If employees believe that an individual manager or a company plays favourites, their trust will be eroded. Even if the manager had a legitimate reason, to act in that way employees around are going to jump to the least flattering, least legitimate conclusion. In this instance the manager's calculation does not take into account the cynicism that the manager engenders in the rest of the organisation (Galford and Drapeau, 2003: 91).

- Participants mentioned that managers did not implement policies in the same way when it came to employees' benefits. They cited the inconsistency in the allocation of days for compassionate leave. According to Galford and Drapeau (2003: 92) employees believed that management was displaying favouritism.

- Another problem that creates mistrust is giving false feedback. This happens when managers do not communicate accurate feedback to the employees. If the manager does not honour the company's systems, that manager will not hear the complaint directly, but it can be seen in the lower quality of competent employees' work.

- Inconsistency is also related to the management's lack of trust of others. As a result they do not give the employees a chance to develop and grow. The organisation ends up losing the trust from these employees and more talent ends up leaving the organisation All these destroy the values and therefore destroy trust, resulting in the team-work breaking causing a negative environment. After a while people tire of this negativity and may even catch the negative bug themselves (Galford and Drapeau, 2003: 92).

These problems were experienced by participants as the behaviours that led to the break in trust in management. This has led to their mental health being affected as stated in their experiences.

Nicholson (2003: 59-60) mentioned that there were a variety of factors that could block peoples' natural motivation. For example, the impediments might appear suddenly, because of stress that has accumulated over time resulting from the product of broken promises at work. The manager needed to look at the employee, not as a problem to be solved, but as a person to be understood. What Nicholson (2003: 59) meant was that there were obstacles that needed to be removed in a work environment. However if promises were forever being broken, the employees' energy was going to fade. The energy of people was often blocked in the workplace owing to a variety of factors. This author advise that instead of pushing solutions on people with force, pull solutions out of them (Nicholson, 2003: 59-60).

The literature reviewed has shown that what the participants have experienced has being documented and has demonstrated that if these issues were not adequately addressed, they could lead to the mental health of the psychiatric nurses being affected. It was therefore necessary to develop strategies to capacitate the psychiatric nurses so as to be able to deal with these challenges in their working environment.

The strategies to be adopted to deal with the experiences of the psychiatric nurses are discussed below.

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3.5 STRATEGIES TO ADOPT TO CAPACITATE PSYCHIATRIC NURSES TO DEAL WITH THE EXPERIENCES OF THE COMPANY

In order to deal with the following themes: emotional and mental distress related to inability to deal with stressful working environment, fear of speaking out related to the culture of silence and lack of trust in management related to a lack of recognition, inconsistency and poor resource allocation, the researcher came up with the following analogy of what the psychiatric nurses are going through and the strategies to deal with these experiences of the psychiatric nurses.

There was a special kind of interaction becoming evident amongst the participants. There were patterns of interaction which embraced behaviour traits, relationships and

the narrative style of their communication. In some instances, stories were told whilst trying to strive for depth.

Kanter (2003: 60) mentioned that the troubled psychiatric nurses' decline generally does not stem from a single factor. It is a result of an accumulation of decisions, actions, and commitments that became entangled in self-perpetuating workplace dynamics. Secrecy, blame, isolation, avoidance, lack of respect, and feelings of helplessness create a culture that makes an already bad situation worse. Once the psychiatric nurses are caught up in this spiral, it is hard to simply stop and reverse the direction. The dynamics boil down to the managers starting to point fingers and deriding the psychiatric nurses. The resulting tensions curtail collaboration and degenerate quickly into turf protection. Increasing levels of isolation engender secrecy. The psychiatric nurses find themselves less and less able to render their services as required, and eventually they came to believe that they are helpless. Passivity sets in. Finally the ultimate pathology of troubled psychiatric nurses takes hold in collective denial, and they enter into a collective pretence to ignore what they individually know (Kanter, 2003: 60-61). Ultimately some of the psychiatric nurses left the services whilst others stayed and became more and more trapped in this spiral. This was depicted in their experiences as outlined above.
Kanter (2003: 61) came up with the following figure to explain what the individual goes through when caught up in this spiral. (see Figure 3.1)

Figure 3.1 CYCLE OF DECLINE AS EXPERIENCED BY THE PSYCHIATRIC NURSES

Adapted from (Kanter, 2003: 61)

The system has momentum, however it is believed that there are strategies that the psychiatric nursing specialist can use to shift the momentum in the psychiatric nurses' favour and for the company on the whole to begin to replace secrecy and denial with dialogue, blame and scorn with respect, avoidance and turf protection with collaboration, and passivity and helplessness with initiatives that will address these patterns.

Based on Figure 3.1 above, these patterns of interaction with participants were viewed as the strategy that should be adopted to revise the cycle and assist them in understanding what the experiences entailed and how that understanding could improve their mental health.

The themes identified below will be used as a basis for the discussion.

Table 3.2 IDENTIFIED THEMES AS STRATEGIES TO ADOPT

1. Capacity development related to the inability of dealing with the working environment. 2. Breaking the silence of psychiatric nurses related to the culture of silence and lack of trust in management. 3. Building a sense of self-worth and dignity for psychiatric nurses was needed to reverse a lack of recognition, inconsistency and poor resource allocation.

These identified themes were seen as view-points on how psychiatric nurses could be capacitated to improve their self image, given a sense of self-worth and dignity resulting in change in their internal environment, Also there is a need to build their capacity to deal with the environment in which they are working.

Another area to deal with would be to capacitate them to enable them to break the silence related to the fear they have of speaking out and to help them build a trust relationship with management.

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The diverse nature of identified themes and strategies to address them clearly demanded a rigorous approach that would involve role players in leadership of the company, management and psychiatric nurses for the success and sustainability.

3.6 OBSERVATION NOTES DESCRIPTION

The independent interviewer came up with certain observations as described below:

These observational notes are descriptions of events experienced through watching and listening. These notes are a purposeful attempt to derive meaning out of the psychiatric nurses' experience of the company. The researcher interpreted these notes in order to ultimately build an analytical scheme (Wilson, 1985: 380).

Table 3.3 OBSERVATIONAL NOTES AND THEORETICAL NOTES

Observational Notes	Theoretical Notes
• Immediacy focus	It would appear that at this point the relationship between the interviewer and the participants was still new and superficial. The question posed was more broad and general. Given the circumstances the participants became focused on their immediate surroundings, thus shallow responses might have been seen by these participants as the safe way of commencing the interview.
• Present orientation bound	As the relationship began to develop between the interviewer and the participants deepened by the use of listening and reflecting, it was assumed that the deeper level of trust would be achieved. As probing followed the internal world experience emerged. However, the participants demonstrated that they were present orientation bound and institution bound. They only saw the pebble before their eyes in describing their experience.
• Operating at operational level	When considering the underlying dynamics of the use of words and phrases expressed the participants were not involved in the greater picture. They were involved in a low level of caring for patients at basic level, which reflected unfavourably on their experience of their functions as psychiatric nurses.
• Lack of capacity to deal with the situation that they found themselves in	Participants found themselves in the situation that was experienced as not supportive. Utilising the limited resources at their disposal needed a capacity to deal with that. As a result it appeared that they lacked the capacity to deal with such issues.
• Complaints about the company and not patients	It seems that the psychiatric nurses were on the periphery of patients' interaction, that there was not much that they could do for the patients except to ensure that their basic needs were met. It might be possible that there was little to tell about patients' problems in this regard and that interaction with patients was very slight. However, this might not be in a negative way due to staff shortage, because all that they were involved in was to see to it that the basic needs were met with the limited resources at their disposal.

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Observational Notes	Theoretical Notes
• Lack of trust in management	There were a number of possible interpretations in this regard. There was an attempt by management to avoid what was happening with patient care because management was not meeting the obligation towards patient care. As a result, to clear their conscience, management would rather avoid walking around the facility to see what was happening. There might be a lack of concern on the part of the psychiatric nurses that management does not take their concerns seriously. There might be an expectation from the psychiatric nurses that management should be involved in the day-to-day running of the facility. This break down in trust has led to too many interpretations.
• Fearful of persecution	The fear of reprisals when these participants validated their internal world experience as a means of exonerating the persons about whom they were speaking. These participants withheld the expression of their feelings as a means of suppressing their anger or fear. There was also fear of power, which resulted in frustration at having new choices, few opportunities for self-determination, or personal autonomy. There was the absence of trust relationships between management and psychiatric nurses.
• Concern that participants being registered psychiatric nurses could not give a good account of themselves not because of language barrier.	It might be postulated that some of the reasons for this are: These were defences to ward off anxiety associated with relating their internal world experience. The fear of reprisals by invalidating their internal world experiences. They had to deny or invalidate their perceptions and feelings as a defence against less effective interactions being experienced as the alternative was despair if their perceptions were valid.

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3.7 INTERVIEW WITH THE INDEPENDENT INTERVIEWER

The following notes were recorded in the course of the independent interviewer's experiences shared with the researcher following her interaction with the participants.

The independent interviewer experienced that the participants felt uneasy. As a result she spent a great deal of time explaining the purpose of the research as well as her role in the research.

The interviewer said she had to reassure the participants of her credibility with the university and that if she should breach the confidentiality, the university will take action against her.

When the interviewer mentioned that she had no vested interest in the company, she could begin to see an element of relaxation within the participants. The interviewer had to explain that, because she observed the unease of the participants when coming into the room.

The interviewer also picked up that the participants were scared to discuss their experiences.

In one facility the working area allocated for the interviews was between the two senior hospital management offices, which made it even more difficult for the participants to share their experiences, and which also made her feel uneasy with this arrangement. When the participants related their inner world experiences they would go to an extent of lowering their voices, look around to check who might be around and they would keep quiet whenever a person entered the room to bring some drinks.

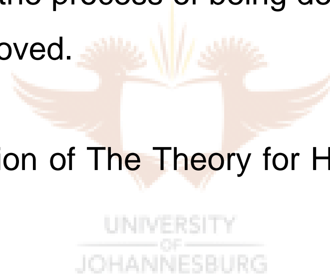
The interviewer also mentioned that she was frustrated by the participants who could not understand what the company culture was all about until she had to explain with examples before they could respond. The interviewer was also frustrated by the participants who could not express themselves clearly in English although these were

registered psychiatric nurses. She realised that she might be missing the rich points that could be expressed by the participants.

The results revealed that the psychiatric nurses lacked the emotional maturity which is related to their interpersonal skills gaps in self awareness and self regulation which were major obstacles, resulting in their reacting inadequately to emotionally distressing circumstances.

This was also validated by the observational notes, theoretical notes and the interview held with the independent interviewer who experienced that the participants were present bound and only saw a pebble in front of their eyes.

Strategies to assist the promotion of mental health related to the psychiatric nurses feelings of self worth and dignity, and emotional maturity were found to be lacking. Once they were engaged in the process of being developed, these psychiatric nurses' mental health would be improved.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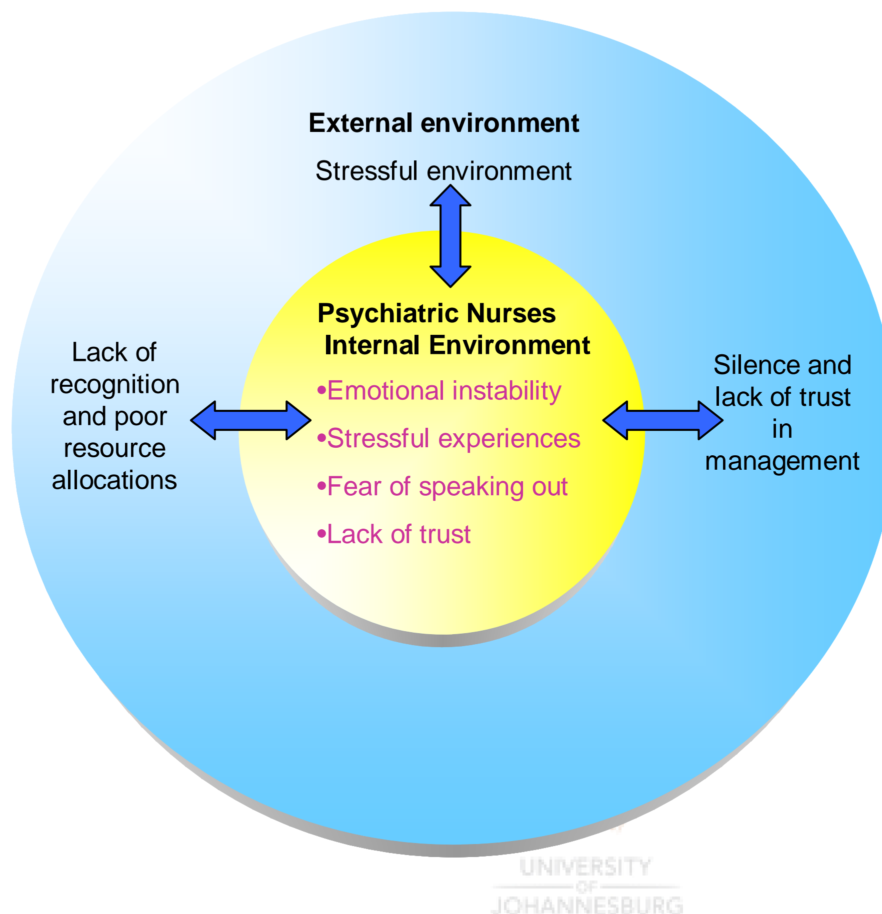
The following is the application of The Theory for Health Promotion in Nursing in this research.

3.8 THE APPLICATION OF THE THEORY FOR HEALTH PROMOTION IN NURSING IN THIS RESEARCH

The Theory for Health Promotion in Nursing assumes that the psychiatric nurses' function within the nurse environment as bio-psycho-social beings with mind, body and spirit and is constantly interacting holistically in their quest for wholeness.

Figure 3.2 below is the illustration of the psychiatric nurses' interaction in the external and internal environment.

Figure 3.2 ILLUSTRATION OF THE PSYCHIATRIC NURSES' INTERACTION IN THE EXTERNAL AND INTERNAL ENVIRONMENT



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The outside circle depicts an external environment which is stressful, an environment which lacks recognition and lack of trust in management, and this is the environment that the psychiatric nurse functioned in as was described in the interviews.

The inner circle depicts the internal environment of the psychiatric nurses which is emotional and stressful. There was fear of speaking out and there was a lack of trust. The application of this theory would enable the researcher to develop a model that would enable these psychiatric nurses to deal with these issues as identified in this research.

3.9 CONCLUSION

This chapter presented the results of the interviews conducted with participants. The chapter also dealt with the analysis of the transcripts of the interviews, field notes compiled by the independent interviewer, and the experiences shared by the independent interviewer with the researcher.

The literature control was applied throughout to contextualise the research and emphasised the trustworthiness of the findings.

The interviews discussed the various attributes and management style that resulted in driving psychiatric nurses out of the company to look for alternative employment.

Areas that made the participants' inner world experiences were discussed and analysed. These findings demonstrated a need for the psychiatric nurses to be capacitated in order to deal with the stressors in the environment in order to promote their mental health.

It was also clear that that management and the leadership played a major role in creating a company culture as depicted in the analysis of findings.

The situation invariably led to obstacles in cultivating the sound mental health of psychiatric nurses as an internal part of their health. Beck et al (1988: 2) stated that mental health implies mastery in the areas of life involving love, work, and play, manifested by, among other things, satisfying relationships with others.

Chapter Four describes a tentative model that will facilitate a quest for emotional maturity through the mental capacity development of the psychiatric nurses in promoting their mental health as a basis of their development and this is based on the findings as described.

CHAPTER FOUR

DEVELOPMENT OF A TENTATIVE MODEL FOR FACILITATING A QUEST FOR EMOTIONAL MATURITY THROUGH CAPACITY DEVELOPMENT OF PSYCHIATRIC NURSES IN PROMOTING THEIR MENTAL HEALTH

4.1 INTRODUCTION

Chapter Three dealt with the discussion of results obtained from the individual interviews conducted with psychiatric nurses and the integration of the literature reviewed. It also covered the analysis of the transcript of the interviews and observations and field notes compiled by the independent interviewer.

In this chapter, the focus will be on the tentative model for facilitating a quest for emotional maturity of the psychiatric nurses through capacity development in order to promote their mental health, as an integral part of overall health. Health promotion will help the psychiatric nurses to change their lifestyles to move toward a state of optimal health. Optimal health is defined as a balance of physical, emotional, social, spiritual, and intellectual health. Lifestyle change can be facilitated through a combination of efforts to enhance awareness, change behaviour and create an environment that supports good health practices (Karch, 2000: 9).

4.2 DEFINITION OF CONCEPTS

The main concepts which were emotional and mental distress related to inability to deal with the stressful working environment, fear of speaking out related to the culture of silence and lack of trust in management related to lack of recognition, inconsistency and poor resource allocation were identified from the data collected. The steps to be followed in the definition of the concepts was the method used by Wandelt and Stewart (1975: 64-69).

These steps were the writing of the dictionary definition for each concept to provide synonyms and to convey commonly accepted ways in which the words are used, and the second step was writing subject definitions from the literature and other sources reviewed.

4.3 IDENTIFICATION OF THE MAIN CONCEPTS

In the interviews conducted, psychiatric nurses identified the environment as the stressor affecting their mental health. This realization arose from their experiences, and their interaction with management and staff in the setting described during the interview.

Unfortunately, this environment created stress, lack of recognition and lack of trust in management. The results revealed that the central theme is the lack of capacity among the psychiatric nurses which is related to their interpersonal skills gaps in self-awareness and self-regulation as major obstacles, resulting in their reacting inadequately to emotionally distressing circumstances.

These findings demonstrated a need for capacity development so as to equip these psychiatric nurses in their quest for emotional maturity. The views expressed indicated that these psychiatric nurses needed to be helped through capacity development to equip them with competences that were related to enhancing them whilst questing for emotional maturity. For the psychiatric nurses to develop these competencies they should become actively involved in the lifelong process of development throughout their career. Emotional maturity is seen as a process which takes one's entire life to develop.

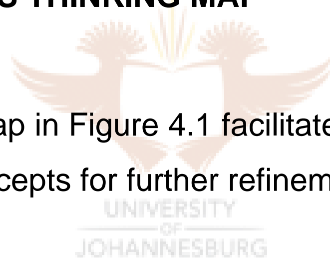
This meant that whilst questing for emotional maturity, these psychiatric nurses would have to work towards improving their physical, psychological and their spiritual well-being. It also meant that psychiatric nurses also had to gain insight about themselves, learn self-awareness and self-regulation and learn to be adaptable to the environment in which they were interacting, so as acquire emotional maturity.

This was seen as reasonable for these psychiatric nurses to take active roles in this capacity development as this would be a process that required them to be actively involved in their lifelong development towards maturity.

It was upon these findings that a quest for emotional maturity through capacity development seemed to be the goal for enabling the psychiatric nurses to build their psychological energy and become self-regulatory and adaptable to the environment in which they were involved.

It was also seen as a strategy that could assist these psychiatric nurses to become emotionally mature. A quest for emotional maturity as a lifelong development has essential qualities for promoting the mental health of these psychiatric nurses and would become the core concept of the model.

4.4 THE RESEARCHER'S THINKING MAP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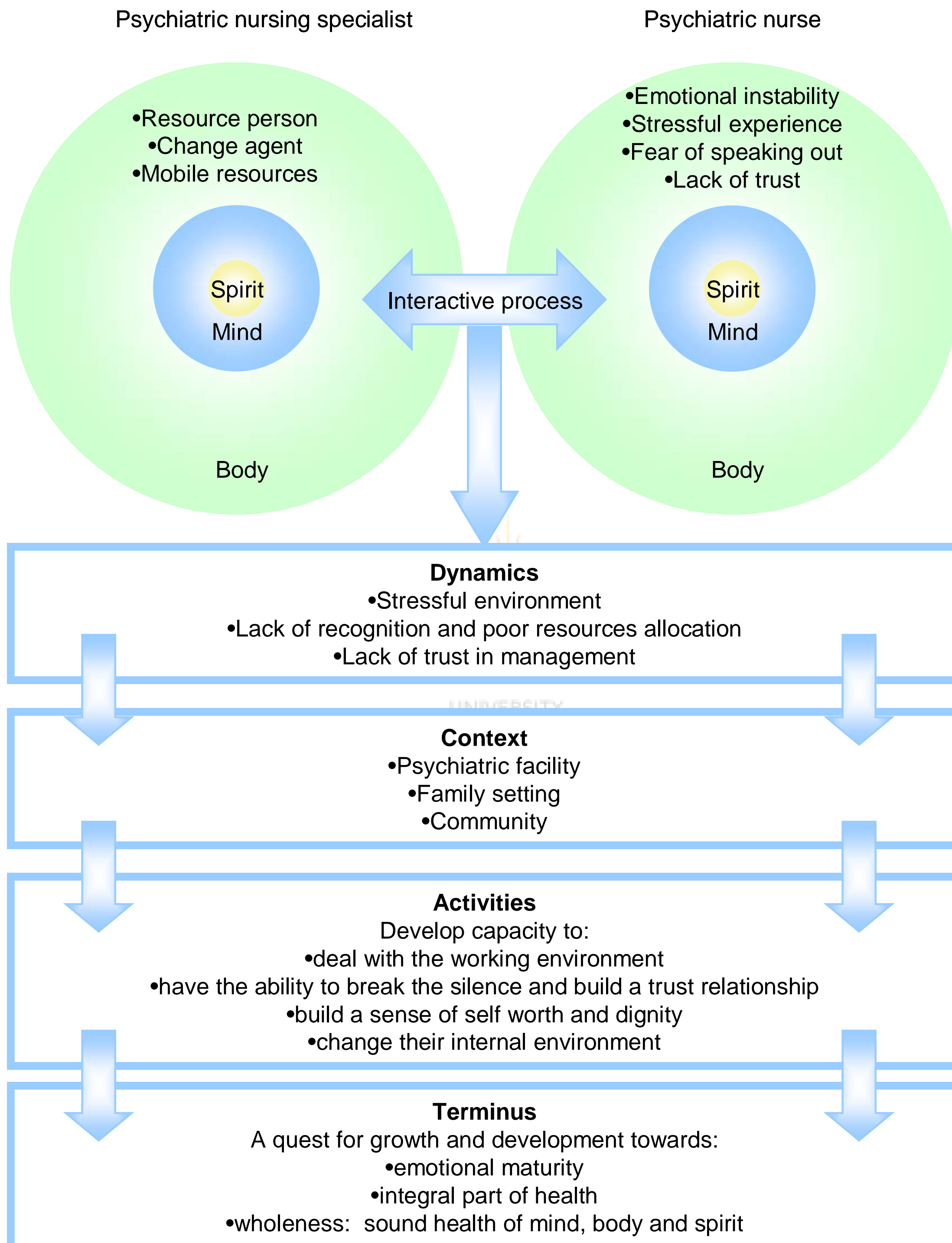
The researcher's thinking map in Figure 4.1 facilitates identification and categorisation of major and associated concepts for further refinement.

Figure 4.1 THE RESEARCHER'S THINKING MAP



(Adapted from Dickoff et al 1968:437)

Subsequent to this, the researcher examined the concept, “a quest for emotional maturity through capacity development”, as a central theme.

4.5. EXAMINING THE CONCEPT, “A QUEST FOR EMOTIONAL MATURITY THROUGH CAPACITY DEVELOPMENT”

In order to produce more clarity on the concept, **“A quest for emotional maturity through capacity development”**, each of the five words that made up the concept was examined separately and then their attributes were combined.

What follows below is the dictionary and subject definitions of these words.

4.5.1 Definition of the Word “Quest”

The researcher used the word “quest” with emotional maturity because emotional maturity is a lifelong process, therefore the psychiatric nurses will be involved in this act of seeking emotional maturity. It is therefore also necessary to define the word “quest” so as to utilise it within the context of emotional maturity. The dictionaries reviewed came up with various meaning of the word “quest”:

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4.5.1.1 Dictionary definition

Readers Digest Oxford Complete Wordfinder (1993: 1251) defines the word “quest” as:

in search or an act of seeking
in pursuit
go about in search of something

Concise Oxford English Dictionary (2002: 1172) gave the following meanings of “quest” as:

a long or arduous search
an expedition by hunting **to accomplish** a **prescribed task**
search for something

South African Pocket Oxford Dictionary of Current English (1994: 736) defines the word “quest”:

in search of or seeking
go about in search of something

Collins Concise Dictionary Plus (1989: 1056) described the word as follows:

looking for or **seeking**
to **accomplish** some **task** such as **finding something**
the object of a search for a **goal** or **target**

South African Pocket Dictionary of Current English (1994: 784) described the word:

go about **in search** of something
search or seeking

Concise Oxford Thesaurus (2002: 700) gave the following synonyms for the word:

in search
in pursuit of
seeking
lookout for
exploration or pursuance

From the dictionary definitions, the word **“quest”** could best be described as **an exploration in search of something** to **accomplish a goal.**

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4.5.2 Definition of the Word “Emotional”

In order to define the word **“emotional”** the researcher first had to define the word **“emotion”** to create a better understanding of the word “emotional”.

4.5.2.1 Dictionary definition

The dictionaries consulted came up with the definitions outlined below:

Collins Concise Dictionary Plus (1989: 189) describes the word “emotion” as:

Any strong feeling as of joy, sorrow, fear and “**emotional**” as:

expressive of emotion
excessively affected by emotion

Collins Concise Dictionary Plus (1989: 189) stated in the explanation that the word **“emotion”** derived from the Latin word “**emovere”** which means **to disturb.**

Standard Dictionary of English language: International edition with special features (1976: 197) defined “emotion” as**:**

> **Any strong manifestation** or **disturbance** of the **conscious** or **unconscious** mind typically involuntary and often leading to complex **bodily changes** and forms of **behaviours** as **act** or state of **excited feeling**
> The **power of feeling**, **with or without** a corresponding trend of **activities**

The word **“emotional”** is an adjective pertaining to, or **expressive of, emotion** is:

> Having **capacity** for **emotion**
> **Moving** or suited to move the feeling or **passion**

Readers Digest Southern African Word Power Dictionary of Current English (1996: 328) gave the following meanings of the word “emotion” as:

> Any strong feeling such as **anger**, **anxiety, depression**, **grief** or **joy**
> Stirring up **excitement** or feelings
> Any of the **strong feelings** of the **human spirit**, **strength of feelings**
> Fullness of the heart, **moving** and **touching** to **move**

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Concise Oxford English Dictionary (2002: 466) defined the word “emotion” as:

> a **strong feeling** such as **joy, anger, or sadness**
> instinctive or **intuitive feeling** as distinguished and defines **emotional as relating to emotions**

Concise Oxford Thesaurus (2002: 270) defined “emotional” as a **demonstrative feeling**

The above dictionary lists the following synonyms for the adjective “emotional”:

> **responsive**
> **powerful**
> **affecting**
> **excitable**
> **haunting**

4.5.2.2. *Subject definition*

The term “emotion” is not an easily definable word. It involves many kinds of **human mental states**, **reaction** and **attitudes** (Springer and Deutsch, 1989: 71).

Goleman (1996: 81) states that the word “emotion” is from Latin **movere** and its root meaning is **to move** which will lead to some or other impulse **to act.**

The literature reviewed gives the description of emotion and states that the word “**emotional”** is an adjective **describing the feeling** that the individual **expresses.** For the purpose of this research the word “emotion” will be defined first, in order to have an understanding of the word “emotional”. From the literature consulted, it was evident that there are many ways in which emotion is conveyed. Emotional information is **reflected** in our **facial expressions**, as well as in less noticeable **physiological signs.**

Emotional information may be conveyed directly in **speech**, or by the **tone** in which information is spoken (Morgan et al, 1984: 32).

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Grings and Dawson (1978: 1) said the word, emotion, covers a wide spectrum of **behaviour** and **experiences**. It was readily identified in **personal conscious awareness**; it represents the **intense experiences** of **joy** and **pleasure** or of **fear** and **anger.**

Grings and Dawson (1978: 2) stated further that from man's earliest conjectures about behaviour, the notion of emotional experience had been present. They said the idea that bodily reactions are intimately involved with emotions could be found in the writings of the ancient philosophers and poets. These authors went on to say that when qualities of personality are described in terms of their characteristics, emotional or feeling tone reference was made to temperament (Grings and Dawson, 1978: 1). Grings and Dawson (1978: 2) also defined emotion as an acute **disturbance** of the individual, psychological in origin, involving **behaviour, consciousness**, **experiences** and **visceral function.**

Phillips and Comfort (1996: 44) say emotions **demonstrate** how you **experience events** that happen in the big wide world. They are like a barometer - up when the day is fine and down when you are under pressure. In other words they are about **insight, instinct, gut responses** and **inner knowing**. They are a sense of something comfortable or right.

Other authors said emotions are the outward display of feelings appropriate to a particular societal culture or situation. We learn how to **display grief, anger, and envy**. Feelings are their subjective experiences. Feelings tell them something about the **quality of our interactions** and **performance** (Gabriel et al, 2000: 296-297).

Gabriel et al (2000: 161) went on to say that emotions were the **outward presentation** of our feelings through **learned social codes.** They might, for example, express their feelings of anger in very restricted or socially acceptable ways during a meeting at work, but more openly at home. However, there are essentially private, internal experiences which often have both psychological and physical manifestations such as stomach churning and a sense of apprehension before an examination (Gabriel et al, 2000:161).

It was also stated by Kassarjian and Robertson (1991: 310) that emotions included such diverse feelings as **love, hate, anger, joy, sadness, disgust.**

Other authors like Weiner (1975: 302) said the word “emotion” came to be used to designate any **agitated, vehement or excited mental state** of the individual. "The joy of gratification is properly called an emotion".

Other literature reviewed defined emotion as an organised, highly **structured reaction** to an **event** that was relevant to the **needs, goals, or survival of the organism**. These authors noted further that each emotion represented a **response to a specific type of event** and each gave rise to a characteristic form of **adaptive behaviour.**

Emotion was described as an innate biologically hard-wired system that **promoted the survival** of the organism by **facilitating efficient adaptive responses** or **reactions** to changing **environmental circumstances.**

Based on the above literature viewed, the definition of **emotion** could therefore be defined as any **power of feeling** which resulted in the **disturbance** of the **conscious or unconscious** mind which led to **bodily change** and forms of **behaviour.**

The researcher has defined the word "emotional" based on how the word "emotion" had been defined and used. The literature reviewed referred to the word **emotional** as an adjective and it was best described as an **expression of emotions.** Cook et al (1997: 172) said the term "emotional" was used when people **express their emotions**, for example, the individual's **behaviour** may range from unemotional and stable to highly emotional and volatile.

Reece and Brandt (1981: 30) said to be emotional:

- was when your emotions were triggered, for example, if you became angry or allowed yourself to become carried away by someone's eloquence, or
- was when the individual expressed feelings such as being **angry, stressed, or bored**.
- One can feel **malicious, vengeful**, **embarrassed**, **and fearful or hurt** especially **when judged negatively.**
- It was also described as a behaviour expression of an **outburst** or **ventilation** during the course of a conversation.

Reece and Brandt (1981: 30) said that **emotional maturity develops** as **you achieve greater understanding of yourself.**

The researcher went on to describe the word "emotional" by incorporating the emotional dimension and emotional qualities. These descriptions are discussed below.

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4.5.2.2.1 Emotional dimension

In order to further understand the word "emotional" the emotional dimensions were outlined. Wilson and Kneisl (1988: 136) said that in the emotional dimension the individual might be **irritable, angry, withdrawn**, or they might cry. The affective response could be assessed through the individual's **subjective description of themselves** as **on edge, uptight, nervous, worried, and tense.**

It was also documented that there were general emotional dimensions as **pleasantness** versus **unpleasantness** and **activation** or **arousal.**

Rawlins and Heacock (1988: 2) however said a major component of the emotional dimension is an individual's affect, the **observable feeling** or **emotional tone** of the individual, for example, **happy, sad, angry**, or **anxious.** These authors said there are other components which include the individuals' report of their feelings, the **congruency of affect** with the individual's feelings.

4.5.2.2.2 Emotional qualities

Some literature reviewed came up with the description of emotional in terms of emotional qualities. It was Duffy (1979: 760) who postulated that emotional quality could be said to emerge only at a special point in the continuum. The qualities of being "emotional" include **self-esteem, self-acceptance**, **self-confidence**, **self-control**, **satisfying relationships** and the **ability to share feelings**.

From the above dictionary and subject definition, "**emotional"** can therefore be described as the individual's **ability to express feelings freely** and facilitating **adaptive** responses to **changing environment** or circumstances.

4.5.3. Definition of the word "maturity"

The researcher began by searching for the definition of "mature" first so as to understand and define the word "maturity".

4.5.3.1 *Dictionary definition*

The dictionary definitions of the word **"mature"** are as follows:

Readers Digest Complete Wordfinder (1993: 943) defined the word "mature" as:

> **Fully developed** powers of **body** and **mind** adult
> **Complete in natural development**
> Ripe **(thoughts and intentions**)
> **Duly careful** and adequate

and defined "**maturity"** in the following words - **readiness, perfection, polished** and **fullness.** Therefore the individual's **quest for maturity** is **seen as a lifelong process**.

Collins Concise Dictionary Plus (1989: 792) defined "mature" as:

> Relatively **advanced mentally**
> **Grown up** (in terms of **plans**)
> Considered **perfected**
> **Fully developed**

and defined "maturity" as the state or **quality of being mature** and **full development.**

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Standard Dictionary of English Language: International edition with special features (1976: 223) defined "maturity" as follows:

> To come to **full development**
> The state or condition of **being mature**
> A time at which a person is **mature fully** or completely/ **fully developed in character** and has **developed powerful thinking**
> **Thoroughly elaborated** or considered **complete .**

South African Pocket Oxford Dictionary of Current English (1994: 548) used the following to describe the word "mature":

> **Sensible**
> **Seasoned**
> **Careful**
> **Considered**
> **Developed fully**

and the above dictionary defined "maturity" as **being mature,** which means that the individual has to be mature in order to present the concept "maturity".

Concise Oxford Thesaurus (2002: 540) used the following words to explain the word "mature" as:

> **Fully developed**
> **Become more sensible**
> **Careful, thorough, deep and considerate**

and defines "maturity" as being **responsible** and **sensible**, **level-headed** and having **wisdom** and **sophistication.**

Concise Oxford English Dictionary (2002: 880) defines the word "mature" as having reached a **stage of mental** or **emotional development** characteristic of **an adult** who has **grown up** or having reached **the most fully developed stage of development** and defines **maturity** as the **state or fact or period of being mature.**

4.5.3.2 *Subject Definition*

Bernard-Phera (2000: 10) uses the word **maturity** within the context of career, and defines the word "maturity" as **one's readiness** to deal with **career related developmental tasks** which one might be **confronted with on a daily basis.** The author refers to a variety of vocational tasks, decisions, behaviours and adjustment processes that are influential in **determining the individual's development.**

Whereas Gerdes et al (1986: 82) describe the psychological maturity as **the goal towards which development should be directed.** These authors stated that maturity should not be seen as a state but as an ideal, and its attainment as a **lifelong process of development.**

"Maturity" will be used with the word "**quest"** because it is seen as a **lifelong process of development,** therefore the individual continues to **quest for maturity .**

Gerdes et al (1986: 82) see maturity as **intellectual maturity** and **emotional maturity** as a degree which a person has **departed from the emotional behaviour appropriate to childhood.** These authors have distinguished between adulthood

which they say is based on chronological age and **maturity** is based on **desirable personality attributes.**

There is also a general agreement that maturity is the **fulfilment of the individual's unique potential**. Gerdes et al (1986: 83) mentioned that mature persons have **a balanced view** of the degree to, and the manner in, which they are **responsible for others**.

Mature persons **do not blame themselves** for matters for which they cannot be held responsible, **nor do they absolve themselves from responsibilities** where it is incumbent **upon them to accept them.** That is why mature persons will **always accept criticisms** from their colleagues in an effort **to improve** themselves (Gerdes et al 1986:82-84).

It was also noted that Van den Aardweg and Van den Aardweg (1993: 146) defined maturity as that age, **state or condition of life at which a person is considered fully developed physically, emotionally, socially, intellectually and spiritually**. They state further that maturity may not be reached simultaneously in all these aspects of development and in fact may, in some cases, never be reached. These authors said that while some of the aspects of development such as physical maturity, could be reasonable and well-defined, most cannot. There are generally **value judgements** made of persons to reflect how **successfully** they correspond to socially and culturally **accepted norms,** within a **working environment**. What is considered emotionally childish in one society may well be an aspect of emotional maturity in another, however, there is a close relationship between maturity, professional commitment and competence (Van den Aardweg and Van den Aardweg, 1993: 146).

It was also the view of Lindgren (1976: 45) who said that maturity may be used in one of two different ways, which are **behaviour** that is **appropriate** to the age of the individual concerned or the behavioural standards and expectations of the adults. Lindgren (1976: 45) further says that there are four aspects of development, namely **cognitive, social, emotional and physical**.

Gerdes et al (1986: 91) equate emotional security with **self-acceptance.** These authors said that self-accepting persons would be less inclined to emotional over-reaction because these persons have a **sense of proportion** and are **able to control their emotions** so that they could **react appropriately**. Gerdes et al (1986: 91) further said that emotional control does not imply that one is constantly cheerful or unemotional. It means being **able to express feelings openly,** but with **consideration** for the **beliefs** and **feelings** of others. It also implies being in **touch with one's own feelings**.

Mature persons have the **ability to tolerate frustration** and not to react impulsively to the clamour of needs and emotions. A mature person **exhibits good self-control**. **Self-acceptance** is a prerequisite for **acceptance of others.** Self-acceptance is seen as a prerequisite for the **attainment of personal authenticity.**

A mature person has the **capacity for growth** and **development throughout life.** Closely aligned to this is an **openness to new experiences** and a **willingness to learn from them.**

This, in turn, demands the **flexibility to accept** the **challenge of change** and to **adjust existing emotional, social, cognitive and value systems** to such change, even through such adjustment may be painful or difficult.

Mature persons, guided by their values and beliefs, function in an **integrated way** by interrelating various **inner systems,** thus **achieving continuity** and **consistency** in their behaviour (Gerdes et al, 1986: 91).

Burke (1989: 9) says the word, maturity, is taken from the work of Maslow (1970) in (Burke, 1989:9). Beyond gaining control over actions, thoughts and feelings, an individual can continue to mature. That is, **become increasingly capable of successfully dealing with the demands of the environment, new understanding, new appreciation of some aspects** of behaviour**.** **Insight** that leads to maturity includes a movement toward action, **toward change.** Burke (1989: 10) says the individual becomes less conscious and self-centred and begins to be more focused

and **realising personal potentials** that are beneficial to **self and others** at the same time.

Burke (1989: 10) cited Maslow's conception of maturity as anything but **passive insight** - it is a call to **productivity and competence**. As such **insight that leads to maturity** moves an individual from understanding to **acceptance, determination** and to **action.**

Burke (1989: 10) said **self-regulation** and maturity are interrelated. This author emphasises the importance of **promoting one's maturity** through **self-regulation.** He also mentioned that maturity can be defined from a humanistic-existential perspective using Maslow's list of the characteristics of self-actualising persons as follows:

- Firstly, mature individuals possess a more **accurate perception of reality** and are **comfortable in relating to the real world.** Mature individuals **live more in the real world** of maturity rather than in man-made throughout conceptions, abstractions, expectations, beliefs and stereotypes that most people confuse with the real world.

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- Secondly, mature individuals **accept themselves**, **others**, and **nature without chagrin** or complaint, that is, they **see human nature as it is** and not as they would prefer it to be.

- Thirdly, mature individuals are **spontaneous**. An **inner naturalness allows thoughts, feelings and actions to occur** without rehearsal, phoniness or artificiality. **Behaviour is determined according to personal values** rather than primarily in response to the opinions and directives of others (Burke (1989: 203).

Burke (1989:203) also listed the characteristics of a mature person as follows:

Problem-centeredness rather than ego-centeredness

A quality of detachment

Relatively free from culture and **environment** so that one is **an active agent** rather than a reactor

A **continued freshness of perception**

An **intense feeling of identification with humanity**

Deep and profound interpersonal relationships with a few special friends

A **democratic character** structure

An **ability to discriminate** between **ends and means** and between **good and evil**

Philosophical and **non-hostile sense of humour**

Creativity of special calibre

Familiarity with peak experiences

Special transient moments of **intense personal awareness**, **integration** and **ecstasy**

Other researchers, Heath and Heath (1991: 34-35), described the four facets of maturity as follows:

- **Becoming more reflectively aware:**

  The mind becomes more reflectively aware of itself

  Interpersonal relations become more symbolisable

  Self-concept becomes more accurate

- **Becoming more other centred**

  The mind becomes more relativistic and empathic

  Interpersonal relations become more caring

  Values become more humane

  Self-attitudes become centred more on others

- **Becoming better integrated**

  The mind becomes more relational and contextual

  Interpersonal relationships become more cooperatively mutual

  Values become more consistently organised

  Self-concept becomes more integrated

- **Becoming more stable and autonomous**
  The mind becomes more resilient, stable and mobile
  Interpersonal relationships become more enduring and selective
  Values lead to commitment and courage
  Self concept becomes stronger and more autonomous

Heath and Heath, (1991: 58-59) said such are the sign posts that guide growing up. It provided a comprehensive but manageable map to guide efforts to understand healthy growth.

Saul (1971: 7-8) outlined the characteristics of maturity as follows:

- **Pathway of development** from the parasitic dependence of the foetus to the independence of a parent with a **capacity** for responsibility.

- **Increased capacity for responsibility** and decreased receptive needs. Relative freedom from the well-known constellation of inferiority feelings, egotism and competitiveness.

- Fully matured individuals would **not feel inferior;** they would derive their major satisfaction from the enjoyment of the productive use of their powers and would be basically kind, responsible, and cooperative rather than competitive towards others.

- Another aspect of maturity consists in the **conditioning** and the **training** necessary for **socialisation.**

- Mature adults are **parental and creative** and are not destructive towards themselves or others. The aggression is available, but normally it serves not infantile, sadistic and masochistic patterns but constructive and productive ones.

- Another attribute of maturity is a **firm sense of reality**, not merely matter of intelligence but also of emotional outlook.

Saul (1971: 16) also mentioned another characteristic of maturity, that is, **flexibility** and **adaptability**. When development is fulfilled, adults are predominantly **independent and responsible** with little need to regress, and are also **giving and productive**, although still able to relax and to receive normally.

They are in harmony with their conscience which **easily integrates** with their mature feelings and behaviour. Their **grasp of reality is clear** and unimpaired by the emotional astigmatism of childhood. They are **discriminating** and **highly adaptable**. Simply told maturity meant not merely the capacity for attributes and functioning but also **the ability** to **enjoy these attributes fully** (Saul,1971: 16).

Gubrium and Buckholdt (1977: 3) said that the psychologists use **maturity, development and growth** interchangeably. They also argue that the important questions were not how people responded to life change or proceeded through stages, but how they **negotiated** and **generated** the **reality and meaning of change**, **stages and development;** how they come to have a sense of them as things separate from themselves and how they subsequently responded to them as real things (Gubrium and Buckholdt, 1977: 3).

Based on the dictionaries consulted and literature reviewed, the definition of **maturity** was best described as the ability to demonstrate that adults are fully developed by exercising self-control and self-acceptance. They are self-regulatory and accept change. They are able to express their feelings openly, and hold a balanced view.

What follows is the definition of the word capacity

4.5.4 Definition of the word "capacity"

The definition of the word "capacity" was derived from the dictionaries and the subject search for the meaning of this word and this was used within the context of mental

capacity because it was the mental aspect that was the key to achieving the growth that was envisaged.

4.5.4.1 *Dictionary definition*

The dictionary definitions of the term “**capacity**” are as stated below:

South African Pocket Oxford Dictionary (1994: 118) defined the word as follows:

Power to contain, receive, experience or produce
Mental power

Readers Digest Complete Wordfinder: A unique and powerful combination of dictionaries and thesaurus (1993: 209) defined “capacity” as:

brain power
capability, potential, or ability
brain’s acumen, skill or talent
understanding, sense, judgement
cleverness, brightness, wit or imagination

Concise Oxford English Dictionary (2002: 206-207) explained “capacity” as:

the **ability** or **power** to do something
having **the quality** necessary to do something
open to or admitting of something
make **capable** or **competent**
enabling them to **penetrate**

Collins Concise Dictionary Plus (1989:189) said “capacity” is:

the **ability** to **understand** or **learn**
the **ability** to do or produce

South African Pocket Oxford Dictionary of Current English (1994:129) uses the following words to describe the word “capacity”:

mental power
having the **ability for improvement**

Concise Oxford Thesaurus (2002: 115) gave the following synonyms to describe capacity: **power, adeptness, potential, proficiency, talent, accomplishment, experience**. All these words gave a clear understanding of the word.

4.5.4.2. *Subject definition*

Therefore the term **"capacity"** is defined as the **ability to produce mental power** which can be stored and be used to **generate competency**, **efficiency, cleverness, intelligence** whilst creating the opportunity to do so.

Mayer and Salovey (1993: 433) defines this term as a type of **social intelligence** that involves the **ability to monitor one's own and other's emotions**, to discriminate among them and to use the information to **guide one's thinking** and **actions.** Holmer (1993: 2) uses the word capacity, as an individual's characteristics orientation towards, and response to, the conscious or unconscious experience of an emotional challenge. Holmer (1993: 3) defined this **capacity** with **the word emotional** and says it is a challenge as any real or perceived threat to an individual's security or **self-concept that stimulates** their **instinctive self-protective tendencies** to withdrawal or aggression. Therefore, **a developed or skilful response** to an emotional challenge is one in which the individual recognises and engages directly with the challenge, **consciously choosing behavioural responses** rather than reacting out of instinct or habit. Holmer (1993: 3) regards this as **capacity building**.

The **capacity for skilful responses** to emotional challenges neutralises instinctive or habitual self-proactive tendencies to denial, defensiveness, or withdrawal that may be involved in generating such responses.

Based on the above, "**capacity"** in this context is related to the **mental capacity** and can thus be defined as the **brain power** or **the ability to produce mental power** to produce **capabilities** and **potential skills** for **understanding**, **judgement**, **imagination** and **cleverness** and this is regarded as **capacity development.**

The next exercise is to examine the word "development".

4.5.5 Definition of the term “development”

In order to come up with the description of the word “development” the researcher went on to search for the meaning utilising the dictionaries and the review of the literature and came up with the definitions as described below.

4.5.5.1 Dictionary definition

The dictionaries consulted provided the following definitions:

Concise Oxford English Dictionary (2002: 392) defined the word “development” as:

a **process** of **developing** or being developed

a specified state of **growth** or **advancement**

a new product or idea or **an event** constituting a **new changing situation**

Readers Digest Oxford Complete Wordfinder (1993: 396) defined the word “development” as follows**:**

bring or come to an active or visible state or **to maturity**

a stage of **growth** or **advancement**

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South African Pocket Oxford Dictionary of Current English (1994: 235) stated the following definitions:

stage of **growth** or **advancement**

new events or circumstances

fully grown

begin to **exhibit mature stage**

a thing that has **developed**

Collins Concise Dictionary Plus (1989:343) defined “development” as:

the act or **process** of **growing**

a product of **developing**

a fact or event especially **that changes** a **situation**

South African Pocket Oxford Dictionary of Current English (1994: 25) had the following definitions:

a stage of **growth** or **advancement**

thing that has **developed**

new event or circumstance

full-grown state

Concise Oxford Thesaurus (2002: 221) offered the following synonyms for the word, "development" : **forming**, **establishment, initiation, origination**, **invention generation.**

4.5.5.2 *Subject definition*

Development is a process of moving towards maturity. This word refers to **a process that takes place throughout one's life**.

The word "development" is defined as **a state of continuous learning** that recognises both the independent and interdependent nature of the world. This refers to **the self-reliance** of individuals as **independent persons** and the **interdependence** of their colleagues and their significant others.

Development incorporates three kinds of learning, that is, practical, integrative learning and vital learning.

- Practical learning is about the **development of competencies** for the things that the individual needs to know and wants to be able to do.

- Integrative learning **maintains the individual's sense of balance** and completeness in order **to become whole**. In the process, individuals learn about beliefs that give meaning and **a sense of liberation** to their lives.

- Vital learning is about the **individual's motivation** and focusing on those aspects of life that she/he values most of all. It enhances their **sense of purpose and fulfilment** .

Tight (1996: 28-29) defines development as an all important primary process through which **individual growth** can through time **achieve its fullest potential**. This growth is enabled through lifelong learning and development **to master defined competencies** (knowledge and skills) to predetermined standards.

Hellriegel, Jackson and Slocum (1999: 118) say that for development to take place, there must be some **initiative and activity** such as **gaining insight** and having the **ability to change** on the part of **the recipient** which **can serve as a basis for guided participation towards maturity.**

Whereas Leddy and Pepper (1987: 84) support the views of the above authors, and say development refers to the process through which individuals, **over a period of time**, are enabled to achieve their **fullest development towards emotional maturity** by demonstrating growth in their professional career.

Maturity can be effective once psychiatric nurses have gained **insight** into themselves and they are **prepared for change** by participating in lifelong development.

Based on the above, the term **"development"** refers to **a process of acquiring knowledge, skills, insight, values and attitudes from individuals' total life** experiences to develop what they need to do that can serve as a basis for guided participation towards **emotional maturity.**

4.6 IDENTIFICATION OF THE MAJOR ATTRIBUTES

In an attempt to define the central concept, "A quest for emotional maturity through capacity development", the first step to identify the major attributes of each of these words, that is, **"quest, emotional, maturity, capacity and development"** was done through a process that identified major attributes, as outlined below:

Earlier on, each criterion that contributed to the understanding of the concept "A quest for emotional maturity through capacity development", was written in bold. Criteria

with similar meaning were then clustered together to form a list of essential and related criteria to be included in their definition.

Following the identification, these words were synthesised to produce a definition of the major concept. In order to perform the reduction process of identified criteria the concept, “A quest for emotional maturity through capacity development”, was defined at the end.

4.7 REDUCTION PROCESS OF IDENTIFIED CRITERIA

All criteria contributing to conceptualisation of the concept “a quest for emotional maturity through capacity development”, were identified from dictionary and subject definitions.

Table 4.1 below lists the essential and related criteria that were reduced for the purpose of guiding the description of the model for facilitating a quest for emotional maturity through capacity development.

Table 4.1 AN OVERVIEW OF THE MAIN ATTRIBUTES OF THE CONCEPTS FORMING THE CONSTRUCT, “A QUEST FOR EMOTIONAL MATURITY THROUGH CAPACITY DEVELOPMENT”

Essential criteria	**Quest for emotional maturity**	**Capacity development**
Related criteria	• Self-awareness • Self-regulation • Self-control • Accept change • Balanced view • Gained insight • Interpersonal relationships • Professional relationships	• Mental power • Lifelong development • Emotionally mature person

The main concept**: ‘A quest for emotional maturity through capacity development’** is being defined in the next page.

The concept was defined and described as the psychiatric nurses' ability to demonstrate that they are **fully developed** in that they have gained **insight** thus enabling them to **express feelings openly** and to exercise **self-control.** They have the **mental power for** lifelong **development in self-awareness** and **self-regulation** and they adapt to **change**. They hold a **balanced view** of the world.

This concept is a developed or skilful response to an emotional challenge in which the psychiatric nurses recognises and engages directly with the challenge, consciously choosing behavioural responses rather than reacting instinctively. Whilst engaged in this process psychiatric nurses will acquire skills, competencies and knowledge in order to confront life challenging issues and this will lead to the improvement in their mental health.

These psychiatric nurses will also acquire the facilitation of their internal and external resources and create mental power to enable them to look from within and be conscious of themselves, thus creating self-awareness. This self-awareness will lead to these psychiatric nurses being able to channel their emotions in a service for a goal. Self-awareness facilitates competency to receive power for happiness. Happiness will promote the mental health of these psychiatric nurses.

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4.8 CONCEPT EVALUATION

The evaluation of the definition of the concept, "A quest for emotional maturity through capacity development ", met the rules proposed by Copi and Cohen (1994: 192-194) and discussed earlier in Chapter Two, which demanded that a definition had to state the essential criteria which in this instance are "a quest for emotional maturity through capacity development".

4.9 CLASSIFICATION OF CONCEPTS

In order to facilitate the process of creating conceptual meaning, the following survey list as outlined by Dickoff et al (1968: 437) was adopted in structuring the conceptual framework. The survey list was designed as follows:

- **Agent** (the person who is to perform the activity)
- **Recipient** (the person who is the recipient of the activity quest for emotional maturity)
- **Framework** (in what context would a quest for emotional maturity be practised)
- **Procedure** (what is the guiding procedure, technique or protocol for the activity)
- **Dynamics** (what is the energy source of the activity, whether chemical, mechanical, or physiological)
- **Terminus** (What is the outcome of a quest for emotional maturity)

A structured relationship is presented in Figure 4.2

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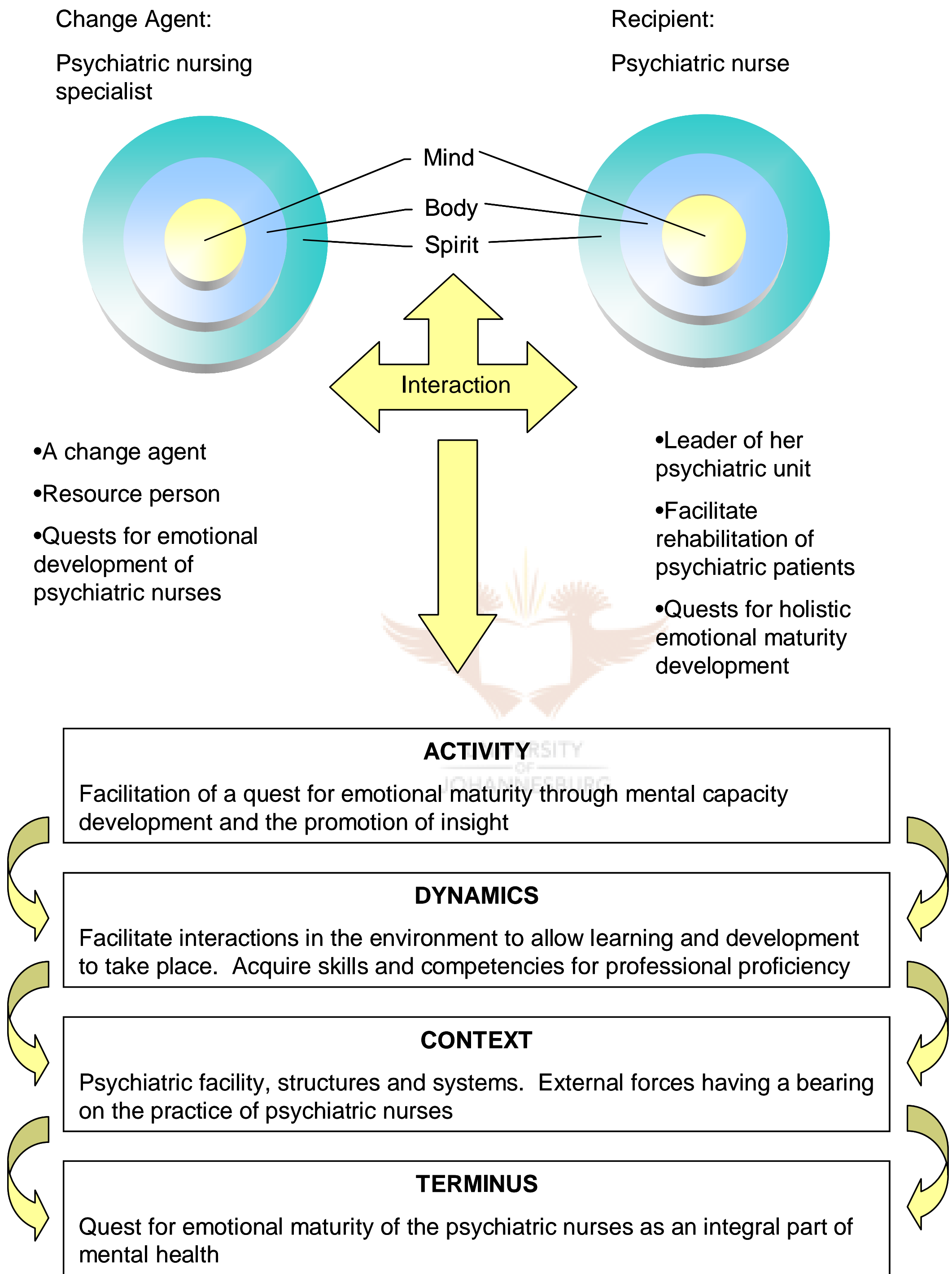
Figure 4.2 ILLUSTRATION OF A TENTATIVE MODEL FOR A QUEST FOR EMOTIONAL MATURITY THROUGH CAPACITY DEVELOPMENT



4.10 DESCRIPTION OF OTHER RELATED CONCEPTS

There are other concepts that are related to the main concept, "A quest for emotional maturity through capacity development", which need to be described as well.

4.10.1 Psychiatric Nursing Specialist

The psychiatric nursing specialist is a practitioner who is registered with The South African Nursing Council as such and holds a Master of Science Degree in psychiatric nursing. This specialist has extensive psychiatric nursing experience. As a result she has skills and competencies in advanced psychiatric nursing.

In this model, the psychiatric nursing specialist has mastered the skills of facilitating a quest for emotional maturity through capacity development, and therefore, to act as a facilitator and as a change agent and also as a resource person, who facilitates the process for a quest for emotional maturity for the psychiatric nurses in order to promote their mental health.

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4.10.2 Psychiatric Nurses

Registered psychiatric nurses are mental health care practitioners who are registered with the South African Nursing Council as such. These practitioners act as caregivers for the chronic psychiatric patients admitted to their unit at the facilities where the research was conducted. These individuals are tasked with facilitating the rehabilitation of those chronic psychiatric patients so that they can function at their highest level of capability with the ultimate aim of reintegrating them back into the community.

These patients have minimal potential for discharge due to the severity of their chronic psychiatric and intellectual disability.

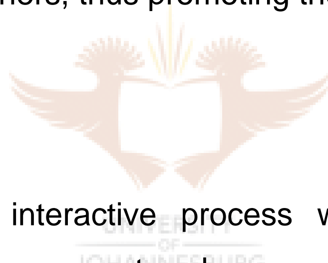
Whilst being charged with this responsibility, these practitioners are to receive support and guidance from management, as well as support from colleagues and other staff to

render quality patient care. They also receive continuous learning and development to acquire the skills and competences needed to function effectively.

In this model, psychiatric nurses are the recipients, who have the quest for their self-development in emotional maturity and therefore cooperate in this development as initiated by the psychiatric nursing specialist. They see this as an opportunity for personal growth towards maturity and advancement professionally.

Through this process they will be able to acquire skills and knowledge to assist them to handle the everyday challenges faced by rendering psychiatric nursing care to psychiatric patients.

As the process is taken further, psychiatric nurses begin to take ownership of their development by engaging in their lifelong process of learning in order to become fully mature independent practitioners, thus promoting their mental health.



4.10.3 Facilitation

Facilitation is a dynamic, interactive process whereby the psychiatric nursing specialist who acts as a change agent and as a resource person to create a positive environment, mobilises resources and identifies gaps and obstacles in the implementation of the skills development in a quest for emotional maturity of psychiatric nurses, with the ultimate aim of promoting their mental health (Rand Afrikaans University Department of Nursing, 2000: 7).

In this model, facilitation focuses on the following: what needs to be done? who needs to be involved? the design, flow, and sequence of tasks such as communication patterns, effectiveness, completeness, appropriate levels of participation, the use of resources, group energy, momentum, capability; and the physical and psychological environment (Justice and Jamieson, 1998: 4-5).

4.10.4 Process

Process refers to the facilitation of a quest for emotional maturity through capacity development whereby the psychiatric nursing specialist initiates a series of strategies and actions to bring about change in the situation of psychiatric nurses. The psychiatric nursing specialist would facilitate the process of developing from one system where psychiatric nurses are being dependent of management to that of leader on the nursing team in their units. During this process, psychiatric nurses develop skills and competencies that would assist them to move from emotional immaturity, that is, lacking the ability to express their feelings openly, not being able to deal with the environment in which they are functioning in, shift and blame attitude, and thereby be enabled to strive towards a quest for emotional maturity.

4.10.5 Promotion of Insight

Promotion of insight is defined as a personal illumination or awareness that changes the psychiatric nurses' appreciation of self (Burke (1989: 384). In this research the psychiatric nursing specialist strives to assist psychiatric nurses to appreciate themselves. This appreciation of self refers to an affective and cognitive process that begins with a new understanding and acceptance of self and leads to a deliberate change in behaviour. Theoretically, the change in behaviour that results from insight moves the person towards emotional maturity

4.10.6 Self-awareness

Self-awareness is defined as knowing yourself as a thinking and feeling being interacting with an everchanging world. In this model, psychiatric nurses focus on getting in touch with their own feelings and being open to experiences. It is upon this statement that Covey (1989: 67) says that self-awareness will enable psychiatric nurses to stand apart and examine the way psychiatric nurses see themselves and the self-paradigm that needs to shift.

Goleman (2002: 84) says self-awareness extends to a person's understanding of his values and goals. Someone who is highly self aware knows where he is headed and

why. Covey (1989: 67) mentioned that the psychiatric nurses' self-awareness does not only affect their attitudes and behaviour but also how they see other people. It becomes the map of the basic nature of mankind. Only when they are able to see themselves will they be able to understand how others see and what they feel about themselves and their world. People who are aware of their thoughts, feelings and reactions can communicate more clearly and openly with others. It is through self-awareness that one becomes conscious of disciplines of weaknesses, disciplines of improvement, and disciplines of talent (Tappan, 1989: 66).

4.10.7 Self-regulation

Self-regulation refers to the psychiatric nurses' ability to control their thoughts, feelings and actions. Self-regulation is like an ongoing inner conversation, it is the component of emotional intelligence that frees individuals from being prisoners of their feelings (Goleman, 2002: 85). Self-regulation is a voluntary process that requires systematic evaluation of the internal (mind, body and spirit) and the external (physical, psychological and spiritual) environment conditions that have led or could lead to a particular goal and the changing of those conditions to attain a goal. In this context some minimal attainment of self-regulation is seen as a precondition for maturity (Burke 1989 : 386).

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For the most part, the goal in this model is self-regulation, that is, in that it relates to improving the psychiatric nurses' capacity to interact successfully and rewardingly with the environment by gaining power or control over actions, thoughts and feelings. Beyond this initial goal, psychiatric nurses seek to understand the why and how of the situation they are trying to control, that is they seek insight into their problems, which is a goal that leads to their quest for emotional maturity (Burke, 1989: 10). Both self-awareness and self-regulation that lead to a quest for emotional maturity are thus an integral component of the goal of this model.

Some approaches emphasise that for the individual to gain self-regulation as part of emotional maturity development, the individual needs to develop insight into the problems. In self-regulation the individual must be able to display self-control when in the relative absence of external constraint and needs to engage in a behaviour that

probably has been less than that of being fearful or silent. Such an approach stresses the ability of the individual to develop a form of self-control over behaviour (Burke, 1989: 8). These related concepts are part of the framework on which the model is based. The application of these related concepts will be seen in the next chapter.

What follows below is a model case for facilitating a quest for emotional maturity through capacity development of psychiatric nurses in order to promote their mental health whilst in the nursing units in which they work.

4.11 THE MODEL CASE

Sr Molele [*not her real name*] is a registered psychiatric nurse employed at a psychiatric nursing unit comprising fifty chronic psychiatric patients. The unit has a staff complement of sixteen of which four are psychiatric nurses. The other staff members are enrolled nurses, enrolled nursing auxiliaries and residential health workers.

Psychiatric nurses each have a case load of twelve to thirteen patients allocated to them. Their role and functions as described in Chapter One is that of a professional, a unit manager, and case manager and an educator of her colleagues and patients.

This psychiatric nurse as the unit manager described the psychiatric facility environment as characterised by oppression and the lack of freedom to express herself freely. Staff around are always suspicious and frightened of making mistakes lest they get reprimanded in front of others. There was a high staff turnover, absenteeism and staff very often reported sick.

Activities of daily living for the psychiatric patients were hard to perform because of the lack of basic things like clothing and soap and hot water to bath the patients. “We often end up dressing patients with torn clothes, because we do not have good clothing”.
Nursing care was difficult to render because clinical equipment was not readily available. “We have to borrow the equipment from other wards such as the BP machines, stethoscope to do our work”.

"*Around here management does not support the professional nurses. We struggle to meet the needs of the patients.*"

Psychiatric nurses have to interact with the members of the multidisciplinary team on matters pertaining to the patients. Some of these team members saw the psychiatric nurse as a person to carry out orders from these professionals. These professionals did not recognise the psychiatric nurse as a member of the multidisciplinary team and a partner in sharing the psychiatric patients' workload.

This attitude of undermining us as psychiatric nurses further stifles and thwarts emotional maturity, thus causing varying degrees of emotional crippling for us to the extent that we feel powerless, because we do not have a legitimate support of management and this has led to the deterioration in this environment.

This resulted in most of the psychiatric nurses experiencing stress due to the environment in which they were functioning. They ended up resigning and leaving or being absent from work due to illness or they simply stayed away from work without valid reasons.

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Sr Molele said that throughout her career in psychiatric nursing, she came to realise that the psychiatric nurse had to acquire coping skills to deal with the demands of this nature. She said that she used to manage to escape the stresses and strains of being in such an environment but of late she said, "I feel like running away" and "always teary with every slight provocation".

Throughout her career as a psychiatric nurse, she developed survival strategies that enabled her to escape the environment, which she experienced as negative and not conducive to building her self-esteem and self-confidence.

This psychiatric nurse mentioned that the facility had been experiencing high staff turnover, absenteeism and poor work performance. The facility had developed the attitude what they term as "yes - but it will not work here". There is a shortage of staff,

equipment is not good, psychiatric patients are troublesome and unmanageable because of the shortage of staff.

As a result the “status quo” remained and staff became de-motivated and ultimately they resigned and left the facility.

The psychiatric nursing specialist shared the experience of this psychiatric nurse with management. Subsequent to this the psychiatric nursing specialist was invited to assist management in what management termed “attitude change”.

It was during these encounters that the psychiatric nurse realised that the issue was not about attitudes but the lack of emotional maturity to deal with the environment that these nurses found themselves in.

The psychiatric nursing specialist had to bring management and staff together and began to discuss how she could assist them to develop capacity for growth so as to enhance their self-esteem, self-acceptance, self-confidence and self-control so that they could have a satisfying relationship and have the ability to share their feelings openly and, in the end, could collectively confront the environment to make it conducive for them to work there. Psychiatric nurses stated that they were committed to quality patient care and had a passion for psychiatric nursing.

Structured meetings and consultations with management, psychiatric nurses together with labour organisation were conducted. This was a way of facilitating buy-in by all, particularly the labour organisations, because of issues pertaining to high absenteeism and high staff turnover, which this facility experienced.

This approach strengthened and mobilised interactions and facilitated the promotion of an environment conducive to expressing and sharing emotions, also for other people to interpret what the individual was feeling so as to be sensitive to that.

The psychiatric nursing specialist ensured that issues were clarified during interaction with management, psychiatric nurses and labour organisations. The psychiatric

nursing specialist encouraged everyone to share their experiences and express their feelings.

The psychiatric nursing specialist also assisted the group to accept their feelings, to be honest with themselves and to develop self-awareness and to be committed to the process of being mentally capacitated.

The group was allowed to talk freely and encouraged to show respect for one another. The psychiatric nursing specialist assisted and supported the group in their attempts to take control of their own emotions and in recognising their mental capacity to deal with issues under discussion.

Through this encounter, ideas, thoughts and feelings were shared. This resulted in the group realising their mental capacity to deal with their own emotions. They were in control and became self-aware. They recognised themselves in roles, and began to practice openness, acknowledgement, mutuality and cooperation.

Interactions demonstrated trust for one another, direct engagement of problems, conflict and interpersonal difficulties experienced during interaction.

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Individuals started to reinforce their development in autonomous self-esteem, self-awareness and self-control. They also developed interpersonal relationships characterised by trust, integrity and justice. This enhanced their efficiency and effectiveness in dealing with conflict and problems at hand and they also responded positively.

Statements such as the ones below were expressed by the group:

we can address this problem this way and that way
we have the ability to change this environment
absenteeism must be tackled head on

As they developed a trusting relationship among the group, the psychiatric nursing specialist provided them with emotionally challenging situations and encouraged them to deal with issues.

The psychiatric nursing specialist used techniques that assisted them to reflect and to practise openness in handling their own emotions and attitudes. This was to motivate them to learn self-awareness, self-regulation, and self-control and to be accountable for their behaviour and emotions.

As trust developed, other questions, which were more constructive, emerged. Relationships with all role-players including the psychiatric nursing specialist strengthened.

From this group it was evident that the meetings could be structured in a form of a workable programme over a period of time.

The psychiatric nursing specialist encouraged the facility to develop an emotional maturity enrichment centre of excellence where a structured programme could be developed and offered on a continuous basis to nurture and support psychiatric nurses working in psychiatric facilities for long term care of chronic psychiatric patients.

After many months of negotiations a centre of excellence for emotional capacity enrichment was established at this facility.

The psychiatric nursing specialist engaged management in the formulation of personal consent forms and in developing a policy for attendance at the centre. Management was also informed that staff members other than the psychiatric nurses could also refer themselves or be referred by management. Groups could be developed to work together or it could be on an individual basis.

The process was formalised and implemented. During the first group session psychiatric nurses were introduced to one another and to the researcher. The researcher assured them of privacy and confidentiality regarding the disclosure of personal issues. The researcher spent time informing them that she would expect the same privacy and confidentiality among the group.

The members of the group were encouraged to share their experiences and to really express their emotions as it would help them to build their capacity to deal with emotionally challenging issues. It was also made clear to them that should they find the interaction uncomfortable in any way, they were welcome to terminate their involvement at any time and that their termination would not affect them in any way whatsoever.

Rules for interaction were then negotiated with the group and implemented. Among other rules, it was emphasised that punctuality was important, respect for each other was crucial and that each member had to practise self-respect, had to be aware of themselves as individuals and to exercise self-control.

Active participation was also encouraged and they had to practise working on the 'here and now', particularly when emotions were expressed.

The interaction contributed to sharing in the discussion. The group began to develop a sense of self-awareness. The use of defences decreased, anxieties that were observed became minimised and the researcher began to feel a sense of openness. As the discussion unfolded, interpersonal competencies and interactions, dominated by positive regard emerged. Acceptance of feelings and a commitment to the process emerged.

The group moved on to become honest with one another when giving feedback to each other. Mutuality and trust became evident.

The session evolved into recognition of self in developing emotional maturity through practice and open acknowledgement of own strengths and limitations, being cooperative and developing communication skills.

As the process unfolded the group became more open and started to facilitate the session. The researcher felt that the group were now learning competencies in emotional control. They became reflective and started to develop the mental power of being in control of their own emotions. Inner feelings were freely expressed and at this point the researcher felt that there was cohesion among the group.

As the group became open with each other they began to encourage and to be supportive of each other. The researcher began to hear statements such as “I feel so grounded and in control of myself and thank you for your openness and courage”. The researcher realised that she had to use less and less verbal encouragement and let the group take charge. At this time the group were able to improve their relationships and move to a level of developing the power of inner feelings/emotions. The members began to be involved in deep introspective reflection.

The researcher noticed the group demonstrating empathy with each other. This particular session saw members reflecting their own emotions and also taking into consideration other group members’ feelings. Those who were defensive and quiet were the ones who were reflecting inner feelings more openly. The researcher felt that the group was becoming aware of themselves. When the researcher realised that the group had bonded well, she created an environment which they described initially as being experienced as negative, for the group to turn it into positive and stimulating for them to work in. The researcher then made the group address issues that were of concern. The group confronted the members who were seen to be “contributing” to the environment that was not conducive to work in.

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The group confronted each other with respect. They expressed their feelings in such a way that it was acceptable. They were able to mobilise themselves into a supportive resource. They were all able to exercise self-control and were able to listen and communicate effectively with each other.

The researcher observed their mental capacity to tackle the problem at hand. The group were direct with each other. As a result the environment was eventually turned into an environment conducive to sharing and cooperation and ‘togetherness’ prevailed. They were supportive of each other. Self-awareness, self-regulation and self-control were demonstrated throughout the interaction. A healthy process was thus developed.

It was during this encounter that a feeling of emotional growth was experienced and the group shared this feeling with the researcher. It took almost eight working sessions to achieve this level of questing for emotional maturity.

The researcher experienced these sessions as enriching and that before the group could achieve this level, they had to first experience feelings within themselves. They needed to acknowledge these feelings and be able to express them. Also during the process, an environment of trust had to be created and members had to be honest with themselves first, and learn to be honest with others. In so doing they developed a sense of trust and could be able to learn to practice self-disclosure.

It was through self-disclosure that they could develop skills for self-awareness, self-regulation and be able to take control of their own emotions. This led to positive behaviour and they began to experience the environment in a different way and began to confront problems in a more positive way. Every problem in the environment was seen as a challenge and that it could be solved collectively. This would be a way of questing for emotional maturity thus improving their mental health.

4.12 CONCLUSION

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A quest for emotional maturity through the capacity development model pointed to the development of strategies that would enhance psychiatric nurses' development of skilful responses to emotional challenge. More specifically the model proposed that the ability to produce mental capacity, monitoring own and others' emotion and self-awareness comprises the core dynamic that will promote the mental health of psychiatric nurses.

The model case suggests that improvements can be achieved through the interaction of the psychiatric nursing specialist, psychiatric nurses, the family, the environment in which psychiatric nurses interact and the community, and that emotional maturity development geared towards psychiatric nurses, would promote their mental health and help them acquire competency to receive power for happiness.

The next chapter will address the model that will serve as a framework for the psychiatric nursing specialist to facilitate a quest for emotional maturity through capacity development of psychiatric nurses in the promotion of their mental health which is an integral part of overall health.

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CHAPTER FIVE

DESCRIPTION OF A MODEL TO FACILITATE A QUEST FOR EMOTIONAL MATURITY THROUGH CAPACITY DEVELOPMENT OF PSYCHIATRIC NURSES IN PROMOTING THEIR MENTAL HEALTH

5.1 INTRODUCTION

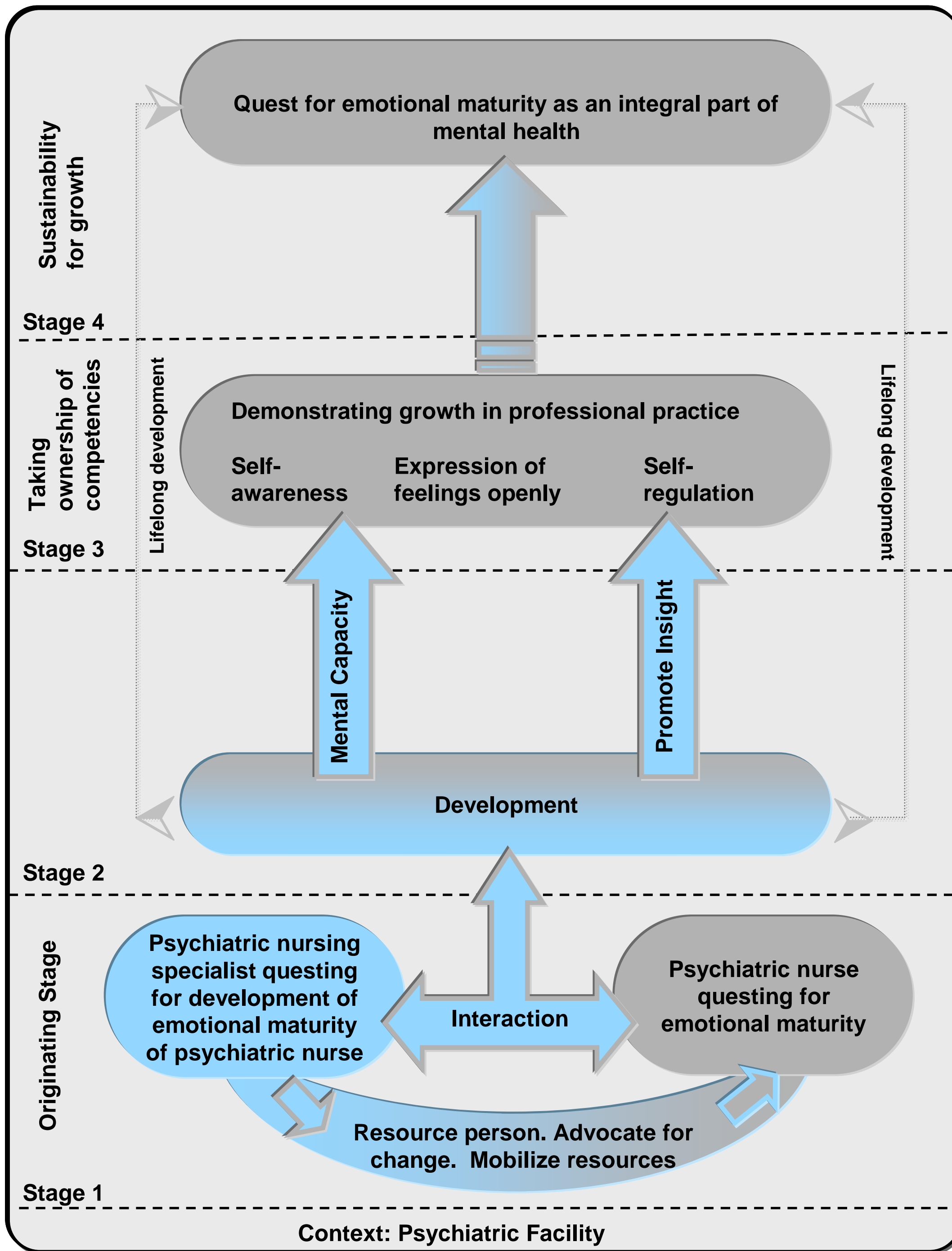
In Chapter Four the researcher dealt with the identification and the definition of the main concepts as well as other related concepts that would form the building blocks of the model.

This chapter will address the model that will serve as a framework for the psychiatric nursing specialist to facilitate a quest for emotional maturity through capacity development of psychiatric nurses in the promotion of their mental health which is an integral part of health. The assumptions, relationship statements, the structure and the process of the model are described in this chapter. This will be followed by the presentation of guidelines for operationalising the model. The chapter will conclude with the evaluation of the model and the guidelines for operationalising the model in practice.

5.2 OVERVIEW OF THE MODEL

The overview of the model is presented in Figure 5.1: A model to facilitate a quest for emotional maturity through capacity development of psychiatric nurses in promoting their mental health, on the next page.

Figure 5.1: A MODEL TO FACILITATE A QUEST FOR EMOTIONAL MATURITY THROUGH CAPACITY DEVELOPMENT OF PSYCHIATRIC NURSES IN PROMOTING THEIR MENTAL HEALTH

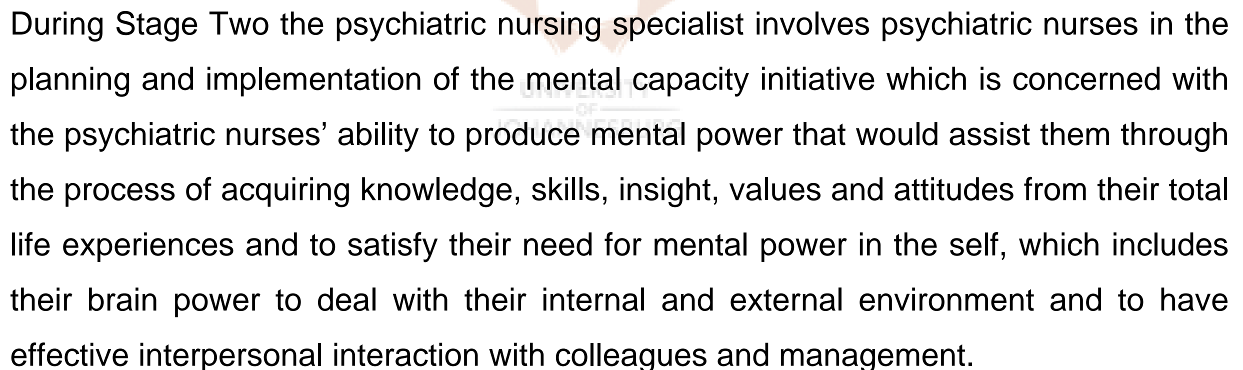


The overview of the model in the previous page entails the stages, One to Four, which are described as follows:

5.2.1 Stage One

Stage One of the model shows the psychiatric nursing specialist and the psychiatric nurses are beginning to work together. In this process the psychiatric nursing specialist initiates a quest for emotional maturity through mental capacity development for the benefit of the psychiatric nurses. The psychiatric nursing specialist act as a resource and a change agent. She initiates a process of engaging the psychiatric nurses in a meaningful way by aiding psychiatric nurses to begin to understand the world around them and to support them in their quest for emotional maturity. Through this process the psychiatric nursing specialist buys into the process thereby releasing the resources at her disposal.

5.2.2 Stage Two



During Stage Two the psychiatric nursing specialist involves psychiatric nurses in the planning and implementation of the mental capacity initiative which is concerned with the psychiatric nurses' ability to produce mental power that would assist them through the process of acquiring knowledge, skills, insight, values and attitudes from their total life experiences and to satisfy their need for mental power in the self, which includes their brain power to deal with their internal and external environment and to have effective interpersonal interaction with colleagues and management.

Mental capacity development aims at equipping psychiatric nurses with skills and competencies in their quest for emotional maturity. Environmental capacity focuses on assisting psychiatric nurses to learn to be open to new experiences and on their willingness to learn flexibility and accept challenges to become equal partners with the members of the multidisciplinary team and colleagues, whilst interacting in the psychiatric facility. This development is geared towards enabling psychiatric nurses with skills and competencies whilst executing their functions as professional psychiatric nurses and as members of the multidisciplinary team. These competencies enable psychiatric nurses to engage in meaningful clinical discussions

with the members of the multidisciplinary team and to be able to contribute meaningfully and also to take leadership of their own nursing unit. This development is driven by the following main strategies which are the promotion of insight and mental capacity. These two strategies work together. However each strategy is aimed at a specific area in the development of psychiatric nurses.

Mental capacity and the promotion of insight when put together lead to the acquisition of competencies such as self-awareness and self-regulation of psychiatric nurses. It can also mean the promotion of understanding of the environment in which the psychiatric nurses are interacting, thus assisting them in understanding why certain practices are emphasised, for example, why the managers emphasise the budget when dealing with them. Through this mental capacity they would be able to gain insight and would therefore have the ability to participate actively and contribute meaningfully to their personal and professional development.

These two strategies are geared towards assisting the psychiatric nurses to gain understanding and thereafter change the way they have been viewing certain practices and begin to change their way of interpreting behaviours. This also addresses the undermining by other members of the multidisciplinary team where some practitioners still believed that psychiatric nurses were there to take orders from them and not accepting the psychiatric nurses as equal partners in the execution of the new Mental Health Care Act (Act No 17 of 2002) and the Regulations thereof.

5.2.3 Stage Three

Stage Three addresses psychiatric nurses who have just completed the development process. These psychiatric nurses have acquired competencies and therefore take ownership in their quest for emotional maturity through capacity development. A quest for emotional maturity is a lifelong development process in which psychiatric nurses must take ownership for capacitating themselves. This is a process that will assist the psychiatric nurses to become interdependent professionals, and to learn to take responsibility for becoming independent professionals capable of applying the competencies acquired in this development.

The psychiatric nursing specialist and the psychiatric nurses become the advocates for the development of the Centre of Excellence for Emotional Maturity in the facility which could be accessed by all the staff members working with chronic psychiatric patients because working with psychiatric patients can be stressful as indicated in the literature reviewed in this research.

5.2.4 Stage Four

Stage Four demonstrates that the psychiatric nurses have acquired the competencies and could now be trusted as independent and interdependent professionals who can practice their profession competently within their legal and professional parameters. This is a demonstration that these psychiatric nurses are on a path for a quest for emotional maturity thus promoting their mental health which is an integral part of their health.

Questing for emotional maturity gives psychiatric nurses the opportunity to interact with management and colleagues as equal partners in the delivery of quality patient care. A quest for emotional maturity through capacity development needs constant nurturing and maintenance. It therefore becomes a lifelong development. These psychiatric nurses continue to play a role in their development by taking a leadership role in their psychiatric unit and in their career development. They need to maintain the status of being registered psychiatric nurses, so that the South African Nursing Council can rely on them and protect their image as psychiatric nurses. Through this development, the community, family and the client (The Department of Health) could rely on them.

Other clinical professionals and management could also trust and rely on them as colleagues and professionals. In addition they maintain their quest for emotional maturity through mental capacity development for self and professional development.

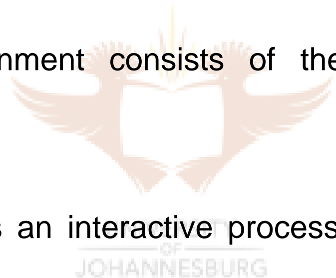
Stage Four ends with the psychiatric nurses in a state of questing for emotional maturity as an integral part of mental health. The role of the psychiatric nursing specialist is to act as a resource person to the psychiatric nurses and to the

management team within the facility, and also to facilitate a quest for emotional maturity through the mental capacity development of these psychiatric nurses.

5.3 ASSUMPTIONS ON WHICH THE MODEL IS BASED

The model is based on the Theory for Health Promotion in Nursing. In the application of this model, the psychiatric nurses, management, colleagues and the psychiatric nursing specialist are seen interacting in the environment in a holistic manner.

- The psychiatric facility includes the external and internal environment.
- The internal environment of the psychiatric nurses, management, members of the multidisciplinary team, colleagues and the psychiatric nursing specialist consists of the body, mind and spirit.
- The external environment consists of the physical, social and spiritual dimensions.



- Psychiatric nursing is an interactive process that facilitates the promotion of mental health.
- Psychiatric nursing interaction indicates a mutual involvement between the psychiatric nursing specialist and the psychiatric nurse.
- The psychiatric nursing specialist demonstrates the state of genuineness by being a sensitive therapeutic professional. She demonstrates knowledge and skills to facilitate the promotion of mental health of the psychiatric nurses.
- Mental health is an interactive dynamic process in the environment of the psychiatric nurse.
- The relative status of the mental health of the psychiatric nurses is reflected by the interaction in the environment.

- The emphasis is on the quest for wholeness.

- Promotion of mental health implicates the mobilisation of resources.

A quest for emotional maturity through mental capacity development will contribute to the promotion of the mental health of psychiatric nurses.

5.4 GOAL

This model serves as a framework for the psychiatric nursing specialist to facilitate a quest for emotional maturity of the psychiatric nurses through capacity development and is an integral part of promoting the psychiatric nurses' mental health which is the ultimate goal of this model.

The psychiatric nursing specialist facilitates the implementation and the transformation of behaviour by the therapeutic use of the self and communication whilst interacting with the psychiatric nurse.

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5.5 CONTEXT OF THE MODEL

The context of the model is the psychiatric facility where the psychiatric nurses function and interact with psychiatric patients, the multidisciplinary team professionals, colleagues and management. They all function as a group with the family and within the community.

The context in this model is currently going through major transformation in terms of the implementation of the new Mental Health Care Act (Act 17 of 2002).

This legislation put more emphasis on the rights of the users and the reintegration of the users into the community and the introduction of the new role that will be played by the multidisciplinary team.

With the introduction of the new Mental Health Care Act (Act 17 of 2002) the psychiatric nurses are considered as members of the mental health care professionals. Their role is going to change from taking instructions from the other practitioners to taking an active role in the implementation of the Mental Health Care Act (Act 17 of 2002) as any other mental health professional is expected to do. For example, they will be participating in the admission assessment of the user together with the other mental health care practitioners. There are some of the mental health care professionals who undermine the psychiatric nurses and still find it difficult to recognise the psychiatric nurses as equal partners in the care and rehabilitation of the psychiatric patients.

Further challenges that the psychiatric nurses are faced with, are for example, the introduction of the admission assessment which leads to decision making by the psychiatric nurse as a member of the professional team, whether or not to admit a user, the writing of the periodical report on the progress of the psychiatric users, to decide whether the user still needs further care, treatment and rehabilitation. All these functions had formerly been the sole function of the psychiatrist. Therefore the recognition of the psychiatric nurses in their new role put a challenge to all the people who are in a psychiatric facility.

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In this model, all these factors in the context of the psychiatric facility are taken into account.

The psychiatric nursing specialist facilitates the process that will enable psychiatric nurses to participate in the lifelong development that will gear them towards a quest for emotional maturity through capacity development. The psychiatric nursing specialist begins to build mental capacity for the psychiatric nurses to begin to gain insight in order for them to understand the situation that they are faced with. The psychiatric nursing specialist also mobilises the resources and advocates for changes in the environment that will encourage the psychiatric nurses to take ownership in their personal development.

In this model, the members of the multidisciplinary team and colleagues are seen as the resources that will be utilised to facilitate a quest for the emotional maturity for these psychiatric nurses, thus promoting their mental health which is an integral part of their health.

5.6 THEORETICAL DEFINITION OF THE MODEL

The following concepts when put together create a model for the facilitation for a quest for emotional maturity through capacity development.

5.6.1 A quest for emotional maturity through capacity development

The concept is defined and described as the psychiatric nurses' ability to demonstrate that they are fully developed in that they have gained insight thus making them capable of expressing their feelings openly and of exercising self-control. They have the mental power for lifelong development in self-awareness and self-regulation and they accept change. They hold a balanced view of the world.

This concept is a developed or skilful response to an emotional challenge in which psychiatric nurses recognise and engage directly with the challenge, consciously choosing behavioural responses rather than reacting out of instinct. Whilst engaged in this process psychiatric nurses will acquire skills, competencies and knowledge to confront life challenging issues and this would lead to the improvement in their mental health. The psychiatric nurses would also acquire the facilitation of their internal and external resources and create mental power to enable them to look from within and to be conscious of themselves, thus creating self-awareness. This self-awareness will lead to the psychiatric nurses being able to channel their emotions in service for a goal, and self-regulation assists psychiatric nurses to be in control of their own feelings and behaviour. Self-awareness facilitates competency to receive power for happiness, and happiness will then promote the mental health of psychiatric nurses.

5.6.2 Quest

Quest can best be described as an exploration in search of something with which to accomplish a goal. The researcher uses the word “quest” with emotional maturity because emotional maturity is a lifelong process of development, therefore psychiatric nurses would be involved in the act of seeking emotional maturity. It is therefore necessary to also define the word “quest” so as to utilise it in the context of emotional maturity.

5.6.3 Capacity

Capacity in this context is related to mental capacity and can thus be defined as the brain power or the ability to produce mental power to produce capabilities and potential skills for understanding, judgement, imagination and cleverness and this is regarded as capacity building. Holmer (1993: 1) says capacity is an individual’s characteristic orientation towards and response to the conscious or unconscious experience of an emotional challenge. Holmer (1993: 1) uses capacity with the word emotional and says it is a challenge just as any real or perceived threat to an individual’s security or self-concept that stimulates their instinctive self-protective tendencies to withdrawal or aggression.

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5.6.4 Development

Development is a process of moving towards maturity. This word refers to a process that takes place throughout one’s life. Development is seen as a process of continuous learning that recognises both the independent and interdependent nature of the world. This refers to the self-reliance of the individuals as independent people and the interdependence of their colleagues and their significant others.

5.6.5 Psychiatric Nursing Specialist

The psychiatric nursing specialist is a practitioner who is registered with The South African Nursing Council as such and holds a Master of Science Degree in psychiatric

nursing. This specialist has extensive advanced psychiatric nursing experience. As a result she has skills and competencies in advanced psychiatric nursing.

In this model, the psychiatric nursing specialist has mastered the skills of facilitating a quest for emotional maturity through capacity development, and therefore, acts as a facilitator, as a change agent and also as a resource person, who facilitates the process for a quest for emotional maturity for psychiatric nurses, in order to promote their mental health.

5.6.6 Psychiatric Nurses

Psychiatric nurses are mental health care practitioners who are registered with the South African Nursing Council as psychiatric nurses. These practitioners act as caregivers for the chronic psychiatric patients admitted to their unit at the facilities where the research was conducted. These psychiatric nurses are tasked to facilitate the rehabilitation of the chronic psychiatric patients so that they can function at their highest level of capability with the ultimate aim of reintegrating them back into the community.

Whilst being charged with this responsibility, these practitioners are to receive support and guidance from management and support from colleagues and other staff to render quality patient care. They also engage in continuous learning and development to acquire the skills and competences necessary to function effectively.

5.6.7 Process

Process refers to the facilitation of a quest for emotional maturity through capacity development, whereby the psychiatric nursing specialist initiates a series of strategies and actions to bring about a change in the situation of psychiatric nurses.

During this process, psychiatric nurses develop skills and competencies that will assist them to move from emotional immaturity, that is, lacking the ability to express their feelings openly, not being able to deal with the environment in which they are functioning in, shift and blame attitude, and to strive towards a quest for emotional

maturity. The psychiatric nursing specialist's role that she plays is in the implementation of a new strategic standard in a quest for emotional maturity through capacity development of psychiatric nurses employed by the company.

Part of this function entails the vision brought by this new strategic initiative, providing input into the company culture, and involving the company's executive team, management and staff as they will be affected by this process. The psychiatric nursing specialist facilitates this process from a system where psychiatric nurses were dependent on management to that of leaders of the nursing team in their unit. This process is associated with the promotion of insight programme. It is aimed at transforming the conditions in the internal environment of individuals, for the purpose of transforming them (Rose and Black, 1985: 43).

5.6.8 Promotion of Insight

Promotion of insight is a personal illumination or awareness that changes the psychiatric nurses' appreciation of self. In this research, the psychiatric nursing specialist strives to assist psychiatric nurses to appreciate themselves. This appreciation of self refers to an affective and cognitive process that begins with a new understanding and acceptance of self and leads to a deliberate change in behaviour. Theoretically, the change in behaviour that results from insight, moves the person towards emotional maturity (Burke,1989: 384).

5.6.9 Self-awareness

Self-awareness is defined as knowing yourself as a feeling and thinking being interacting with the ever-changing world (Tappan, 1989: 66). In this model psychiatric nurses focus on getting in touch with their own feelings and being open to experience. It is upon this above statement that Covey (1989: 67) says that self-awareness will enable psychiatric nurses to stand apart and examine even the way psychiatric nurses see themselves and undergo a paradigm shift.

Goleman (2002: 84) says self-awareness extends to peoples' understanding of their values and goals. People who are highly self-aware know where they are headed and why.

If psychiatric nurses are aware of their thoughts, feelings and reactions they can communicate more clearly and openly with others. It is through self-awareness that they become conscious of weaknesses, improvement, and talents.

5.6.10 Self-regulation

Self-regulation refers to the psychiatric nurses' ability to control their thoughts, feelings and actions (Burke, 1989: 386). Self-regulation which is like an ongoing inner conversation, is also the component of emotional intelligence that frees individuals from being prisoners of their feelings (Goleman (2002: 85). Self-regulation as defined by Burke (1989: 386) is a voluntary process that requires systematic evaluation of the internal (mind, body and spirit) and the external (physical, psychological and spiritual) environmental conditions that have led or could lead to a particular goal and the changing of those conditions to attain a goal. In this context some minimal attainment of self-regulation is seen as a precondition for maturity.

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For the most part, the goal in this model is self-regulation, that is, it relates to improving the psychiatric nurses' capacity to interact successfully and rewardingly with the environment by gaining power or control over actions, thoughts and feelings. Beyond this initial goal, psychiatric nurses seek to understand the why and how of the situation they are trying to control, that is, they seek insight into their problems, and that leads to their quest for emotional maturity. Both self-awareness and self-regulation that lead to a quest for emotional maturity are thus integral components of the goal of this model (Burke, 1989:10).

In self-regulation the individual must be able to display self-control when in the relative absence of external constraint. The individual needs to engage in a behaviour that is less fearful. Such an approach puts emphasis on the individual to develop a measure of self-control over behaviour (Burke, 1989: 8).

5.7 RELATIONSHIP STATEMENTS OF THE MODEL

- The process of a quest for emotional maturity through capacity development takes place between the psychiatric nursing specialist, psychiatric nurses and the colleagues within the context of the psychiatric facility.

- The process for a quest for emotional maturity allows psychiatric nurses to gain insight, and to develop self-awareness and self-regulation and for this to happen, the psychiatric facility's environment needs to be transformed to create an environmental condition conducive to allow expression of feelings without fear and to develop trust in management in order to facilitate the mastery of competencies for a quest for emotional maturity.

- For a quest for emotional maturity to succeed, a multi-dimensional approach must be adopted. This makes it easy to practise self-awareness and self-regulation which leads to a quest for emotional maturity.

- The more psychiatric nurses gain control of themselves and the environment (the psychiatric facility) the more they would be willing to express their feelings openly thus promoting their mental health.

- The more psychiatric nurses practise the skills acquired through capacity development, the more likely they will be able to internalise these skills and competencies that would lead to their mental health being improved.

Details of the structure, process and stages of the model for facilitating a quest for emotional maturity of psychiatric nurses in promoting their mental health is described below.

5.8 DESCRIPTION OF THE STRUCTURE OF THE MODEL

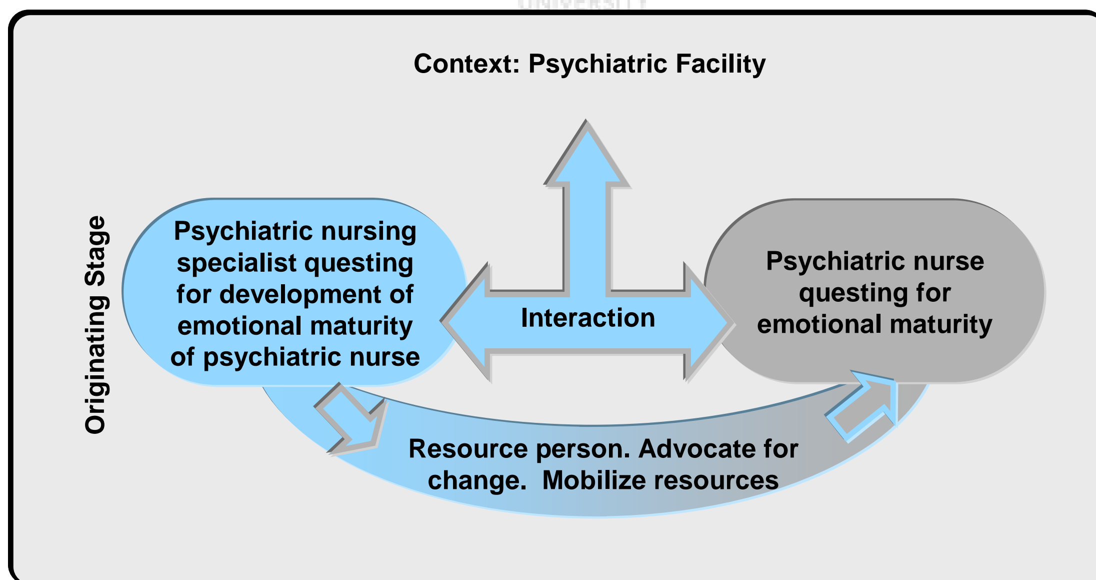
The concepts identified and defined in Chapter Four are given structural form to clarify their relationships by means of a symbolic representation as outlined in Chinn and Kramer (1991 : 116-117).

The structure of the model gives an overall form to the conceptual relationships in the model and includes the description of the procedure in handling capacity development to acquire emotional maturity.

The figure below depicts the interaction between the psychiatric nursing specialist and the psychiatric nurse in their quest for emotional maturity.

This interaction is within the context of Figure 5.2 Stage One: Structural form depicting the psychiatric nursing specialist, psychiatric nurses and the psychiatric facility as the context.

Figure 5.2 STAGE 1: ORIGINATING STAGE



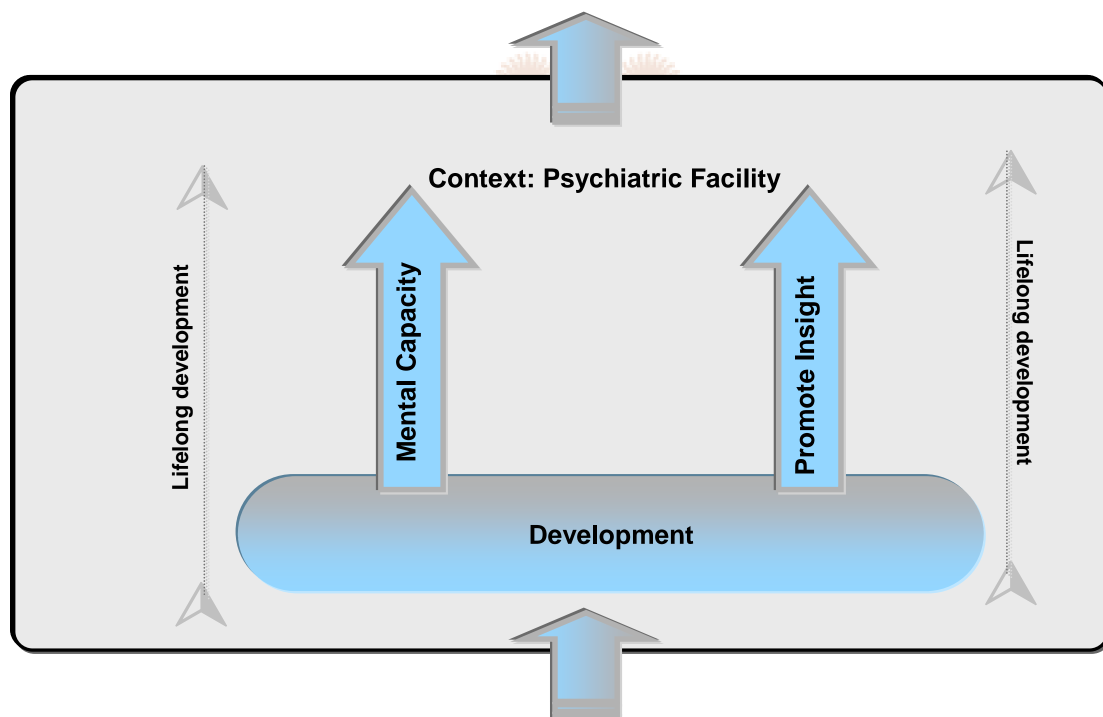
In Figure 5.2 the psychiatric nursing specialist is in the blue coloured oval diagram and the psychiatric nurses are represented by the grey coloured oval diagram. These two are connected through a blue/grey arrow pointed both ways to the psychiatric

nursing specialist and the psychiatric nurses demonstrating the interaction between the two.

The arrow demonstrates that the psychiatric nursing specialist is initiating an interactive process as a resource person. She advocates for change and mobilises the resources to facilitate a quest for emotional maturity of the psychiatric nurses. This process occurs within the context of the psychiatric facility and is represented by the blue/grey colours in the form of arrows pointing towards the psychiatric nurses.

The background colour of light grey represents air which signifies that there is a vision for the psychiatric nurse in their quest for emotional maturity.

Figure 5.3 STAGE 2: CAPACITY DEVELOPMENT

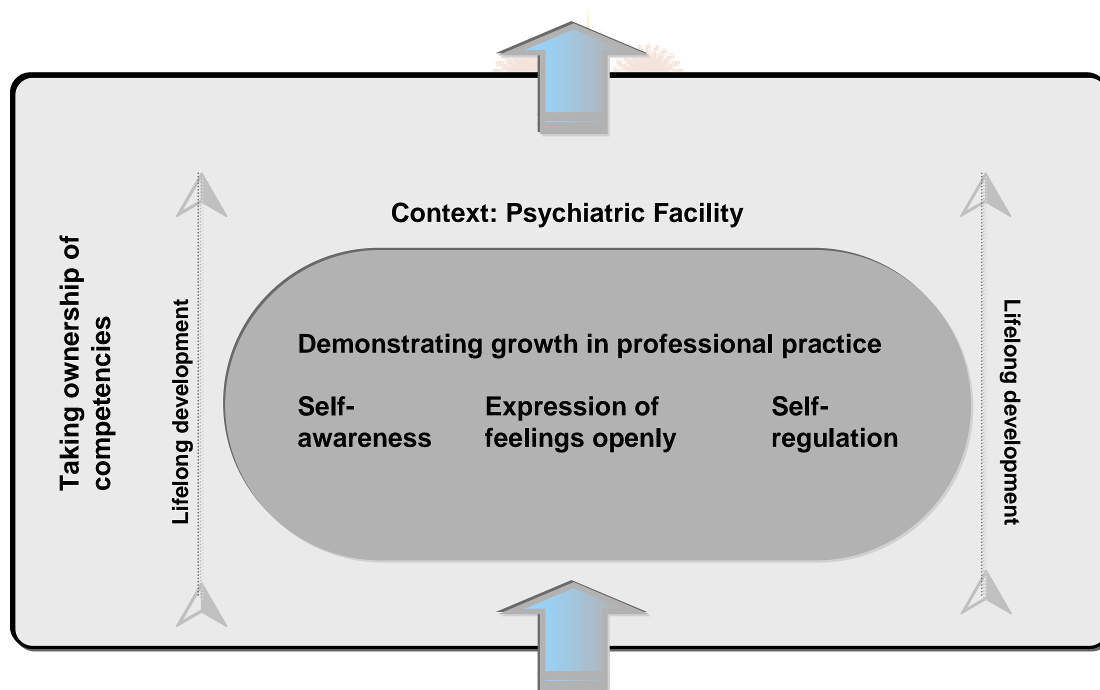


In the above figure the process of capacity development starts with the activities facilitated by the psychiatric nursing specialist who begin with the promotion of insight. The activities, namely, the promotion of insight and mental capacity, are represented by the blue/grey arrows pointing towards growth in professional practice. These

arrows are surrounded by lifelong development which signifies that this development lasts for a lifetime. Psychiatric nurses begin to move from the position of being vulnerable to stress, being silent due to fear and lack of trust in management and begin to gain the competencies required so as to be confident and caring as professionals.

This development takes place within the context of a psychiatric facility which is represented in the background shaded by a light bluish grey signifying that the psychiatric nursing specialist has vision and uses communication as a means of reaching out to psychiatric nurses in their quest for emotional maturity.

Figure 5.4 STAGE 3: TAKING OWNERSHIP OF COMPETENCIES



In this stage psychiatric nurses have just received the mental capacity through the development process that they were engaged in. The psychiatric nurses now take ownership of the process of internalising the competencies for their own professional development.

These competencies (self-awareness, expression of feelings openly and self-regulation) place the psychiatric nurses at a higher level of functioning within their profession.

These competencies are represented by the grey oval diagrams which demonstrate the ability to gain self-awareness, to express emotions freely, and to exercise self-regulation with the ultimate goal of a quest for emotional maturity. This oval diagram is surrounded by the colour light grey signifying that there is vision for the psychiatric nurses in acquiring these competencies.

Figure 5.5 STAGE 4: SUSTAINABILITY FOR GROWTH AND ADVANCEMENT

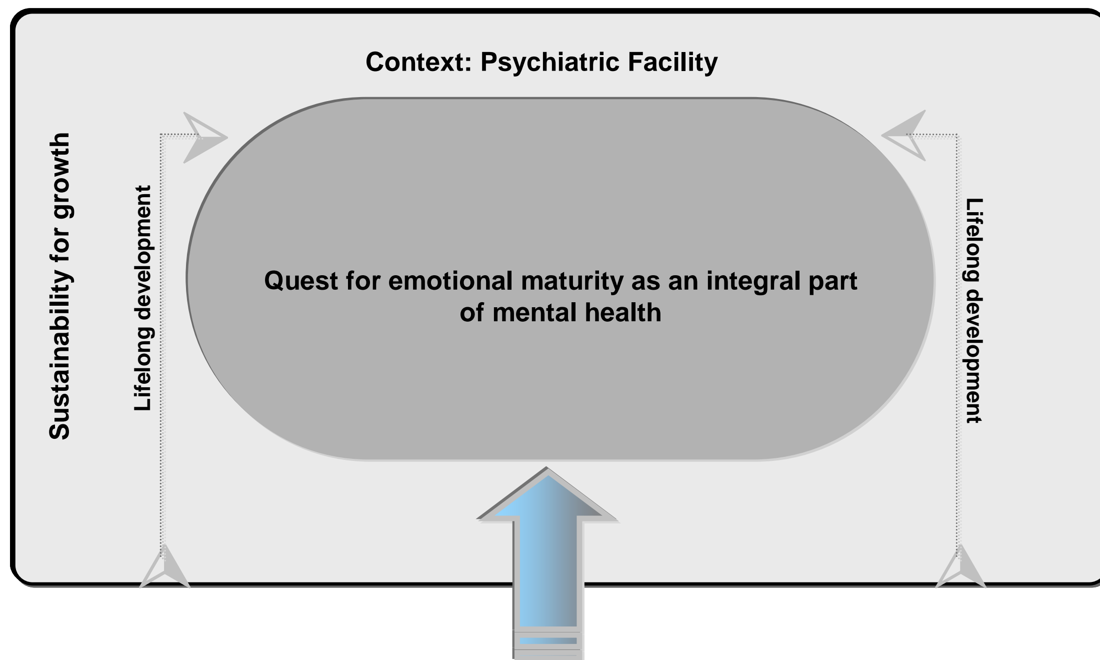


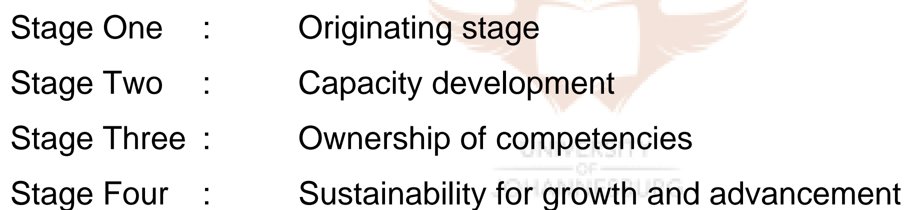
Figure 5.5 depicts psychiatric nurses in the last stage, which begins to show the successful acquisition of the competencies for their professional practice. They are now being crowned as champions, because they can now interact, partner and participate and enjoy being with the multidisciplinary team, by demonstrating emotional maturity in all their dealings as registered psychiatric nurse practitioners.

These psychiatric nurses can pursue their career towards being psychiatric nursing practitioners. This forms an integral part of mental health. A quest for emotional maturity is a lifelong learning process which needs to be sustained in order to promote growth.

They have to continue with this development in order to quest for emotional maturity in order to promote their mental health throughout their lives. Failure to do so could affect their mental health and could lead to regressing to the initial stage of vulnerability to stress.

5.9 PROCESS DESCRIPTION OF THE MODEL

The process of the model for facilitating a quest for emotional maturity through capacity development takes place in stages which overlap with each other and which are:



Stage One : Originating stage
Stage Two : Capacity development
Stage Three : Ownership of competencies
Stage Four : Sustainability for growth and advancement

These stages are interdependent and are discussed as follows:

5.9.1 Stage One: Originating Stage

This stage is referred to as the beginning stage. It indicates the psychiatric nursing specialist is interacting as a resource person and a change agent in the environment (internal and external) of the psychiatric nurse.

This psychiatric nursing specialist begins the process of facilitation of a quest for emotional maturity through capacity development by promoting insight regarding psychiatric nurses' experiences. The context in which this interaction is taking place, is within the psychiatric facility.

Both the psychiatric nursing specialist and the psychiatric nurses are questing for emotional maturity, although the psychiatric nurses' participation at this stage is minimal because the psychiatric nursing specialist as the initiator acts as a resource person and advocate for change.

This stage mainly focuses on:

- sharing of information and imparting knowledge
- the mobilisation of the resources to effect change
- getting the buy-in of the model

5.9.1.1 *Sharing of information and imparting knowledge*

The origination of the process begins when the psychiatric nursing specialist as a resource person begins to engage management, the multidisciplinary team and colleagues with the psychiatric nurses in a positive and constructive manner.

The psychiatric nursing specialist starts taking the role as a resource person by sharing the findings of the research and how the lessons learned can be beneficial in addressing the successful implementation of a lifelong development in a quest for emotional maturity.

She becomes the voice of the psychiatric nurses by sharing their experiences on the following:

- The gap between the current situation current company culture of "Unwritten Ground Rules" (UGRs) and the desired company culture.

- The experiences of psychiatric nurses with regard to their interaction with management and the members of the multidisciplinary team, relating to matters affecting them and their families.

- How these experiences hamper their leadership role as unit managers as well as how they affect their mental health.

- Issues that lead them to be silent and fearful and to display lack of trust in management.

- The need of these psychiatric nurses to develop a quest for emotional maturity, in order to be recognised as leaders in their own units, to participate in the rehabilitation of psychiatric patients, and to gain respect and recognition from the multidisciplinary team and management and to redefine the company culture (UGRs) that support the growth and development of these psychiatric nurses.

5.9.1.2 Mobilisation of resources to effect change

In order to effect change, the psychiatric nursing specialist needs to have a structured programme, and for the programme to be implemented, she needs resources, both internal and external so as to begin to engage psychiatric nurses in their development on a personal level and at the professional level. The mobilisation of resources includes the creation of a therapeutic environment conducive for the successful implementation of the capacity development initiative.

For these nurses to be emotionally mature, Burke (1989: 207) says some means must be devised for enhancing their maturity by bringing their behaviour more in line with the expectation of society, thus potentially adding to the individuals satisfaction in life. This is accomplished by providing the psychiatric nurses with new information and experiences that promote increasingly mature behaviour.

The psychiatric nursing specialist negotiates with management to allocate resources needed for the initiation and the mobilisation of other resources. This model needs to address the vulnerability of the psychiatric nurses in terms of the physical and mental stress experienced by them whilst interacting with management and the members of the multidisciplinary team and colleagues.

The psychiatric nursing specialist also needs the buy-in by members of the multidisciplinary team and colleagues who will also act as facilitators of change in the psychiatric facility by taking ownership of this model and by participating in the capacity development programme.

The psychiatric nursing specialist together with the staff must develop a common understanding of what the process will entail as well as the developing potential to enable themselves whilst participating in this initiative.

In order to effect change in the psychiatric nurses' situation, the psychiatric nursing specialist must:

- Be competent in interpersonal skills which include communication skills, negotiation skills and presentation skills.
- Have a good understanding of the code of good ethics in advocacy.
- Possess facilitation skills and group therapy techniques.

All the above skills will be needed when conducting workshops and seminars on knowledge based workshops.

Management, the multidisciplinary team and colleagues have to be convinced that this process is imperative to effect change.

The psychiatric nursing specialist also applies her knowledge and skills to change management and facilitates this transition. This change is about culture change in terms of the unwritten ground rules (UGRs) to visible culture change in terms of how "we do things around here".

Culture change goes with unlearning the old UGRs to transforming those negative UGRs to positive UGRs. This transformation will enable the psychiatric nurses to change the way they interact with management, and staff to become facilitators themselves of their own development thus becoming resource persons and assisting in the transformation of the company culture, that is, the transformation to positive UGRs.

5.9.1.3 Getting the buy-in of the model

Lastly, it is about buy-in of the model for facilitating a quest for emotional maturity through capacity development. This is a lifelong development and it serves as a guideline for the successful implementation for the promotion of the psychiatric nurses' mental health.

The psychiatric nursing specialist acts as a resource person to facilitate this buy-in. She advertises and markets the model to all the members of staff of the psychiatric facility.

5.9.2 Stage Two: Capacity Development

This development is facilitated by adopting the capacity development strategy and the promotion of insight. The central strategy here is the mental capacity. The other strategy, that is, the promotion of insight is a supportive strategy to mental capacity to drive the increase in capacity development of psychiatric nurses.

5.9.2.1 Mental capacity

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The model in Figure 5.1 (page 143) shows that mental capacity is central and the other supportive strategy being the promotion of insight. This development focuses on enabling the psychiatric nurses to deal with those issues that they are faced with in their daily interaction with the environment in which they are functioning. For them to deal with those issues they first have to develop insight into the situation and accept that there is a need for them to embark on this process of development.

This process includes the interaction with management, members of the multidisciplinary team, colleagues, patients and families. Therefore a quest for emotional maturity would assist psychiatric nurses to cope with the experiences by taking responsibility and ownership for change rather than acting in an immature way. In this way they would be promoting their own mental health.

5.9.2.2 Promotion of insight

Through the promotion of insight, the psychiatric nurses will be made aware of their immature way of dealing with issues in the environment, such as with fear and silence, and lack of trust in management, so as to become emotionally mature in their dealings. This has a lot to do with mental capacity development. This transformation will include group work, learning and development, adopting principles of adult learning such as modelling and experiential learning to name just a few. The promotion of insight and dialogue increases the mental capacity to begin to act in a way that will bring about change in the situation in which they find themselves. Psychiatric nurses need to be assisted in learning to express their feelings openly without fear, to be vocal on issues pertaining to their welfare and those of the patients, and to begin to learn coping mechanisms related to emotional maturity. As deduced from the interviews, psychiatric nurses expressed fear, anger, hopelessness, remained silent on issues, and shifting blame became their coping style. These nurses had to begin to take ownership of their development, whilst management and the members of the multidisciplinary team had to begin to treat these psychiatric nurses with dignity and respect so that they could take ownership of the units that they are in charge of.

5.9.3 Stage Three: Ownership of Competencies

The psychiatric nursing specialist continues to mobilise the resources in order to promote professional development. She also advocates for the transformation of the culture of the company (UGRs) which is going to nurture a quest for emotional maturity of these psychiatric nurses in order to promote their mental health.

The focus here is to acquire competencies in order to manage the psychiatric unit effectively. The psychiatric nurses need to be given the opportunity to gain confidence and have the mental power to act in pursuit of their professional enrichment.

The psychiatric nursing specialist will facilitate the process of ensuring that these psychiatric nurses further their career in advanced psychiatric nursing in order to become specialists in psychiatric nursing. This process will further facilitate a quest for

emotional maturity. It will enable these nurses to develop outwardly from within as indicated by Covey et al (1994: 238).

The psychiatric nursing specialist also initiates the turning around of the company culture represented by the negative UGRs to positive UGRs where psychiatric nurses will experience trusting relationships, a win-win agreement on issues pertaining to quality patient care and team work without coercion by members of the multidisciplinary team with accountability by all (Covey et al 1994: 246).

For these to happen, the psychiatric nurse must internalise this process. The competencies are self awareness, the ability to express feelings openly and self-regulation. The psychiatric nurse applies these competencies in their capacity as a unit manager and a mental health care practitioner.

5.9.4 Stage Four: Sustainability for Growth And Advancement

Psychiatric nurses continue to internalise these competencies to an extent that they become champions of their own self-development. A quest for emotional maturity is a lifelong process which has to be sustained through continuous capacity development of the self.

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They have to continue to practise reflection of their inner self and utilise the feedback that they receive from their colleagues for continuous improvement. Management have to create opportunities within the psychiatric facility for the psychiatric nurses to practise these skills and to coach their junior colleagues and mentor them towards their lifelong development as well.

Through this development, the transformation of the negative UGRs to positive UGRs takes place, and this leads to a quest for emotional maturity, thus promoting the mental health of the psychiatric nurses.

The development of guidelines as a framework for operationalising this model in practice will follow.

5. 10 EVALUATION OF THE MODEL

Evaluation of the model was performed by a panel of experts and feedback was provided by the panellists who are experts with doctoral degrees in nursing science and have extensive experience in qualitative research and theory generation. The model was also presented to the multidisciplinary team and executives of the company.

Feedback received was that the model needed to be refined so that the initial concepts that formed part of the model must relate with each other so as to promote clarity. The model was then refined and now satisfies the criteria for evaluation as described by Moloto (1999: 176-177) as follows:

- **Clarity**
  There is evidence of both semantic and structural clarity because the definitions are considered to be adequately defined and the connections between concepts are lucid. The evidenced consistent use of definitions and structural forms in the model lends evidence of semantic and structural consistency.

- **Simplicity**
  Simplicity is evidenced in that only core concepts are utilised in the model; no unimportant concepts have been introduced to create unnecessary complexity.

- **Generality**
  The situation to which the model is applied is that of the psychiatric nursing specialist, the psychiatric nurses, management and multidisciplinary team and colleagues' interaction, within the context of the psychiatric facility. The generality thereof is not confined in this context only, but can be extended to be applied in other settings where the psychiatric nursing specialist interacts with the psychiatric nurses, management and the multidisciplinary team.

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- **Empirical applicability**

  This refers to the extent to which empirical indicators are readily identified for the concepts in the model. The definitions generated for this model are specific and sub-concepts have also been defined. There is, therefore, evidence of empirical applicability.

- **Consequences**

  Evaluation is performed on how the theory guides research and practice, and it also refers to the feasibility to operationalisation of the model in practice, education and research. This will be discussed in Chapter Six.

  The essential consequences of this model are that it provides a theoretical framework to be utilised by the psychiatric nursing specialist to facilitate a quest for emotional maturity of psychiatric nurses through capacity development. It is also unique in that it attempted to identify the problems through the findings in the interviews conducted and that the mental health of psychiatric nurses is compromised to a certain extent.

- **Meaning and logical adequacy**

  Meta-theoretical and theoretical statements for this model have been taken from the Theory For Health Promotion in Nursing (Rand Afrikaans University, Department of Nursing, 2001). The researcher has constantly worked within this theory and as such, the meaning and logic of the researcher's model for a quest for emotional maturity of psychiatric nurses through capacity development is considered valid in the context of this publication.

- **Predictability**

  This model has progressed to the situation-relating level of theory generation and as such has inherent predictive value. The researcher can now predict the influence of obstacles in the promotion of a quest for emotional maturity through capacity development of psychiatric nurses.

5.11 GUIDELINES FOR OPERATIONALISATION OF THE MODEL IN PRACTICE

The guidelines for the implementation of the model in practice are formulated in order to achieve the following goals:

- To facilitate personal development of psychiatric nurses through the internalisation of the development activities so as to become mature professionals, and to gain power to practise independently and be recognised among the mental health care professionals and management.

- To promote a quest for emotional maturity of the psychiatric nurses through capacity development to acquire competencies that will enable them to practise their profession as independent and interdependent mental health care practitioners.

5.11.1 Originating Stage

This stage is about beginning a process for a quest for emotional maturity through capacity development. The psychiatric nursing specialist focuses on the environment of the psychiatric facility and the psychiatric nurses, members of the multidisciplinary team and colleagues within this context.

5.11.1.1 *Mobilisation of resources becomes important in the implementation of the programme*

Overleaf are the objectives and activities that the psychiatric nursing specialist facilitates in order to capacitate psychiatric nurses in their quest for emotional maturity.

Table 5.1 THE PSYCHIATRIC NURSING SPECIALIST MOBILISES THE RESOURCES

OBJECTIVES	ACTIVITIES
Mobilisation of the resources	**Negotiation with management** Prepare clear proposals for the implementation of the difference programmes, for example: • Negotiate for a budget for this programme • Focused group discussion with the members of the multidisciplinary team **In-service education** • This would be conducted on a weekly basis (peer group education and professional teams, learning and development sessions). **Clinical professionals in dialogue forum** • Clinical professionals in dialogue forum to be negotiated as a structure that could serve the purpose of the implementation of the programme for a quest for emotional maturity. • Persuade the clinical professionals to form the support team for these psychiatric nurses. • Get their buy-in and the collaboration with the psychiatric nurses. • Involve these professionals in information sharing. Convince them on the importance of creating a service culture (UGRs) that is geared towards promoting quality patient care and promote human dignity.

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OBJECTIVES	ACTIVITIES
	• Persuade them to engage in participating in these programmes for self-development and capacitating their mental health care practitioners as they would become their partners in the implementation of the New Mental Health Care Act (Act 17 of 2002). • Convince them that by engaging in these programmes they themselves would acquire skills and competencies that will assist them in their personal and professional enrichment. **Negotiate for capacity building in human capital:** • Negotiate with management to create a position of an Employee Assistance Programme (EAP) Officer to support such an initiative and also to assist all employees on issues pertaining to work related issues that affect the mental health. • The EAP officer will take over the programme to ensure that this process will be sustained, ensuring the quest for emotional maturity of these psychiatric nurses and colleagues in a psychiatric facility.

5.11.1.2 *The psychiatric nursing specialist as a resource person*

The psychiatric nursing specialist as a resource person engages herself in the activities in the facility that creates an opportunity for successful implementation of the programme.

Table 5.2 THE IMPLEMENTATION PLAN FOR THE PSYCHIATRIC NURSING SPECIALIST AS A RESOURCE PERSON

OBJECTIVES	ACTIVITIES
The psychiatric nurse specialist as a resource person	She engages herself in the activities in the facility that creates an opportunity for successful implementation of the programme. These opportunities are: • Multidisciplinary team meetings that the psychiatric nursing specialist attends with management and the members of the clinical professionals including the psychiatric nurses. • Attending structured in-service education that is conducted at the facility. • Heads of Department meetings facilitated by management where decisions are made. • Hospital liaison lekgotla (committee) meetings which involve the patients' families, members of the multidisciplinary team and community representatives and management.

The psychiatric nursing specialist uses these opportunities to communicate and outline her strategy for implementing the mental capacity programme for the psychiatric nurses in their quest for emotional maturity.

5.11.1.3 Advocating for change through communication

During this process of advocating for change, it must be borne in mind that change brings about resistance, discomfort, rejection and even anger to some people. The psychiatric nurses and their colleagues are no exception to this. It is therefore imperative that all these people are supported during this period.

A common understanding needs to be created for this change to happen and to realise how this change will transform the culture (UGRs) of the company.

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Table 5.3 THE ACTIVITIES TO BE IMPLEMENTED FOR ADVOCATING FOR CHANGE THROUGH COMMUNICATION

OBJECTIVES	ACTIVITIES
Advocate for change through communication	Focus on practical, effective listening skills and assist everybody who will be participating to develop these listening skills by: • Concentrating on what is being said, and how the message is being conveyed. • Knowing how to avoid false and selective listening. • Limiting external disturbances as noise and interruptions distort information. • Establishing good rapport by listening in a non-judgemental manner. • Demonstrating empathy by putting self in the situation of the psychiatric nurse. • Clarifying messages by summarising what has been said, from time to time during discussions. • Keeping calm and displaying patience. • Allowing the group to express their feelings regarding the change envisaged. • Stating the facts accurately and the intentions up front. • Being a critical listener by analysing the content discussed. • Talking with enthusiasm and conviction. • Not doubting information that is presented by the group.

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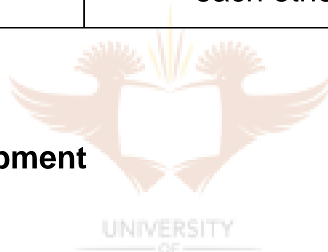
OBJECTIVES	ACTIVITIES
	• Keeping verbal and non-verbal messages congruent at all times. • Communicating clearly and being precise and to the point. • Acknowledging and appreciating feelings that are expressed and demonstrating caring behaviour. • Communicating the change that is envisaged, for example, the company culture (positive UGRs) that needs to prevail in the company, for example, saying "around here we need to treat each other with dignity and respect".



5.11.2 Capacity Development

In this stage there is active involvement of psychiatric nurses and the psychiatric nursing specialist.

The psychiatric nursing specialist facilitates the process of capacity development and the psychiatric nurses become active participants who become fully involved.

In Table 5.4 overleaf are the objectives and activities that the psychiatric nursing specialist facilitates in order to develop capacity for psychiatric nurses in their quest for emotional maturity.

This process is about mental capacity development. The process involves the promotion of insight, self-awareness and self-regulation. It also involves the ability to express feelings openly.

Table 5.4 CAPACITY DEVELOPMENT

OBJECTIVES	ACTIVITIES
Promote insight	**Self-concept to promote self-understanding:** • Assist the psychiatric nurses to revisit personal script and to reflect on what self-concept is about, that is, who you are and where you are coming from. This helps to determine own attitude and behaviour throughout life. **Self-understanding:** • Psychiatric nurses should identify their own attitudes and behaviour and link them to own behaviour and feelings and understand that behaviour at a particular point in time.
Promote and improve self-awareness	**Self-acceptance:** • Take responsibility for own behaviours and actions. • Acknowledge the blind spot in the self. **Self-determination:** • Make decisions to confront the limitations. • Live with the limitations that are beyond change by self. • Accomplish activities of benefit to the benefit of self. • Successful action enhances understanding, acceptance and determination. • Psychiatric nurses learn to acknowledge their own strengths and limitations. • Accept the limitations as challenges that need to be changed in terms of behaviour.

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OBJECTIVES	ACTIVITIES
	• Be aware and conscious of own identity, acts, thoughts, feelings and emotions. • Gain knowledge of own mental and physical potential. • Acknowledge own spiritual needs. • Acknowledge own interaction with self (intra-personal communication and dynamics). • Explore own feelings and thoughts, memories and stimuli. • Listen and accept feedback from others. • Accept feedback as developmental areas particularly feedback that addresses limitations and emphasises strengths. • Engage in role-playing to learn to improve self-awareness through self- disclosure, by revealing other parts of self that one has discovered through this programme. • Engage in unfamiliar activities. This will help in learning about areas in oneself of which one is not aware. • Accept self unconditionally and do not be hard on self. • Give time to internalise areas that one has just discovered and begin to acknowledge these new areas.
Promote self-regulation by:	Psychiatric nurses learn to: • Understand the rationale behind certain behaviour by exploring this behaviour in order to develop an understanding.
Reduction of stress within self	Reduction of stressful issues by: • Improving the capacity to live competently on a day-to-day basis.

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OBJECTIVES	ACTIVITIES
	• Engaging in biofeedback training techniques such as: Relaxation techniques, Exercises / gym, Yoga
Decrease shyness, self-consciousness	• Engage in assertiveness training • Address the changes in awareness of self through cognitive restructuring, for example, an understanding of self-defeating patterns of behaviour and their development and begin to deal with those issues. • Confront their limits and capitalise on their strengths.
Develop interpersonal relationships	• Gain interpersonal support and confront areas that need to be developed, for example, feelings of insecurity and own fear. • Understand the underlying issues that lead to insecurity and fear. • Increase the ability to remain relaxed during interaction with management so as to have the mental capacity to apply their own minds during interaction rather than resorting to silence. • Accept responsibility for own actions. • Take ownership of the development programme in order to successfully achieve the goals that are set. • Psychiatric nurses must create an environment in their own units where they could begin to utilise the knowledge and skills to the fullest, for example, during in-service education, group discussions and as professionals in dialogue forums.

OBJECTIVES	ACTIVITIES
Increase mental capacity	• Create a paradigm shift from being immature individuals and strive towards a quest for emotional maturity. • Focus on their own needs and areas of development.
	• Continuously evaluate their own development by getting feedback from colleagues and management. The psychiatric nursing specialist must assist the psychiatric nurses to: • Set goals that are meaningful and achievable. • Utilise the available resources to maximise own development. • Encourage the psychiatric nurses to redefine the existing values in their own units and encourage them to make a commitment. • Encourage them to display openness, honesty and instil excitement in them to embrace the promotion of mental capacity development.

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Table 5.5 TAKING OWNERSHIP OF THE COMPETENCIES

Psychiatric nurses need to take full ownership of their own development.

In this table overleaf the description of the objectives and the activities related to these objectives, are provided.

OBJECTIVES	ACTIVITIES
Enable the psychiatric nurses to practise within the legal and professional boundaries as prescribed in the legislation governing the practice of the psychiatric nurses	• The psychiatric nursing specialist must ensure that psychiatric nurses internalise all the legislation and regulations that govern the practice of psychiatric nurses as independent, interdependent and dependent practitioners. • Must utilise the learning structures mentioned in these guidelines to further enhance the knowledge of the psychiatric nurses on the interpretation of the legislation.
Motivate for the support of the psychiatric nurse when experiencing mental pressure related to this programme	• The psychiatric nursing specialist must identify supervision services that are available and link the psychiatric nurses to such support services, for example: Individual and group therapy services Counselling services Focused parent support services
Enable the psychiatric nurses to acquire the developmental tasks related to personal growth in own profession	• The psychiatric nursing specialist must continue to advocate the improvement of the working environment for psychiatric nurses and in this process assist the psychiatric nurses to speak up on issues that hinder development in the environment. • Encourages psychiatric nurses' creativity and innovation whilst managing their own units.

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OBJECTIVES	ACTIVITIES
	• The psychiatric nursing specialist must identify mentors in the facility and persuade management to implement mentorship programmes that have been identified as a need by the Human Resources Department. • Assist the psychiatric nurses to develop trust in themselves and to develop self-supervision in all the activities which they are doing, for example, the use of the checklist and self-assessment tools.
Promote trust in management	The psychiatric nursing specialist must: • Ensure that management keep to their undertakings and promises and the psychiatric nurses must do likewise. • Encourage management to recognise positive traits and accomplishments of psychiatric nurses. • Insist that management demonstrate respect by treating the psychiatric nurses as professionals and acknowledging their skills and competencies. • Communicate with regard to the psychiatric nurses' strengths and limitations. • Clarify expectations and prevent future misunderstandings and conflicts.

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OBJECTIVES	ACTIVITIES
	• Stress that management must create a therapeutic environment that is caring. • Ensure that management demonstrate honesty and genuineness in all their dealings with the psychiatric nurses. • Ensure that the psychiatric nurses accept accountability in their process of development.

5.11.3 Sustainability for Emotional Maturity

Psychiatric nurses' ability to become maximally adaptive is the function of emotional maturity which is the last part of the model.

Beyond gaining self-regulation over actions, thoughts and feelings, psychiatric nurses can continue to quest for emotional maturity, that is, to become increasingly capable of successfully dealing with the demands of the environment.

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In an ideal human development, emotional maturity keeps pace with chronological age, that is, as individuals become older, they become less self-conscious and less self-centred and become more capable in dealing with challenges, and more focused on realising personal potentials that are beneficial to self and other (Burke, 1989: 9). Psychiatric nurses must therefore engage this process as they will be maturing with time as stated.

Below are the objectives that are geared towards continuous enhancement of the competencies acquired in the programme in order to maximise their potential for self-enrichment and self-actualisation. Self-actualisation is seen as the highest level of development according to the work of Maslow (1970) in (Burke, 1989:9-10).

Table 5.6 SUSTAINABILITY FOR GROWTH AND ADVANCEMENT

OBJECTIVES	ACTIVITIES
Develop an attitude of lifelong development	The psychiatric nursing specialist must encourage the psychiatric nurses: • To quest for lifelong development through exposure to courses offered outside of their company. • To develop a reflective diary and that they could then develop strategies in dealing with issues that they have diarised. • To form discussions/journal clubs or book clubs to increase their knowledge base power. • To engage in programmes that facilitate self-analysis, through competency development centre, for example, self assessment tools (360° management assessment systems).
Incorporate lifelong learning as a value in the company	The psychiatric nursing specialist must instil the value for lifelong learning and sustainability in management for such development by continuously evaluating and rewarding all those individuals who are developing themselves and thus developing their units through awards for excellence and endeavour for individuals, the groups and the units, so as to sustain lifelong learning.

OBJECTIVES	ACTIVITIES
	• Achievements to be recognised through performance management systems that reward individuals for good performance.
Encourage workshops and seminar presentations by the psychiatric nurses	• Encourage the psychiatric nurses to begin to engage in research in their own settings with the ultimate aim of presenting the research done at conference and workshops nationally and internationally. • Capacitate them to be able to get sponsorships for such research. • Encourage them to publish articles on their experience in a programme that is gearing them to quest for emotional maturity.

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5.11.4 Evaluation of the Guidelines for Operationalising the Model

These guidelines were presented at the workshop held in June 2004 for the clinical care team from all the psychiatric facilities managed by the company.

This group of professionals were involved in all the psychiatric facilities as members of the multidisciplinary team. The group was formulated as a strategic initiative in preparation for the implementation of the New Mental Health Care Act (Act 17 of 2002) when it becomes effective.

The purpose of the workshop presentation was:

- To share information

- To share best clinical practices that would facilitate the implementation of the psychiatric standards, one of which, is the implementation of a visible rehabilitation programme that is outcomes based.
- To share an understanding and the rationale for implementing this model.

The team felt that this model had to be implemented not only in Gauteng Province facilities where the study was conducted, but to be used countrywide throughout the company.

It was also felt that this knowledge had to be shared with the company's major client that is The Department of Health in the Provinces that the company has dealings with. The group also believed that the experiences of the psychiatric nurses were also being experienced by other professionals in a similar way. They all concurred in accepting the model and were eager to support the implementation.

The model was also presented to the experts in the field of psychiatric nursing. In general these experts were impressed with the model and are of the opinion that this model would add value to the company as a whole. Specific comments were directed to the clarity of the model and that it had to be simplified in terms of the flow from Stage One up to Stage Four so that it would be would be logical.

5.12 CONCLUSION

This chapter dealt with the comprehensive description of the structure and the process of the model for facilitating a quest for emotional maturity for psychiatric nurses, through capacity development in promoting their mental health. What followed was the formulation of the guidelines for the implementation of this model in practice. The objectives were formulated with the activities that would be used to guide the implementation of these guidelines. The model was presented to the panel of experts and the research promoters for justification.

The next chapter will deal with the conclusions, limitations and recommendations.

CHAPTER SIX

6. CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

In the previous chapter the researcher dealt with the structure and process of the model to facilitate a quest for emotional maturity through capacity development of psychiatric nurses in promoting their mental health.

The guidelines to operationalise the model were also discussed in depth.

This chapter will deal with the conclusions made regarding whether the objectives of the research have been met. It will also highlight the limitations in the research. The chapter will conclude with the recommendations on how the model will be utilised in nursing and within the company.

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6.2 OBJECTIVES

The research dealt with the development of a model to serve as a framework for the psychiatric nursing specialist to facilitate a quest for emotional maturity through capacity development of psychiatric nurses in promoting their mental health within a specific company.

The researcher looked at the extent to which the following objectives have been met.

6.2.1 Objective One

What experiences did the psychiatric nurses have with regard to the company culture and how they dealt with those experiences?

The research which was exploratory, descriptive and contextual in nature was conducted. Data collection was done by conducting in-depth semi-structured interviews utilising an independent interviewer. The participants were a sample of psychiatric nurses drawn from the company's psychiatric facilities within the Gauteng Province. These participants took part in this research voluntarily.

Results obtained were analysed and were then categorised into themes. The findings were discussed within the literature reviewed. The previous chapters dealt with the results obtained from the research.

It was evident from the research that psychiatric nurses experienced the unwritten ground rules (UGRs) as company culture seen as "the way we do things around here". Psychiatric nurses experienced the environment as not conducive to facilitating that good clinical psychiatric nursing takes place.

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Three themes that hampered the psychiatric nurses' meaningful contribution to total quality patient care and thus affected their mental health in terms of the level of stress that they showed, were identified in this research. This has led them to feel frustrated, unhappy, tearful, and has resulted in a high staff turnover. They also adopted silence as a way of avoiding being ridiculed by management or avoiding confrontation with management. This behaviour caused them to bottle up issues that bothered them. They felt angry and resentful and displayed a lack of trust in management.

Inconsistency, blame shifting, poor resource allocation that prevailed in management resulted in trust being lost. As a consequence, the mental health of the psychiatric nurses became affected because they were preoccupied with the negative issues that prevailed in their environment.

Most managers had a hard time dealing with subtly difficult behaviour, for example, people who have a tendency to humiliate others. As a result psychiatric nurses tried to work around these individuals because management did not deal with the situation. Galford and Drapeau (2003: 91) mention that these behaviours destroy values and therefore destroy the trust resulting in teamwork breaking down. This makes for a negative environment.

The literature reviewed assisted in putting their behaviours into perspective and also assisted in seeking strategies that would address the mental health of these psychiatric nurses.

To conclude this part, the findings showed that there was a need for a model that could serve as a framework to develop capacity for psychiatric nurses so as to promote their mental health.

6.2.2 Objective Two

To develop a model that would serve as a framework for the psychiatric nursing specialist to facilitate the implementation of a quest for emotional maturity of the psychiatric nurses through capacity development.

The objective was reached by using theory generative design based on the results of the in-depth interviews with the psychiatric nurses. The research design was descriptive, exploratory and contextual in nature. A detailed description of the design was given previously in this research document.

The findings of the research suggested that a quest for emotional maturity through capacity development could be achieved, and recommended that the psychiatric nurses had to engage in this development because a quest for emotional maturity was a lifelong process.

The literature reviewed indicated that in order for the psychiatric nurses to quest for emotional maturity through capacity development, they need to be engaged in lifelong learning and developing. A quest for emotional maturity through capacity development

was an attempt to enable the psychiatric nurses to deal with the challenges associated with dealing with issues whilst caring for psychiatric patients.

The concepts forming the main concepts were analysed separately, looking at the dictionary meaning and the subject use of the concepts.

A list of the main criteria was formulated from the dictionary meanings and the subject sources. This list was further reduced to essential criteria. The essential criteria were further synthesised to form the main definition of the main concept. A visual representation depicting the structure and process of the model was then developed.

The literature reviewed taught that emotional maturity was a lifelong process of capacity development. For the psychiatric nurses to quest for emotional maturity they needed to strive for personal development throughout their careers and lives. The literature also suggests that professional development was a must for all professional nurses who wanted to stay abreast of their profession.

As indicated earlier in this research, the scope of the psychiatric nurses in the implementation of the new Mental Health Care Act (Act No 17 of 2002) required competency in dealing with issues that were going to be challenging to them.

Avoiding issues, and remaining silent on issues that are important to quality patient care would not assist them to become independent practitioners. Their colleagues would continue to undermine them. Therefore the psychiatric nursing specialist must continue to advocate that the environment must be conducive for positive development to take place. This would result in the psychiatric nurses being mentally capacitated to deal with issues in their psychiatric nursing units

Deductive reasoning was utilised as a method of inferring relationship statements from the described model. Four stages of the model were fully described in Chapter Five of the research.

6.2.3 Objective Three

To describe the guidelines as a framework for operationalising the model in practice.

The literature reviewed in this regard suggested that, for the psychiatric nurses to be mentally capacitated, other members of the team and colleagues needed to participate as well and that the process had to be aligned to other activities within the psychiatric setting.

For this purpose the model is to be embedded within the development programmes that were taking place in the company. It had also to be aligned to the transformation of nursing that is currently taking place in the country, for example, the Nursing Bill and the drafted Nursing Charter.

The guidelines for operationalising this model as developed within this context, were described.

Objectives and activities for attaining each of the stated objectives were suggested in this research.

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In view of the above it was concluded that these objectives have been achieved.

6.3 LIMITATIONS

The three limitations in this research are:

The first limitation is that the researcher as an executive manager within the company was compelled to employ the services of an independent interviewer who was an experienced psychiatric nursing specialist and an expert in qualitative research. Although she was experienced in interviews, the interviewer experienced a language barrier, even though the participants were all able to understand English. However, whilst striving for depth, she experienced the language to be an obstacle as the participants could not always express themselves and she missed out on the rich

points. Psychiatric nurses would have used their African languages where they found difficulty in expressing themselves.

Muller (1993: 145) states that language, even with the best interpreter, can be a barrier to understanding. There are phrases and concepts which are not translatable. Even if a literal translation is given, much of the meaning can be lost. In highly symbolic languages which most African languages are, there are additional difficulties. The very nature of the symbol is such that a part of its meaning remains unconscious and inaccessible to the conscious mind. Muller (1993: 145) further stated that in terms of the linguistic-relativity hypothesis, each language allowed individuals to conceptualise in ways not open to others. The ways in which persons expressed their interpretation and experiences of events depended on the language used. This implied that there was no one reality shared by all, but that what was experienced is a construction shaped by language.

Muller (1993: 145) went on and said that, according to Benjamin Whorf, the gap between different language groups reflected the differences in their world views. Muller (1993:145) stated that it was the structure of the language that a person customarily uses which influences the way in which environment was understood and conceptualised. Somehow this might have influenced the psychiatric nurses' responses during the interviews.

The second limitation of this research was that it was limited to selected psychiatric facilities managed by the company. For practical reasons, the research had to be concentrated using one Province out of the six Provinces in which the company operated. The reason was to try to focus in the province with the majority of the psychiatric facilities so as to capture and understand the psychiatric nurses' inner world experiences of the company from a broader view. This was a way of making the psychiatric nurses begin to share their experiences of the working environment.

The third limitation was that the model and its guidelines had not been operationalised in clinical psychiatric nursing practice, nursing education, and nursing research, for the purpose of this research.

6.4 RECOMMENDATIONS

Recommendations will be made for operationalisation in nursing research, nursing education and clinical nursing practice.

6.4.1 Operationalisation in Nursing Research

Other research methods should be used to evaluate the application of this model in practice. For example an hypothesis such as the following could be formulated "psychiatric nurses who participated in a lifelong capacity development programme are more emotionally mature than those who did not participate".

This hypothesis could be empirically researched for acceptance, modification or even rejection.

6.4.2 Operationalisation in Nursing Education

This model could be utilised as a module in the psychiatric nursing education programme. Although the psychiatric nursing curriculum includes interpersonal skills, the guidelines developed will be an addition to the already existing curriculum to assist the psychiatric nurse learner to master the necessary skills in a multidisciplinary context wherever possible. Psychiatric nurses should be assessed on their ability to apply management skills in the management of the psychiatric nursing units and to be able to evaluate their own practice in such a setting.

The model could also be considered for use by the learning and development department to enable the multidisciplinary team, nursing and hospital management to attend leadership development courses. This model should be accredited and become part of the skills development programme within the company.

6.4.3 Psychiatric Nursing Practice

The guidelines developed have been geared towards the promotion of the mental health of psychiatric nurses within the clinical psychiatric setting of the company.

In operationalising the model the following should be borne in mind:

- Psychiatric nurses will need to be accepted by the other members of the multidisciplinary team as partners and independent practitioners for them to engage in a lifelong process for a quest for emotional maturity in order to promote their mental health.

- Psychiatric nurses themselves have to accept that they need this development as part of their lifelong development. In return they will be able to practise and apply the model in clinical practice with management and their colleagues in their daily encounters. This will facilitate the promotion of their mental health. In so doing they will be able to handle the challenges faced in nursing psychiatric patients.

- Psychiatric nurses need self-awareness and self-regulation in their internal world, as this has a bearing on how they interact with management, the multidisciplinary team and colleagues in clinical practice. The awareness refers to the ability to open up on issues that hamper their functioning as psychiatric nurses, and how they can confront issues that hinder them from delivering quality patient care in their psychiatric nursing unit. By doing this they would be promoting their mental health.

- Management need to be aware of their own behaviour and how to conduct themselves whilst interacting with psychiatric nurses. Stumbling blocks to good interaction must be identified and removed so as to facilitate openness and interaction. By so doing they will be assisting the psychiatric nurses in promoting their mental health.

- In the same way management need to be well aware how the specific external environment attributes which prevail in a therapeutic interaction may affect the practice of psychiatric nursing. Management need to create an environment that allows good clinical psychiatric nursing to take place.

6.4.4. Corporate Governance: Management Duties and Responsibilities

According to the King code of corporate practice and conduct (Corporate Governance Series, 2000: 20-21) on corporate governance, management has to ensure that strategic issues such as the corporate reputation, operational issues, staffing levels and compliance issues with respect to the adherence to all applicable legislation, regulations, codes of best practice and adherence to company standards are followed.

The existence of the following is important:

- Company culture and prevailing standards of ethics and corporate conduct
- Management philosophy and operating style
- Quality and extent of communication within the company
- Quality and experience of staff
- Organisational structure and methods of assigning authority and responsibility
- Nature and degree of individual empowerment at operational level
- Relevance and application of corporate policy statements, supporting standards and procedures
- Efficiency of operational processes and supporting information systems
- Frequency and standards of reporting and review
- Performance monitoring, measurement and reward mechanism

Executive management need to enforce these practices at facility level so that psychiatric nurses can experience a new culture within the company that promotes their quest for emotional maturity through capacity development.

The King code of corporate practice and conduct (Corporate Governance Series, 2000: 22) clearly stipulates good corporate governance which advocates how management is expected to behave for the company to realise its goals and growth. The company relies on the psychiatric nurses to deliver quality patient care, therefore the company's executives need to embrace this model to ensure that psychiatric nurses are supported by hospital management in terms of what has been outlined above.

Management need to acquaint themselves more thoroughly with the specific capacity development needs of the psychiatric nurses, questing for emotional maturity with whom they will be interacting. Factors such as the provision of material and human resources, communication, the creation of a conducive therapeutic environment, changes envisaged in the implementation of the new Mental Health Care Act (Act 17 of 2002, and the varying degrees of assistance required to meet these needs are all factors which need to be addressed by management. These factors are crucial in promoting the mental health of the psychiatric nurses.

Psychiatric nurses might find the change in behaviour by management makes it increasingly difficult to mobilise the element of trust and acceptance of this change. Management would need to be thoroughly cognisant of how such change in the internal environment in the psychiatric nurses would affect their interaction with management in order to address the issues raised.

Management need to have clear goals of what they would like to achieve in this interaction in order to employ skills and competencies needed to implement this model. Failure to accept that the therapeutic interaction is to facilitate the promotion of mental health of psychiatric nurses may result in unrealistic expectations, disillusionment, frustration and a complete abandonment of the interaction in clinical psychiatric nursing practice.

In return psychiatric nurses are required to practice therapeutic interaction in a clinical setting so as to internalise these skills as part of their quest for emotional maturity so as to promote their mental health. The joint utilisation of this model by the psychiatric nurses and management must be emphasised.

Psychiatric nurses in this model are not the passive recipients of the capacity development, but active participants who are questing for emotional maturity.

The operationalisation of this model in clinical practice is not restricted to any given time but must become part of the day-to-day encounter with the rest of the clinical team and management.

6.5 CONCLUSION

This chapter concludes the final stage of this phase and of the research. The research objectives have been achieved in that a quest for emotional maturity of psychiatric nurses through capacity development has been shown in this research.

The first research phase was then used as a basis for the formulation of the model for a quest for emotional maturity of the psychiatric nurses in order to promote their mental health through capacity development.

Central to this research was the second phase of the research where the experiences of the psychiatric nurses of the company culture in a form of UGRs was critical to the facilitation of the mental health of these psychiatric nurses in order to promote their mental health and that a quest for emotional maturity would be attained through capacity development .

The limitation of this research was highlighted previously, mainly being that the model has not been operationalised in nursing research, nursing education and in clinical practice. However the guidelines to address the above have been described in the previous chapter.

The major limitation of this research is that the model has not been operationalised in clinical nursing practice, nursing education and nursing research, however, the recommendations have been made for such a purpose.

The researcher concludes by stating that there are guidelines which have been described on how to operationalise this model in practice.

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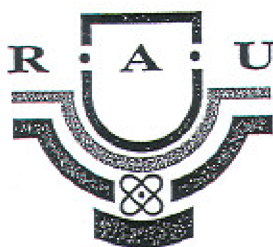

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11 November 2001

Managing Director
Lifecare Special Health Services (Pty) Ltd
PO Box 539
Randburg
2125

Dear Sir

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I am a Doctoral student at Rand Afrikaans University, Auckland Park, Johannesburg. I am presently engaged in a research study entitled, **A model to facilitate the promotion of mental health of psychiatric nurses within the corporate culture in a specific company**. This study is conducted under the supervision of Professors M Poggenpoel and CPH Myburgh, of the Faculty of Education and Nursing.

This study has been approved by the Ethics Committee of the Faculty of Education and Nursing of the Rand Afrikaans University.

The overall purpose of the research is to develop and describe a facilitative model for the Advanced Psychiatric nurse practitioner to nurture and improve the mental health of psychiatric nurses in psychiatric facilities managed by Lifecare.

I want to ask your permission to interview Registered Psychiatric Nurses in Lifecare Psychiatric Facilities. Participation in this research is voluntary and the participants can withdraw at any time without penalty.

To complete this research study I need to conduct interviews with Registered Psychiatric Nurses. The interview, which will run for approximately 1 hour will be audiotaped for verification of finding by my supervisors and an independent coder.

The name and dignity of the participants will be preserved by observing the following ethical standards throughout the research process:

- voluntary participation and freedom to withdraw without penalty
- informed consent
- to omit their names during the discussions related to the studies
- by observing confidentiality by keeping all raw materials under lock and key
- the information related to the interview will not be accessible to anyone, except for my supervisors and the independent coder
- my contact address and telephone numbers will be provided for in case participants needs to discuss matters arising from the study
- field notes will be destroyed and audiotapes erased as soon as it is conveniently possible
- the summary of the research study will be made available to participants if they so wish and
- the participants are assured the freedom to participate or not and this means that they can terminate at any time they feel necessary to do so

Their participation in this study will benefit other Registered Nurses who have similar problems in their life and as individuals they will discover their potential and will be enriched for having participated in the interview.

Yours faithfully,

D SEKHUKHUNE [Mrs]
Doctoral Student

PROF M POGGENPOEL
RN, PhD
Co-Supervisor

PROF CPH MYBURGH
H.ED, B.SC; B.SC (Hons), M.COM, B.ED, M.ED, D.ED.
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2002-02-05

TO WHOM IT MAY CONCERN

TITLE OF RESEARCH PROJECT: "A model to facilitate the promotion of mental health of psychiatric nurses within the corporate culture in a specific company."

RESEARCHER: Mrs D Sekhukhune

SUPERVISORS: Prof A C Gmeiner, Prof M Poggenpoel and Prof C P H Myburgh

The Research Ethics Committee of the Faculty of Education and Nursing of the Rand Afrikaans University evaluated the research proposal and consent letters of the above research project and confirms that it complies with the approved Research Ethical Standards of the Rand Afrikaans University.

The study supervisor and researcher demonstrated their intent to comply with the approved Ethical Research Standards during the conduct of the research project.

Your sincerely

AABotes

ANNATJIE BOTES (PROF)
CHAIRPERSON: FACULTY RESEARCH ETHICS COMMITTEE

Appendix 3

LIFECARE

SPECIAL HEALTH SERVICES [PTY] LTD
REG NO 82/00915/07

Lifecare House
267 Surrey Avenue
Ferndale 2194

P O Box 539, Randburg 2125
Tel : (011) 449-4999
Direct Tel : 449-4909
Fax : (011) 886-0383
Trevor.Frankish@newname.co.za

02 March 2005

Mrs D. Sekhukhune
Lifecare Special Health Services (Pty) Limited
267 Surrey Avenue
FERNDALE
Randburg

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

Verbal permission was granted in November 2001 as requested in your letter dated 2001-11-13.

This letter serves to confirm, in writing, that your research studies within Lifecare Special Health Services have been approved.

Yours sincerely

T.M. Frankish

Dr. T. Frankish
Managing Director

Directors: Dr T M Frankish [Managing Director], D D Sekhukhune, Dr M A Uys, S H Pote, G S Preller, M R Moavodi

TRANSCRIPTION 15

R: This is a sensitive microphone, it should pick up your voice well, even though it is soft. Let's start then: Please describe for me your experience of the company culture in the time you have worked for LifeCare.

X: My experience here, that I'm overworked.

R: OK

X: I'm very much overworked because, um, our capacities are very high, I'm short staffed. There are too few nurses, and like in a ward whereby there are many, there are patients. For instance I have 57 patients, but their condition is critical, because they are hyperactive, they are very retarded. So it seems like you are working with hundred patients. And then they expect a lot from you, there must never be a mistake in our ward. And again patients get injured, they, you should know where the patient was. I, when, it's impossible when they are running around. Like I said, they are hyperactive. So if, if maybe there is 6, or 5 or 6 patients to one nurse, then you could say, I know. But sometimes I work with three nurses, on a sub-professional level. In the morning they have to dress, they are fed, some of them they choke when they are fed, so they need total care, these patients, that's why I say we have shortage of staff.

R: So this makes it very heavy.

X: Yes, I am accountable for whatever happens. You must see what happened, because they, they injure themselves, some times. And that causes work stress where you, you cannot cope. Ja, you have to supervise, and that goes, the nurses also rely on you, for knowledge, they are not trained like yourself. So I have to be their eyes, ears, as well, uh, as the patient.

R: Mm.

X: And then my experience again is my performance here. I have been working for the company for 22 years, on the third it was 23 years. And then, I still am abused. There is no promotion, and I do the work of the CPN, of like during weekends, in charge of the hospital. Ja, I, I do their work, and the work in the ward as well. Even in night duty I, I am treated as the supervisor, to run the whole unit. And then the salary doesn't satisfy me because of the work which is not my work. And I do it well, I think Monday I gave them a full report, the work that I have done.

R: So there is no recognition for this?

X: They give, they get night duty allowance. But is nothing extra, because all get it. I am still a PN. I don't know, I don't know, maybe the company, but if you have to be promoted, you have to go and interview. Sometimes you are go there when, for you go for the interview, only to be passed, and someone else. And they don't ask questions related to our work. They will ask you about policies, OK it is in the ward, but there is no time to read them, as I explained to you.

R: Yes.

X: If there was time maybe one day, um, you would not want to take and read policy, not all of them. And you are not allowed to take them home to read. But if you, you cannot photocopy here, right because now, if somebody is working there he will see you are making a photocopy. Then you can run into trouble.

R: Let me see if I follow. I'm hearing a bit of an impossible situation, where there is no time to read policy, but it is also not accessible to you when you do have time off, because you can't take it with you.

X: Ja, impossible. Like I said really, I'm overworked and stressed out. But at least if there is incentive ...

R: Yes.

X: Um, then you, you could at least be happy, and also give promotion. It has always been like this, this way. Before at least the, the whole unit, we had lots, lots of patients, more than 200 patients. Before we were enough because we would be allocated 5 patients, each on the ward. But now is four, or three on duty. And in the ward, if we have maybe 209 patients, you have maybe 32 nurses. But then the patients were transferred, and nurses were given early retirement, some were retrenched, some transferred, uhm, uhm, to other services, LifeCare facilities, hence they never were replaced. So is a problem of about 5, 4 or 5 years.

R: But you have stayed.

X: Ja, I like it here, I liked it here. Very much, and I enjoy them, like maybe if they are physically ill, I like to see them getting well. Like then you see him, he is very sick, and he gets well, and you feel very contented that you have contributed something. Ja, ja, I like my patients. And I enjoy my work as long as I am not overloaded. When I'm busy with some patients, maybe busy with written work, or whatever, now we have to do patient care. Everything now on your shoulders, with no-one beside you.

R: OK you've spoken about the culture as it relates to nursing staff, and then you mentioned the satisfaction you get from patient care. What other aspects of company culture have you experienced?

X: Like for instance, some patients, not satisfactory. Like for instance, patients' clothes, we have to, some of them must repeat clothes. Like a trouser, he must wear it two times, in high-functioning wards. But in my ward, he have to wear torn clothes. When you complain to the laundry, they say the patient tore the clothes, so they must wear them. They don't understand, because they are lay person. Then our seniors, they promote their attitude, because they encourage the laundry to allow patients to repeat trousers. Even for high-functioning, there's only one high-functioning ward for that. They can repeat trousers, but the rest of the hospital they, they have to change every day. And at times there's no tissue

in toilets. Even if you are all work-orientated, it's a problem, you don't find any tissue in your toilets, because they put tissue three times a week, in the toilet.

R: Mm.

X: And this torn clothes, they hired Spot-On, I don't know if they mend clothes or what. But mostly they wear torn clothes. The patients tear them, they take them off if they don't like to wear clothes. Off, in the roof. You have to give him some more, off, in the roof. We have a group, they call them residential health workers, you have to get them, some they are ladies, to see that the clothes are taken from the roof. Then take it to the laundry, that's how they also torn. Ja, it's really hard for me here.

R: And you said you get no assistance from your superiors?

X: They don't do anything, instead they condone it. They even encourage you to promote unhygienic conditions. Like encourage you to give patients clothes which are torn, to allow patients to repeat trousers, and they don't have trousers underwear. No underwear. No males or females. Like I said at high level, they keep their underwear, but these, they don't have underwear, and no tissue. Some of them, they cannot wipe themselves. And then they have to repeat trousers.

R: And those trousers might have faeces on them, or urine?

X: Ja, at one stage, we were even taken to meet with senior, to wear gloves, asked to, to adjudge the trouser, to see whether the patient cannot repeat it. And you can see it's dirty, you cannot give it even to your child. And um, I think it, it really sad to, as a professional nurse, to actually inspect state of the clothes, lots of trouser with lots of faeces, and then you have to pick those trousers that are better. (Pause) At times, you are forced to go and do it.

R: Mm, this is a distressing thing for you.

X: When you think you are in charge of patients, you get told to leave your work to go and do other things.

R: So some of the ways basic nursing care happens is a problem.

break tables, doors, there is nothing in order in that ward. So if there were enough psychiatrists, we have one psychiatrist for the whole unit, even he's working at Z (another Lifecare facility). So that at least he can concentrate maybe for two wards. Not the whole unit and Z. Then the patients can be treated well and be calm. If you ask the psychiatrist, he says this patient have been on that medication for very long time, and they don't get better, what's the use of the drugs? Stop it, or maybe gradually stop it. Then the patient starts the restlessness. No, I thin like, my patients are severely retarded, they'll never get better, but it's a problem, because we hear he will hit other patients, he will hit nurses, other nurses as well. When they are off medication they just come here, because OT, they refuse to have them there because they are more aggressive. In my ward they, they are retarded, even if, all medication, there's no difference. They are hyperactive, destructive, there's nothing will cure them.

R: So generally from you I'm hearing a story of very difficult working conditions, with little support in managing these things well.

X: Yes, they are not supportive. I'm not talking here of money, but thank you, you know, supportive thanking you. And promotion, ja. Thank you, you know somebody can say thank you, at least you are trying. But you are always wrong here, the attitude of our seniors really, they don't understand. They are not there. They only come there to criticise, they make your life difficult as well, ja. You are pressurised this side, and this side.

R: It sounds like your commitment to your patients is what keeps you going.

X: Ja, I like it here, I like here. And it doesn't mean I can't function in other hospitals, I quite often go to Bara. And then I sit there, you see the instructions. I grab the things, I help, I can't just stand there while a nurse is busy with my patients, as if I don't know what they are doing. And if it was not my age, I will go somewhere. But now, I'm old, ja.

R: Well X, you have certainly shared your contributions. Is there anything further you would like to add?

X: No, just what I have said.