

**EXPERIENCES OF CHILD PSYCHIATRIC NURSES:  
AN ECOSYSTEMIC STUDY**

**by**

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I declare that *Experiences of child psychiatric nurses: An ecosystemic study* is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.



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## **ABSTRACT**

This dissertation reports on the lived experiences of four child psychiatric nurses. The territory of child psychiatric nursing is explored in this investigation through the punctuation of many voices within this field of study. The methodology of the investigation is descriptive phenomenology and Colaizzis' steps in descriptive phenomenology (map) are used to discover and describe the different template theories (the territory) that are unique to each of the four child psychiatric nurses who were interviewed. Following this, a story is punctuated, which is referred to as the structural synthesis. It is the heartbeat of the investigation. The dissertation concludes by reflecting on the paradox of how the invisibility of the child psychiatric nurses allowed for the visibility of the dissertation and encourages the reader to ask pivotal questions about the important role of the child psychiatric nurse, working as part of a multidisciplinary team, in order to improve patient care.

## **KEY TERMS**

Ecosystemic epistemology, post-modernism, constructivism, social constructionism, object-relations theory, child psychiatric nursing, multidisciplinary teams, child psychiatric in-patient unit, nurse-patient relationship, descriptive phenomenology, bracketing, structural synthesis.

**IN LOVING MEMORY OF**

**JACO FERREIRA**

**3 JUNE 1974 – 30 DECEMBER 2009**

**YOU WILL ALWAYS BE WITH ME**

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## **CHAPTER 1**

### **INTRODUCTION**

This is an ecosystemic investigation of the lived experiences of four child psychiatric nurses. The ecosystemic way of thinking encourages us to: challenge the traditional way of linear thinking through a process of constructing new realities, by looking at multiple realities and punctuating these realities through an awareness that the whole is bigger than the sum of the different parts. Central to this process is the acknowledgement that the individual who conducts the research is as much part of the context and the process as the individuals who are being observed. Ecosystemic thinking encourages self-referential observations to facilitate multiple descriptions – or richer descriptions – of that which is being observed.

The context of this investigation is a children's ward in a psychiatric hospital where I did my internship as part of a six-month rotation in 2003. In my exposure to the context and the different role-players within the context, I observed the important role of the child psychiatric nurse in the daily interactions with the children who were admitted. I further observed that the importance of their roles is sometimes not acknowledged in the children's treatment plans. It became apparent that the struggle to find a voice was not only visible in the children that I worked with, but also in the nurses. Through these observations, I decided that I wanted to do my dissertation on exploring the reasons behind these silences. My own struggle to find a voice as a clinical psychologist was also mirrored in the years that followed: I became 'invisible' as an intern psychologist and



never completed my dissertation, until now. The importance of the work that the child psychiatric nurses do, the sadness of many children who are suffering from mental disorders and my own passion for working with children led me to my current reality – the completion of the investigation.

The aim of this investigation is to describe the lived experience of four child psychiatric nurses. The aim is further to include self-reflection in order to allow new learning and fresh patterns to emerge and to give an accurate description thereof. What follows is a brief outline of the different chapters of this dissertation.

In **Chapter 2**, the distinction is drawn to an ecosystemic epistemology; where I construct and punctuate different ‘lenses’. These lenses have enabled me to give meaning to that what I have observed and have allowed me to create a psychological frame of reference for this investigation. These building blocks are all seen as part of my ecosystemic umbrella and are reflective of ecosystemic thinking, which encourages different ‘lenses’ through which one can view different realities. The lenses and voices under the ecosystemic umbrella that will be explored are: an ecosystemic lens; a post-modern lens; and a psychodynamic lens. Central to this chapter is Bateson’s view of epistemology. Bateson’s (1979) term ‘epistemology’ refers to the assumptions, philosophies and points of view that people use to make sense of the world or phenomena, for example, a belief system used to understand the world.

In **Chapter 3**, the territory of child psychiatric nursing is explored through the different punctuations of many voices within the field of study. A distinction is drawn on the specific terrain and referred to as a psychiatric hospital setting within the field of national mental health under the national Department of Health. Another distinction is drawn on the in-patient psychiatric hospital setting, where children are admitted and an exploration of the challenges that nurses are faced with in working within this field are punctuated. The territory is investigated by looking at the traditional role of the nurse, the role of the psychiatric nurse and the role of the child psychiatric nurse. Aligned with ecosystemic thinking is the acknowledgement that the whole is bigger than the sum of the different parts, hence the exploration of the different roles. No role exists in isolation. The territory is further explored through the punctuation of what happens when people meet in the territory. The focus is punctuated from the nurse's perspective in relation to the children, the multidisciplinary team, the families and in relation to the nurse herself, through the lens of different voices that have drawn distinctions in the past in the form of written text. The chapter includes a section of self-reflection, which is punctuated through reflective spaces to allow for double description.

In **Chapter 4** another distinction is drawn on the specific context of four child psychiatric nurses working in an in-patient hospital setting, and is punctuated as a distinction within a distinction. This distinction forms the context of the remainder of the investigation and a cybernetic complementarity is punctuated as methodology and analysis of the dissertation (*the it*), the epistemology of ecosystemic thinking and the literature review (process leading to *the it*). The methodology of the investigation is descriptive

phenomenology and can be seen as the map of exploring the territory. This map is punctuated in an exploration of phenomenology as a philosophy and a methodology. Central to phenomenology as a philosophy are key concepts of intentionality, universal essence, transcendental subjectivity, phenomenological reduction and free imaginative variation. These concepts are punctuated to understand the map better. The specifics of the map are punctuated as a distinction is drawn on the directions on the map that will allow the reader to understand descriptive phenomenology as a methodology. The steps that are followed to achieve this are as follows: bracketing; analysing; intuiting; and structural synthesis in the chapter. The four participants of the investigation are also introduced in this chapter.

In **Chapter 5**, the specific territory of the four child psychiatric nurses are visited by following the map of descriptive phenomenology. A further distinction is drawn on another map of a house. The different rooms of the house are punctuated as a bracketing room, four different rooms, a public area – connecting the four rooms – and a meditation room. This map allowed me to discover and describe the different template theories that are unique to each of the four rooms. It further allowed me to see the different parts before interacting with the whole, in the form of a story that is punctuated within the chapter and is referred to as the structural synthesis of the investigation. The different themes that are discovered in the different rooms are tabulated and form the basis for the construction of the structural synthesis. The structural synthesis is punctuated in a story within this chapter. The story is about the lived experience of a child psychiatric nurse and includes self-reflections of the nurse. It is the heartbeat of the investigation.

Phenomenology refers to the structural synthesis as ‘essence’. Through this punctuation, I believe that I honour Husserl’s aim of descriptive phenomenology (Kleinman, 2003) in ‘going back to the things themselves’. I hope that each child psychiatric nurse reading this story will be able to see himself/herself in it. I further trust that each person who interacts with the text and who has been part (or is still part) of child psychiatry, can allow themselves space for reflection. This can be achieved in visiting the meditation room and being brave enough to ask if the system creates the problem and challenge themselves to bring about change and better patient care.

In the final chapter, **Chapter 6**, an integration of the different chapters is punctuated when looking at the lived world of the child psychiatric nurse. This is referred to as the map of the findings or the drawing of a distinction in which the findings are punctuated (territory). In such a way the findings can create context for thinking about the child psychiatric nurse. The content of this map is punctuated and is explored as: the role of the child psychiatric nurse; the nurse-patient relationship; a therapeutic environment; the membership of the nurse in the multidisciplinary team; and the need for supervision or support groups. This final chapter explores the lived world of the child psychiatric nurse under the umbrella of an ecosystemic epistemology (Chapter 2), through the voices of the different literature (Chapter 3). It integrates the findings of the template theories that were discovered in the house and punctuated in the structural synthesis, through the personal reflective lens of an intern psychologist doing this investigation. The chapter ends by looking at ‘after thoughts’ – thoughts about the thoughts – and include some recommendations for possible future studies.

## **CHAPTER 2**

### **AN ECOSYSTEMIC UMBRELLA (EPISTEMOLOGY)**

#### **INTRODUCTION**

Hoffman (1981) defines an epistemology as the study of how we know our knowing. Bateson's (1979) term 'epistemology' refers to the way people view and make sense of the world according to what they have learned and what they believe. This implies interaction and recursiveness between what we know and what we see, which can further influence what we know. Bateson (1979) often compared epistemology to the process of living. Anderson and Goolishian (1988) speak of a therapist's epistemology as a tool that needs to be discovered and that this tool affects the way in which we perceive our lives and act them out recursively in the therapeutic interactions with people.

In the same way that my epistemology affects the way that I interact with people, it also affects the way that I explore this investigation – and how I interact with it. My epistemology is an ecosystemic epistemology or 'umbrella', as I refer to it in this chapter. The points of view that I use to make sense of the lived experience of child psychiatric nurses are influenced by a number of factors, which allowed me to discover my way of knowing, interacting, seeing and understanding the world.

Firstly, how I know my knowing is because of my academic studies. My psychological points of view are mostly influenced and affected by my Masters training in Clinical Psychology at Unisa, where I explored ecosystemic views in great detail in 2001 – 2002.

My Honours training at the University of Pretoria (1999) – where a big focus of the training was on psychodynamic concepts – also influenced the way in which I make sense of the world and myself and the way I interact with it.

Secondly, my internship (2003) contributed to knowing where my academic training became ‘real’ to me. The six months that I worked at the children’s ward, specifically, influenced my way of thinking about my thinking when attending many ward rounds, relating to the different members of the multidisciplinary team and relating to the children and their families. What I saw influenced my knowing, and is central to this investigation.

Lastly, I strongly agree with Bateson (1979) that one’s epistemology is discovered in the process of living. The years after my studies and internship (2004 to current) made me question my being and my knowing, which allowed me to reflect, inform and reform my identity. The completion of this investigation is in acknowledgement thereof, re-establishing my being in this world. In the same way this investigation allows me to further develop my epistemology, which will again inform and shape my future path in life.

All of the different concepts that are reviewed and explored in this chapter influence the way that I see, and affect my way of interpreting this investigation. Similarly, this chapter aims to enable the reader to achieve a better understanding of the context in which the child psychiatric nurse works – allowing reflection, dialogue and further investigation

into the sensitive matter of caring for children instead of focusing on curing children.

This can be seen as paradoxical to the nursing profession, which is traditionally more a curing than a caring profession. I fully appreciate the notion that, within this frame of reference, I am as much an outsider as an insider.

Ecosystemic thinking encourages the use of different lenses through which one can view different realities. These different lenses affect the investigation in allowing even more layered or rich descriptions of the context. Hoffman (1993) uses the concepts of *lenses* and *voices* interchangeably in her literature. In this chapter, I explore the different voices and lenses, all of which are building blocks within my epistemology - included under my ecosystemic umbrella. Firstly, I explore the ecosystemic epistemological lens – and the different voices within this way of thinking – and then I explore the post-modern lens and the voices within that school of thought. Lastly, I explore elements of the psychodynamic lens and some voices within that school of thought.

In my view, an exploration of the different concepts in this chapter assists the investigation, and informs the review in later chapters of the psychiatric nurse's interpersonal and intra-personal interactions. This, in turn, enables a further understanding and sensitivity around the different lenses the nurses are using to punctuate their realities – in order to facilitate further dialogues and meanings, and bringing about more visibility to the important work that they do in caring for children.

Anderson and Gehart (2007) refer to an authentic (safe) space where people have ample opportunity for full expression and where people are accepted, no matter how small or

cynical their thoughts or needs are. This investigation hopes to create such an authentic space for the voices of the psychiatric nurses and everyone else who interacts with it.

## **AN ECOSYSTEMIC EPISTEMOLOGY (INVESTIGATION) LENS/VOICE**

### **Introduction**

The ecosystemic school of thought advocates a move away from the traditional linear cause-and-effect model. The difference between a traditional school of thought and an ecosystemic, post-modern school of thought is that, within such a paradigm, the privileged position of observation does not exist. Therefore, the very power hierarchies existent in traditional schools of thought are questioned (Becvar & Becvar, 2000, Doherty, 1999). It is a voice that encourages the deconstruction of the traditional (or accepted) view to make way for multiple realities.

Within this epistemology is an acknowledgement of the importance of the human ecology surrounding a particular system – of which the observer is a part. The term ‘ecosystemic’ is derived from a combination of the words ‘ecology’ and ‘systems’ (Carruthers, 2007). According to an ecosystemic epistemology, a researcher can only fully understand an individual’s experience by observing how his/her social context is punctuated (Keeney, 1993). It further acknowledges that within this human ecology, context is the most important where relationships and interactions are more important than the sum of individual parts (Hoffman, 1993).



This investigation explores the lived reality of child psychiatric nurses. The ecosystem/context of these nurses is pivotal, and their perceptions of their reality cannot be viewed in isolation from their context. Similarly, my own constructions cannot be seen in isolation from my ecology/context. The importance of the relationships that the nurses have with each other, the children, the members of the multidisciplinary team and with me (while doing the investigation) is thus more significant than an isolated focus on the individual realities as constructed by each of them. The importance of the meta-context is also kept in mind, as this investigation is done within the context of a psychiatric hospital where the emphasis is placed on curing rather than on caring. Within this frame of reference, understanding does not happen in isolation, but in a process of shared meaning and involvement, where the context informs the process and the process enables me to draw new distinctions and punctuations. The purpose is therefore to develop an understanding of our knowing.

Central to an ecosystemic epistemology is the need to reflect. According to Carruthers (2007), this school of thought recognises that many characteristics of life are reflections of reality. This stance accepts and encourages a plurality of voices and multiple realities. This reflective space is further characterised by a focus on holism rather than on dualism (Keeney, 1993): it is not about either/or, but about where either/or becomes one side of the same coin.

The different voices within my ecosystemic lens (which can also be referred to as the fundamentals of my ecosystemic view) are explored and contextualised further in this

investigation. These different voices have helped me to understand and make sense of the world that I live in. In this sense, I am completely in agreement with Keeney (1993), who stipulates that, within this frame of reference, the emphasis is on connection, co-creation and relationships through language, which leads to knowledge.

I invite you, the reader, to connect to this text, to challenge what you read and to form a meaningful interaction with not only the text, but also with the people behind the text, including the author.

### **Dualism versus holism**

Ecosystemic thinking challenges dualities. According to Kelly (as cited in Terre Blanche & Durrheim, 1999), dualistic language and thinking can easily lead to the splitting up of 'reality', which disrupts the mutual interaction and connectivity of the context and the system, blurring relevant patterns. Ecosystemic language, for example, language that avoids dualities and attempts to preserve connectedness, requires maintaining and preserving an awareness of these complete interactions (Hoffman, 1981; Keeney, 1993).

Within the field of study of this specific investigation, where I need to be sensitive to the bigger context, this aspect of holism is challenging when interpreting the interview data. Hoffman (1993) speaks about taking a position that is a step removed from the operation (investigation) itself so that one can perceive the operation in a more holistic way – forming views about views. When thinking about the context of the psychiatric nurse, I need to be sensitive for terms such as pathology, disorders, anxiety and depression, and

constantly remind myself that these concepts need to be seen in relation to the system/context with which they are connected. Keeney (1993) and Hoffman (1993) advocate such a holistic view by saying one must think of the system creating the problem, not the problem creating the system.

This brings me to the next concept of an ecosystemic view that needs to be explored in order to create context for the other lenses/voices within this epistemology, namely the drawing of distinction. One must, however, bear in mind that all of these concepts are related and one cannot view or understand them in isolation; rather, they need to be seen in relation to each other.

### **Drawing distinctions and the lens of punctuation**

The importance of ecology, interaction and holism within this frame of reference has been outlined. These concepts create the context for an ecosystemic epistemology.

Within this epistemology there needs to be a way in which I can communicate what I see. Through my interactions with the different voices within this paradigm, the importance of drawing distinctions and punctuating observations needs to be outlined. Keeney (1993) says that this exact aspect assists an individual to construct a reality. This not only enables me, but will also enable everyone who reads this investigation, to draw some new distinctions from the co-created reality.

Varela (as cited in Keeney, 1993) points out that drawing distinctions enables us to create “physical boundaries, functional groupings, conceptual categorisations, and so on, in an

infinitely variegated museum of possible distinctions” (p. 20). The drawing of distinctions enables me to describe and compare what I have seen in my interactions with what I have distinguished. In this investigation, for example, I choose to draw the following distinctions that form the platform for the context of investigation. I decided to investigate the lived experience of child psychiatric nurses; this is the categorisation (grouping/ boundary) for this study. In line with ecosystemic thinking, another part of this distinction is the acknowledgement that this distinction needs to be studied in relation to the bigger context with which it interacts. Keeney (1993) further states that the observer first distinguishes and then describes.

The description of that which has been distinguished can be seen as the punctuation. Punctuation is thus the next logical step within ecosystemic thinking. Keeney (1993) also speaks of indications. Again, there are so many options in punctuating realities, seeing that this too is influenced by the individual’s bigger context. What I choose to punctuate within any specific context might be completely different to what another person punctuates when observing the same group of people. This supports the fundamentals of this frame of reference, namely that the observer is part of that which is being observed. In this investigation, I choose to punctuate from the perspective of four psychiatric nurses who all work within the parameters of child psychiatric nursing within a psychiatric hospital. At this point it is important to not only remind myself, but the reader as well, that punctuation is not an isolated/ fixed action, but it is ongoing.

Neither punctuations nor the drawing of distinctions are fixed. Keeney (1993) speaks of three different ways in which therapists draw distinctions that can assist them in understanding their knowing. Firstly, primary distinctions inform the parameters for the investigations, as outlined above. Secondly, in later chapters I need to draw distinctions that will organise the raw data (phenomenological methodology). This entails the drawing of patterns that connect what has been punctuated. Finally, Keeney (1993) refers to the stepping back action (reflection) of the therapist, where he/she examines what he/she has done. The therapist/ researcher simultaneously acknowledges that there are other ways of interacting with the same data, which can lead to different distinctions and punctuations. I follow this model in the proposed investigation; the last step happens in the final chapter, where I reflect on the thinking about the assumptions (distinctions and punctuations) that I have made.

Keeney (1993), Bateson (1979) and Von Foerster (1981) all investigated the concept of *logical typing*, where one has an appreciation for including paradoxes when doing research and in drawing distinctions. Keeney (1993) points out that “self-referential paradoxes can be used as conceptual building blocks for an alternative view of the world” (p. 30). In this way I am as much a participant as the other participants who I am observing in doing this investigation. Thus, all statements that I make are self-referential. Logical typing can, in itself, be seen as a way of drawing further distinctions, punctuating a fuller awareness of my own patterns of knowing.

In the drawing of distinctions and in the punctuation of that which is being constructed, it is important to acknowledge the *recursion of realities* and the *dormitive principle*. Both these concepts are integral to my own epistemology and shape the way that the distinctions are drawn in this investigation. Keeney (1993) says that, when an observer allows his own observations to be included in what is being observed, it points to recursiveness and allows for richer descriptions. Thus, the researcher allows his/her own views to interact with that which is being observed. In doing this investigation I allow my own thoughts and experiences of interacting/working in the children's ward, in Keeney's (1993) words, to "point to the same snake, while indicating the order of recycling" (p. 32). The recursive matter of this investigation further includes my own struggle to find words for that which I have interacted with and observed, allowing for more interaction and new reflections.

Bateson (1979) explains a *dormitive principle* as a more abstract description of what one is trying to explain and says it can sometimes happen when one is using the lens of recursion. This happens when one uses an abstract word for what you are seeing. In the context of a psychiatric institution, this can easily happen when, for example, a psychiatrist, psychiatric nurse, psychologist, or any member of the multidisciplinary team, mentions in a ward round that a child is depressed, because he/she saw the child crying during one of the group sessions. What happens in such an example is that the individual is including his/her own views in that which is being observed. Keeney (1993) says that when an action is reframed into a category of the action (like the example above) by an authority figure, it can easily maintain or escalate such a context – often

leading to unfortunate consequences. I believe that this is a valid tool in interacting with the text and definitely contributes to my 'making sense' in later chapters.

What I have identified thus far as beacons in my ecosystemic epistemology enable me to move to a more practical level now, where I explore what happens when people meet and realities are constructed in an ecosystemic way. One must, however, bear in mind that as outlined in the introduction section, the emphasis is on relationships and interactions. This will allow the reader to understand the way in which the raw data (which is also very alive) will be described and interpreted within the relational domain, later in this investigation.

### **The meeting place – lens for understanding interactions and interpreting voices**

Before looking at the way in which interactions for this investigation are interpreted, it is important to acknowledge the role that the ecosystemic epistemology views the interpreter as occupying in the interpretation. According to this view, the interpreter is as much part of the observed system as any of the individuals who are observed (Keeney, 1993). In such a frame of reference there is no chairperson in the meeting, but everyone meets each other on the same level. By reading this investigation, the reader also forms part of the meeting, and is an equal member. Even though the overt agenda is agreed upon, it is also important to keep in mind that each member attends the meeting with a different agenda. Thus, my agenda is different to those of the nurses with whom I spoke. The inclusion of the different agendas allows for a plurality of realities and understandings. Hoffman (1993) says: “as we move through the world, we build up our

ideas about it in conversation with other people” (p. 88). I am not the same person as I was at the time of studying or at the time of doing my internship; similarly, I will not be the same person after the completion of this investigation. This is an investigation into my current reality and how it interacts with the realities of the child psychiatric nurses. This forms the basis of the way in which we meet.

The luxury of working in an ecosystemic frame of reference is that it provides space for double description when trying to understand or describe that which is being observed. According to Bateson (1979), a double description takes place within any relationship when both views about the same phenomenon are described and referred to. He adds that any relationship is the product of a double description. Bateson (1979) points out the following:

*It is correct (and a great improvement) to begin to think of the two parties to the interaction of two eyes, each giving a monocular view of what goes on and, together, giving a binocular view in depth. This double view is the relationship.* (p. 146)

According to Keeney (1993), this allows a therapist to view the whole of a relationship when bringing these different punctuations together, enabling the therapist to organise patterns in different ways. In identifying the different patterns of relating, one cannot exclude the relationship style. In other words, one needs to characterise the ways in which the different members interact with each other, to allow for a further double description. As a researcher, I include myself and the ways in which I interact in the investigation. These interactional styles form an essential part of ecosystemic thinking,



which assists me in analysing the ‘minutes’ of the meeting. According to Becvar and Becvar (2000), there are three relationship styles that can be identified. The first relationship style is complementary relationships; they have a high frequency of opposite kinds of behaviour. The second is symmetrical relationships, known for a high frequency of similar behaviour. The third relationship style, according to Becvar and Becvar (2000) is parallel relationships, where both individuals who interact are flexible and accept shared responsibilities.

### **Cybernetic complementarities – the contact lenses of my ecosystemic knowing**

Many people know the difference between wearing glasses and wearing contact lenses. For me, both allow me to see, but contact lenses allow me to view the exact outside world a little bit more clearly and almost bring it closer. In short, my seeing became a lot easier after I started wearing contact lenses. In the same way, the concept of cybernetic complementarities assists me in viewing the ecosystemic world a little bit more easily. It helps me to understand many of the concepts and definitely assists me in the interpretation of the data in later chapters in this investigation in a holistic manner. Ecosystemic thinking proposes an appreciation for both sides of any distinction that is drawn. Keeney (1993) refers to this aspect as cybernetic complementarities, and states that it provides an alternative framework for describing distinctions. Varela (as cited in Keeney, 1993, p.32) refers to this as the “the it/the process leading to the it”.

In line with this, I name and explore some of these cybernetic complementarities, which contribute fundamentally to my thinking about the investigation, and which assist me

further in the completion of this investigation when interacting with the voices of the psychiatric nurses. This allows for each interaction to bring to the fore some new opportunity of knowing about the knowing. Integrated into these complementarities are the ecosystemic concepts of holism and double description. The punctuation of these relationships is also recursive in nature, which assist me continuously in completing this investigation.

#### Distinctions on *territory/map*

Several voices within this school of thought have reasoned about these concepts and the importance of both (Bateson, 1979; Hoffman, 1993; Keeney, 1993). Bateson (1979) states that the map is not the territory, while Hoffman (1993) contends that the map is the territory. The way that I draw the distinction is to say that the map leads you to the territory. For the purpose of this investigation, the territory represents the views of the psychiatric nurses about their roles, and their understanding of their experience in working at the children's unit. The map is the exploration and my attempt to understand which factors contributed towards this punctuation, and assisted the nurses in arriving at the territory. On a personal level, it is for me to read and understand more fully the map that has led me to this point in time (territory) and to see if there is a link between these maps and the territories. If so, this can contribute to the punctuation of proposed new and different territories to develop a new understanding of the work of the child psychiatric nurse.

### Distinctions on *being/becoming*

Firstly, I am aware that the completion of this investigation contributes to my own being, in becoming a clinical psychologist. I also investigate the way that the nurses are punctuating their roles to develop an understanding of their own being and process in becoming a child psychiatric nurse.

### Distinctions on *stability/change*

As with most cybernetic complementarities, these concepts are interrelated. Keeney (1993) says that both are complementary sides of a systemic coin. “Cybernetics proposes that change cannot be found without a roof of stability over its head. Similarly, stability will always be rooted to underlying processes of change” (p. 70). Becvar and Becvar (2000) refer to these aspects as *morphostasis* (a system’s tendency towards stability) and *morphogenesis* (a system’s tendency towards change). In this investigation, I explore these concepts when interacting with the interviews, to see if the psychiatric nurses view their lived experience as one that is characterised by change or stability. This can also be kept in mind when caring for children, as what needs to be assessed is whether the medical professionals (myself included) offer enough stability when working (facilitating change) with these often severely traumatised and abused children. In this regard I need to acknowledge that one of my biggest motivations in undertaking this investigation was an acknowledgement of the stability that the psychiatric nurses create. I believe that it is their stabilising effect that needs to be integrated more holistically into the treatment plans of the children.

### Distinctions on *voice/voicelessness*

The drawing of this distinction can also be seen as a motivation for this investigation in that, in my observed interactions with multidisciplinary teams, I did not hear the voice of the nurses whom I had observed to be playing a central part in the treatment of the children. In merely completing this investigation, I hope that it contributes to the acknowledgement of the voice of the child psychiatric nurse. I am also aware of the challenges within myself to be able to voice that which has been voiceless for many years. Again, I am also of the belief that the children's unit is a unique space of creating opportunities for children (with the help of all who are involved) to find their voices and to be heard.

### Distinctions on *attachment/detachment*

The drawing of this distinction and reviewing it as a cybernetic complementary is also extremely important in working with the children who are admitted to the unit. Apart from the interplay of my own interaction between these two concepts, it is also kept in mind when analysing the data of this investigation. What is also important within this complementary is to reflect on the causes of either attachment or detachment, and the need for creating alternative realities. This concept can also be linked to construction, deconstruction and the co-creation of new realities (Keeney, 1993).

Distinctions on *context/system*

This distinction is kept in mind throughout the investigation and includes orders of recursion, patterns of relationships and striving towards holism in describing and interpreting observations.

The above distinctions/ cybernetic complementarities are not exclusive in my investigation, but are inclusive in my formulation of ideas and knowing about knowing. These ideas are further developed and revisited in later chapters, which allow for the generation of more realities that can be linked to again further the already formulated understandings in the field of study.

## **A POST-MODERN VOICE – DISCOVERING OF SUNGLASSES**

### **Introduction**

The knowing about the knowing of many of the fundamental assumptions of the ecosystemic epistemology (in which I was trained) became even more alive to me after I discovered and connected with some of the texts of the post-modern theorists. These viewpoints definitely form a part of my epistemology and I incorporate them under my ecosystemic umbrella. I could compare this process to the discovering of sunglasses, in that it protects my eyes while making that which I perceive look a little different.

The essence of post-modernism is to allow something new to evolve, rather than predetermining the rules for what is real and valid in the world. This requires resilience on the part of the researcher (Doherty, 1999). Anderson and Gehart (2007) state that,

within this perspective, the notion of knowledge and language as generative and relational is central. In other words, knowledge is conveyed through language and language can correctly represent knowledge. For the purpose of this study, it means that the spoken and unspoken language of the psychiatric nurses in relation to me (in the interview) and in their interactions with others, has the potential to generate new understandings and meanings.

The two lenses/voices that are further explored under this section are those of constructivism and social constructionism. The section ends with a description of collaborative thinking, which highlights the importance of being with someone, listening and not-knowing. This assists me in the drawing of distinctions, punctuations and interpretations of the process in this investigation. At the core of the post-modern voice/lens is the importance of reflection. This process entails me sitting back to re-view all that I have viewed and all that needs to be viewed – the realities of the past, present and future. Hoffman (1993) says that there is a possibility for something new at each point of interaction and reflection about interaction.

### **The voice of constructivism**

Maturana and Varela (1980) – who can be seen as two of the big voices within this voice – say that the lens through which anyone observes the world is always the ‘self’. They also acknowledge the importance of language and the unpredictability of life. The concept of objectivity has also been questioned by constructivists. Von Glasersfeld (1984) says that it is not possible to achieve an objective view of the world, because

observations will always be influenced by the observer and the way he/she perceives. Von Glasersfeld (1984) further states that one should not look for truth in our attempts to understand the world, but rather for fit. Hoffman (1993) argues that with constructivism, the emphasis is on meaning and discovering the template theories of people – what they believe about the world – because they will act according to these templates. Varela (1979) further states that there is a mind in every unit that people interact with. The importance of this lens, to me, is highlighted by the voice of Braten (as cited in Hoffman, 1993), where he speaks about a space individuals carry by their sides for the virtual other. “By this he does not mean merely space for the other person, but a space for another view” (p. 43).

In doing this investigation, a number of aspects are kept in mind, which have already guided me to a constructivist point of view. I subjectively felt that, through my perceptions, there is a similarity between what I have observed, and what I need to discover or say in my interactions with the child psychiatric nurses. In doing this investigation, the emphasis is on formulating this similarity in a language that enables people who interact with this study to get a better understanding of the template theories of the child psychiatric nurse, as viewed through the eyes of another – in order to create a space for the construction of more views and different realities. Hoffman (1993) states that with constructivism, there is no ‘Gods-eye-view’; rather, the emphasis is on allowing yourself to understand the private realities of people.

### **The voice of social constructionism**

Gergen (as cited in Hoffman, 1993) defines social constructionism by saying that what we know evolves not primarily within the individual nervous system but in the interactions and language that is spoken between people. How we get to know what we see is thus a direct result of the ideas that we build up in conversation with other people. This entails a shift from constructivism. In this frame of reference, the emphasis is on listening to people instead of changing them (Hoffman, 1993). This aspect of social constructionism is important in this investigation. My hope is that through it I am able to identify what I have observed in my interactions with the nurses, namely their skills to listen to the children that they interact with and their ability to create a space where the children feel safe to interact and voice their life stories.

My concern was that this important knowledge sometimes did not get included in the treatment of the children. In my view, the emphasis in many ward rounds was as a direct result of constructivism, as punctuated by the members of the multidisciplinary team, excluding the voice of the person who is discussed.

Social constructionism attempts to articulate people's common, shared forms of understanding the world (Carruthers, 2007). Anderson and Gehart (2007) further state that "social constructionism concerns itself with the way that people arrive at their descriptions, explanations and understandings of themselves and their worlds" (p. 12). This is explored in later chapters of this dissertation, to see if the nurses shared an understanding about their worlds and to investigate the way in which they arrived at their



understandings. The process of understanding is “the process of immersing ourselves in the other’s horizon” (Anderson, 1997, p. 39).

The challenge is to, while immersing myself in the reality of the other to understand their way of looking and seeing, to also remain aware of my own reality. This is where the importance of reflection and recursion is needed with the ability to generate ideas about the ideas that have just been constructed. My epistemology includes both, in that both these constructs can also be seen as having a complementary relationship.

The next section is about the concept of dialogue and language as important tools within the post-modern lens, which assist me further in this investigation. This creates yet another space for thinking about language and dialogue, drawing yet another cybernetic complementary.

### **Post-modern distinction on *dialogue/language***

Without language, no dialogue can take place; the one shapes the other. According to Anderson and Gehart (2007), in a post-modern tradition, language can be seen as the vehicle through which individuals construct and make sense of the world. This includes all the ways in which we respond to each other, whether it is spoken or unspoken.

Language without context is only words. Anderson and Gehart (2007) state the following:

*What is created in and through language (realities such as knowledge, truth and meaning) are multi-authored among a community of persons.*

*The reality that we attribute to the events, experiences and people in our lives does not exist within the thing or person; instead, it is socially created within a particular culture and is continually shaped and reshaped in language. (p. 9)*

Language is creative. Anderson (as cited in Anderson & Gehart, 2007) refers to dialogue as a form of conversation where one can either talk or converse with another or with oneself and search for meaning and understanding through this process. Dialogue that happens through language between people creates spaces for meaning and interpretation where new realities can be constructed can be seen as generative. Similarly, inner dialogue can, according to Anderson (as cited in Anderson & Gehart, 2007), also be generative, seeing that it can give shape to unspoken words.

Thinking about the dialogue and language for this investigation is visible on many levels and becomes even more visible as the investigation progresses. Firstly, my inner dialogue is constantly present through the punctuation of reflective spaces, which shape the dialogue that I have with the investigation as it is created. The language of the investigation (discussed in greater detail in the methodology chapter) takes the form of direct and indirect dialogues that I have with the child psychiatric nurses. This investigation also focuses on the inner dialogue of the psychiatric nurses, and the effects that it has on their dialogue with the children and the different members of the multidisciplinary team. Also important is an acknowledgement of the context in which the language is shaped and the dialogue happens, as the participants (me included) are part of a medical context. In such a context, diagnostic tools and manuals shape the

language and dialogues of individuals. This investigation therefore focuses on that aspect. What is important too is that the above punctuations are not fixed but are simply what I construct at this point in time.

## **PSYCHODYNAMIC READING GLASSES: THE OBJECT-RELATIONS**

### **LENS/VOICE**

#### **Introduction**

In reflecting on my studies and internship that followed, both the voices of ecosystemic and psychodynamic ways of thinking were present and allowed me to develop understanding, formulate thinking patterns and cautiously enter spaces with individuals (children and adults) to facilitate new understandings. Thus far, in this chapter, I have outlined the fundamentals of my epistemology and the way these fundamentals assist me in my understanding. I cannot, however, conclude this chapter without visiting and exploring that which has been very real to me in my development as a psychotherapist. It has been a definite map that led me to many territories, this one included.

In the process of revisiting some of the literature on object relations, in preparation for this chapter, I also discovered a new knowing about my knowing: realising how many of the concepts in object-relations theories can be viewed as cybernetic complementarities. I was also sensitised to the importance of context in this way of thinking. Ecosystemic thinking advocates an approach to holism instead of dualism (Anderson & Gehart, 2007; Hoffman, 1993; Keeney, 1993). I fully agree with this. In such a way, I am more than comfortable to add this thinking to my epistemology. I am comparing the object-relations

lens to that of reading glasses. Reading glasses are often used to read the 'fine print'. The whole action of reading instead of seeing points to the attainment of knowledge of a different kind. In reflecting spaces, what I read assists me (and has assisted me) in what I see, again informing and guiding me to that which needs to be read.

### **The fundamentals of my object-relations lens**

The basic stance of this way of thinking is the consideration it gives to the interactions between people from infancy right through to adult life. Gunter (1971) says that the way that most of the theorists (including Fairburn, Klein, Mahler, Sullivan and Winnicott) within this way of thinking punctuate, is with an emphasis on the first meaningful relationships that infants develop with their objects and the impact thereof right through their lives. According to Gunter (1971), all of these theorists claim that they remain loyal to the father of psychoanalytical thinking (Freud), yet they developed a new way of thinking about the traditional psychoanalytical framework. Gunter (1971) further states that within this frame of thinking: "only object-relational thinking can deal with the problem of meaning and motivation that determines the dealing of one person with another, and the way they change and grow in the process" (p. 46).

The pioneer in the object-relational field is Melanie Klein, and Gunter (1971) states that her work is the real turning point in psychoanalytical theory and therapy within the psychoanalytical (Freudian) movement. Klein regarded an infant as an arena for inner struggle that is projected onto the world he/she interacts with, as the infant matures. Gunter (1971) says that:

*This means that the infant is never able to experience real objects in any truly objective way, and the way he does experience them depends more on his own innate make-up than on the real attitude or behaviour to him.*  
(p. 54)

This concept points to the subjectivity of that which is being observed and assists me in analysing the data in later chapters as well. This also leads me to draw an important distinction between the descriptions of the observed (object of study) versus the way in which I observe/view. In reviewing the theory of Klein (Gunter, 1971), I was led to yet another aspect of holism, namely that Klein's theory needs to be read in totality. She constructs a number of realities that need to be seen in relation to each other. This affirms the importance of seeing the individual in context, while punctuating from the first years of development.

The two object-relational positions of an infant (according to Klein) need to be named, as this also contributes to my knowing and assists me in making sense of the world.

According to Klein (as cited in Gunter, 1971), these two object-relational positions, which the infant experiences first with the mother as primary object, exert an important influence on relationships throughout life. Gunter (1971) says that "they are, in fact, a description of the two major problem positions in which the child finds himself as he tries to work out his relationships with the object world, beginning with the mother" (p. 61). Klein calls them the paranoid-schizoid position and the depressive position. Within the first position the infant moves from being withdrawn from the object-relation world

(schizoid) to where the infant is in relationship with the world, but feels persecuted by his/her objects. In the depressive position, it seems that the infant has overcome the paranoid difficulties and enters more fully into whole-object relationships. According to Gunter (1971), this position is marked by guilt and depression after the discovery that he/she can hurt those he/she had become capable of loving. The importance of these positions is highlighted in Gunter's (1971) explanation that with bad mother-infant relationships, the infant might fluctuate between perceptions of persecution. This leads to withdrawal and can lead to ambivalent relationships later, resulting in feelings of guilt and depression.

An understanding of these positions becomes important in this investigation, seeing that the psychiatric nurses will observe/ feel many of these reactions in the children that they work with. In my discussion in later chapters, I keep this in mind, firstly to see if the nurses mention some of the emotions as outlined above; and secondly, to see what happens to these emotions when they are projected onto the psychiatric nurse. Is there a space for reflection for that which is being observed? In my reflections I also recall some of my observations, in order to create a double description. My investigation is not accurate or aligned to my epistemology if I do not include this.

### **Some other voices within this lens**

Within the object-relational field many voices (theorists) followed. All of them place an emphasis on the importance of the environment and the ability/inability of the environment to offer meaningful objects in the first stages of life (Buckley, 1986). In

addition, they emphasise the effect that this has on any individual in the way that he/she subsequently interacts with others.

Mahler (as cited in Buckley, 1986) phases in the separation-individuation process of an infant, punctuating the importance and sensitivity of the mother-child relationship. Her construction implies that an available (present) mother can allow a child to individuate in a way that will assist him/her in relationships later in life, by developing a healthy sense of self in relation to others. Winnicott (as cited in Buckley, 1986) introduces the important concept of the holding environment when referring to the parent-infant relationship. "Holding, precedes what he calls living with and the development of object relationships. Inadequate maternal care prevents the infant's coming 'into existence' in the larger sense" (p. 150). Sandler (as cited in Buckley, 1986) also investigated the development of object relations and the role that affection plays in that development. Within their frame, they specifically looked at the need for reassurance and affirmation through interactions of the infant with the environment.

All of these voices construct the need for an environment that is present, and has the ability to hold. This can be borne in mind when looking at individuals who might not have been given such opportunities in early life; also, that in such individuals, those exact needs (internalised constructions of the outside world) might be recreated when interacting (acting out) with the environment in later life. It implicates further a need for such individuals to attach and be granted the opportunity to recreate. The way in which children and nurses interact within this space is further developed in psychodynamic

language (for example, concepts like defence mechanisms – in the forms of projection, introjections, transference, counter-transference, repression, splitting and denial). These concepts form part of the language when I wear these reading glasses and are further explored in not only the literature review, but also in the dialogue, when analysing the themes in looking at the lived experience of child psychiatric nurses.

### **THE UMBRELLA EXPERIENCE**

In the above sections I have drawn distinctions and punctuated viewpoints that all form a part of my understanding of the world and which will specifically assist me with this investigation, when looking at the lived experience of child psychiatric nurses. Central to all of this is me – another individual – trying to understand what so many people are struggling with, an on-going exploration of the self in the world and trying to find meaning therein. This is my reality, my epistemology, for now.

Hoffman (1993) states:

*Now we are going to make a new-way path. So you take a shovel, you take a ground-hacker, you take a hairpin. If all you got is a hairpin, you take a hairpin and you start digging. And you dig in all directions: up and down, in and out, right and left. Not in a straight line. Nothing natural or interesting goes in a straight line. As a matter of fact, it is the quickest way to the wrong place. And don't pretend that you know where you are going. Because if you know where you are going, that means that you have been there, and you are going to end up exactly where you came from. (p. 1)*



## **CHAPTER 3**

### **LITERATURE REVIEW**

#### **INTRODUCTION ABOUT THE INTRODUCTION**

In the previous chapter I explored/ voiced my ecosystemic epistemology and the different lenses/voices under that umbrella which assisted me in the drawing of distinctions up to this point in my investigation. This also assists me in the writing of this chapter and the remaining chapters in this dissertation. My ecosystemic epistemology proposes a holistic approach where the whole is bigger than the sum of the different parts. It further proposes a ‘stop-pause-reflect’ model, which assists in the knowing about knowing and thinking about thinking. This chapter can thus be seen as part of the previous one, but different. The lens of the previous chapter allows for further reflection, as the literature regarding child psychiatric nursing is reviewed and voiced in this chapter.

The distinctions that I draw in this chapter and the punctuations that follow assist in creating context for the interpretation of the voices of the child psychiatric nurses. In ecosystemic language, the literature review assists in the exploration of the territory as explained through different individuals punctuating their views of the territory. Again, it seems worthwhile to remind you, as reader, that just as your punctuations happen subjectively, so too are my punctuations influenced by my subjective drawing of distinctions. What is important is to remember that the meta-context (territory) remains the same – an exploration of the lived world of the child psychiatric nurse.

The aim of this study is to give a voice, through creating a space for the child psychiatric nurse, by looking at the nurse in relation to the external environment (client, family, multidisciplinary team members and reader) and internal (self and in-patient unit) and to then provide a rich description of the lived experience of child psychiatric nurses. In order for this to happen, a study was undertaken, reviewing the most recent literature regarding psychiatric nursing and mental health nursing.

## **INTRODUCTION**

The importance of caring for children is high on the political agenda of most countries of the world. When looking at children's health, one needs to look at their physical as well as mental health. In his article McDougal (2005) clearly states that children's mental health is finally recognised as everybody's business. In her article, Mohr (1999b) illustrates how interventions in an in-patient psychiatric unit for children can lead to children's lives being negatively affected forever, if there are conflicting ideologies within the unit, and if the needs of the children are not thoughtfully considered. She refers to the epiphany experience (as defined by Denzin in 1989), which can be defined as "those moments that fundamentally alter, contour and signify a turning point in a person's life" (Mohr, 1999b, p. 230). These experiences normally happen in social situations that entail a crisis. Mohr (1999b) ends her article by saying that having had such an epiphany experience, individuals can never quite be the same again in their approach to life.

In this chapter, I explore the importance of the context that the child psychiatric nurse is part of, seeing that the above aspects cannot be interpreted without having a sense of the context. According to Norton (2004), the milieu of the in-patient unit can either be therapeutic or not, and the environment has an effect on the children who are admitted – for better or worse. The territory of the in-patient unit is explored in this chapter. Key functions of a therapeutic environment are also explored. The effects of a non-therapeutic milieu for the children as well as the nurses are reviewed, as punctuated through different literature.

Central to the care of children's mental health is the child psychiatric nurse, especially when looking at the role of the nurse in an in-patient psychiatric setting. Delaney (2006) reflects on the unique opportunity that the nurse has when working in an in-patient unit, having 24-hour exposure to the children, in that they can really understand the hospitalised children through observing their cognitive, regulatory and emotional processes. Haber (2000) states that Peplau (referred to by many as the mother of psychiatric nursing) consistently referred to psychiatric nursing as an art and a science. She sought to define the lens through which psychiatric nursing could identify its unique professional focus (Haber, 2000). This punctuation is explored further when looking at the role of the psychiatric nurse in this chapter. The importance of drawing this distinction, in terms of creating a reality where the total function of the nurse can be acknowledged as both an art and a science, needs to be noted here. This is aligned with ecosystemic thinking, where acknowledgement is given to the whole being bigger than the sum of its parts (Keeney, 1993).

***Reflection space: The ward round perceived as an art or science?***

*I have observed in my interactions and in working with child psychiatric nurses that the art of their work was sometimes not visible. This was especially true in the weekly ward rounds, where I observed that the nurses took an administrative role, speaking usually to confirm compliance or side effects of medication. They did sometimes mention if there were difficulties with some of the children. However, I observed that this was mostly content feedback and that there were seldom interpretations by the nurses or new ideas brought to the table with regards to the treatment of the children.*

Sutton, Maas, and Krug (1974) comment that the psychiatric nurse, in her interaction with the multidisciplinary team, sometimes only reports on certain information without explaining or elaborating their observations and interactions with the children, therefore minimising their important roles. They say that the reason for that might be that they feel inexperienced and/or insecure in formulating concepts and communicating their understandings of complex interactions within the group. The analysis of the interviews with the nurses, in later chapters, seeks to explore possible reasons for this silence. Sutton et al. (1974) end their article by urging psychiatric nurses to take a strategic position in the total treatment milieu and remind them of their unique competence in working with children.

Baldwin (2002) did research on the role of the psychiatric nurse in child and adolescent mental health services in the United Kingdom. She concludes that it is of concern that

psychiatric nurses are not able to define what is unique about their roles in the multidisciplinary teams, unlike the other professionals who attend the ward rounds, who can clearly state what the purpose of their roles are. I myself, for example, as an intern psychologist, knew that I had to report on the therapy sessions that I had with the children. Baldwin (2002) ends her article by also urging psychiatric nurses to develop a clearer rationale and articulation for their roles in multidisciplinary teams.

A central tenet of this investigation, to better understand the art of psychiatric nursing, is a review of how psychiatric nursing is punctuated in the relevant literature. What follows is an exploration of the literature on the different punctuations of the role of the child psychiatric nurse, embedded in the role of the psychiatric nurse, embedded in the role of the nurse. In this chapter, I also explore the interactional domain of the child psychiatric nurse – the realities that are constructed between people. The ability of the child psychiatric nurse to form a meaningful relationship from the first meeting with the child is pivotal in the treatment of the child. This is supported in a study of Sjostedt, Dahlstrand, Severinsson, and Lutzen (2001), where they reflect on the first nurse-patient encounter, and the importance for the nurse to consciously and intentionally encourage the patient to enter into a relationship with her and that, if the child feels safe in this first encounter, they will later be able to share his/her suffering without feeling forced to do so.

The factors that enable the development of a therapeutic relationship are also explored, as well as the factors that hinder such a relationship. Included in that are concepts of

psychodynamic theories, such as primary defence mechanisms, anxiety and attachment/detachment, transference and counter-transference. The relational domain is not exclusive with regards to the nurse in relation to the children, but also in relation to anyone with whom she interacts. A concept that has assisted me greatly in thinking about the relational territory of the child psychiatric nurse is the work that Bion did. Bion (as cited in Sprince, 2002) speaks of the relationship container/contained as a constantly recurring pattern:

*It is a relationship observed between one individual and another, between an individual and a group, between a group and an organisation. In the form most familiar to psychoanalytical thinking, the mother's mind receives, contains and transforms the projections of the infant.*  
(pp. 159-160)

I also name this a cybernetic complementarity: container/contained. Seed, Torkelson, and Karshmer (2009) argue that, although progress has been made in bringing psychiatric mental health nursing into the 21<sup>st</sup> century, there are still two areas that lag in this. First is the need to identify research agendas that link psychiatric nursing to improve patient care, and second is to find a way in which system issues that affect patient care can be addressed through the inclusion of core psychiatric nurse competencies. As the aim of this investigation is to create a space for reflection on the important work of the child psychiatric nurse, my research agenda is on both of these levels. I believe that children are the leaders of tomorrow. I further believe that my working in the children's in-patient unit for six months created an epiphany experience for me, where it first silenced me. Doing this investigation is to make sense of my experience, but more importantly to

voice that which I feel lies central to better patient care at the unit. This is a building block for my continuation of working with children. I am fully aware that as this process evolves, more distinctions and punctuations will become available to my consciousness.

## **THE TERRITORY (CONTEXT) OF THE CHILD PSYCHIATRIC NURSE**

### **Historical context**

The historical context of an in-patient unit for children began with the Child Guidance Movement. In the late 1920s, for the first time, research in relation to children had begun, and treatment agencies were organised for children who needed psychiatric care; these units were often isolated from medical schools or hospitals (Middleton & Pothier, 1974). Middleton and Pothier (1974) further state that there was no conception of the role of the psychiatric nurse in the system at the time. The nurses became more frustrated with their roles, realising that they needed more training on how to use the self in therapy and in interactions with the psychiatric patients (Middleton & Pothier, 1974). Their role only became evident in the 1930s, when somatic therapies became dominant in the in-patient treatment of children with psychiatric difficulties. Middleton and Pothier (1974) state that it seems that the nurses' needs were further noted and became evident in the enactment of the Mental Health Act in 1946 in America, as one section of the law provided for the specific training of psychiatric nurses.

### ***Reflection space: Struggle for visibility***

*The invisibility of the psychiatric nurse (who was indeed already very visible in the wards) needs to be noted, seeing that I find it extremely interesting that the psychiatric*

*nurse had to voice her frustration or need to be acknowledged since the start of her involvement in in-patient care treatments.*

### ***Reflection space: A female distinction***

*In this dissertation I focus on the psychiatric nurse as female. This is to create an accurate reflection space of my interactions with the nurses who I have personally met and who have continued to be 'with me' following the years after my internship. In the same way, the drawing of distinctions of this investigation and punctuations included in that is from a male perspective. Aligned with ecosystemic thinking, it is not an either/or approach but rather an inclusive space where – even through the punctuations will happen accordingly to that which was named – it is to be shared with and applied to anyone who interacts with the text, irrespective of their gender.*

According to Kolko (1992), the number of in-patient treatment facilities had increased after the 1940s in America, up to a point in the 1970s where most community centres in America provided in-patient hospitalisation services for children. He further mentions that the six major elements of in-patient treatment for children, which were identified in 1957 by the American Psychiatric Association, were still incorporated by most treatment plans for children, but that the emphasis differed from programme to programme. Kolko (1992) names the six elements as follows: “parent participation, a therapeutic atmosphere, individual psychotherapy, somatic therapies, education and medical services” (p. 4). I could not find any specific research (literature) with regards to the history of in-patient treatment facilities in South Africa. In my experience of interacting



with the in-patient unit the only element (as per above distinction) that was not part of the treatment plan for the children was the use of somatic therapies.

**The context today – not punctuated by specific date: refers to the present**

There is more than enough recent evidence in the literature supporting the need for and value of in-patient treatment centres for children who experience psychiatric difficulties (Benson & Briscoe, 2003; Ellila, Valimaki, Warne, & Sourander, 2007; Kolko, 1992; Messinger, 2007; Mohr, 1999a; Norton, 2004). Kolko (1992) specifically states: “The in-patient setting offers multiple opportunities for therapeutic contact, for monitoring of dangerous or disturbing symptomatology, and for decision making as to follow up and disposition” (p. 6.). This is specifically important for children. Ellila et al. (2007) write about the complexity of the diagnosis of children disorders and the value of in-patient treatment facilities in that it offers children a chance to have corrective experiences in forming meaningful relationships.

When looking at the in-patient context today, what seems to be more important is the reflection on how to create a context that is more therapeutic for children with the current reality, which is in itself one of the reasons for this investigation. The biggest challenge for the psychiatric nurse and the different role-players involved in the treatment plans at the in-patient units seems to be the pressure of time, in a setting where more and more children are referred for treatment with limited resources. In an article by Norton (2004) entitled *Re-thinking acute psychiatric in-patient care*, he punctuates the difference between acute in-patient psychiatric wards today as compared to those of the 1960s and

1970s, in that the patients' average length of stay is greatly reduced and the percentage of psychotic and detained patients is higher, as is the level of risk of violence. The impact of this on staff and what is expected of them, and what they expect of themselves, makes it difficult to create a therapeutic, safe ward environment for those in their care. Kolko (1992) supports this by saying that the transition to shorter in-patient hospitalisation treatment for children provides limitations for the treatment, in that it contributes to weakened peer relationships, staff frustration, disappointment, fatigue, more frequent escalation in serious behaviour and system conflicts about the overall purpose of admission. Benson and Briscoe (2003) further highlight that, owing to financial limitations, the current focus of in-patient psychiatric nursing is on rapid stabilisation of the patient.

Another challenge of the context of today that I want to include (draw a distinction on) is the importance of medical treatment versus therapeutic atmosphere (as two of the elements identified in the previous section). Norton (2004) mentions that there is no patient left untreated by the in-patient environment: you are either treated well or poorly. Thus, part of the meta-context is the strong emphasis on the medical model with the focus being on the curing of patients rather than on caring for patients. Benson and Briscoe (2003) support non-pharmacological interventions within the in-patient unit, saying that what is most important in the environment is the ability of the child to be able to form a therapeutic relationship with the psychiatric nurse. This relationship gives the child the opportunity and safety to create new (more acceptable) realities in his/her patterns of interaction. This therapeutic environment will be addressed more comprehensively in the

next section. No one can escape the diagnosis of psychiatric patients when working or relating to a psychiatric hospital setting on any level. The reality is that it is the language, a way of punctuating and drawing distinctions within such an environment. An ecosystemic approach does not advocate either/or approaches. Rather, it is about trying to see and reflect on the whole rather than on parts of the whole (Keeney, 1993). Strayhorn (as cited in Hasselt & Kolko, 1992) states that there was once an era where there was no space for a medical and psychological model in the treatment of psychiatric patients, and that it was almost as if practitioners could only handle one major conceptual model. Within this model, the focus was on diagnosis and treatment (through medication) rather than on the individual. It is through this model where the shift is established from seeing patients instead of people.

My investigation explores, describes and interprets the child psychiatric nurse's views about the current context, and the effect that the context has on them. This ensures a double description, creating spaces where questions can be asked and statements can be made with regards to the context of the child psychiatric nurse in South Africa. Thus far I have briefly punctuated some viewpoints on the territory of the child psychiatric nurse working at an in-patient hospital setting. As part of the distinction on the context, I also explore aspects of a therapeutic environment (central to effective patient care) and thereafter punctuate the different role-players who explore the territory together.

### **A therapeutic context (milieu)**

Central to my investigation is for me and everyone who interacts with the text to create a space for reflecting on the work of the child psychiatric nurse, creating new realities for better patient care. This in itself can be defined as a therapeutic context. On a more concrete (content) level, a therapeutic environment can be described as an environment that maximises therapeutic processes and minimises destructive processes within in-patient units (Norton, 2004). For many years psychiatric hospitals have been constructed as closed-off environments, which separate *normal people* from *abnormal people*. Norton (2004) says that, instead of viewing in-patient hospital settings as sanctuaries for disturbed people, they need to be viewed and interacted with as places that promote healing through social support, community and therapeutic interventions.

McDougal (2006) refers to the shared responsibility of nurses and all professionals who interact with the children to create a therapeutic context. He describes such an environment as a place where every child is given every opportunity to reach their fullest potential and to enjoy better mental health than before they were admitted. Mohr (1999b) says that in a therapeutic milieu, children are in an environment where they are sheltered from painful and frightening stressors. Here they can learn new relationship skills and the ability to cope better in interactions, which they can then apply in the external world.

Benson and Briscoe (2003) mention that both structured and unstructured components play a part in the creation of a therapeutic milieu. Structured components can be perceived as the everyday planned activities of the children in the ward (as per the treatment plan). The authors state that the unstructured components are the nurses' ability

to observe the interactions of the children with each other and that the expert nurse is flexible enough to allow unstructured behaviour and/or routines when needed. Aligned with ecosystemic thinking, it is not an either/or approach. An environment that becomes too structured and has no space for free-flowing action and observation can be non-therapeutic. This is reflected in Mohr's (1999b) article, where she quotes the reflection of a child (who was eight at the time of his admission) as follows:

*It was always rules. I kept wondering whether this was a hospital or a prison. And I mean you would at least think that there would be some bend like for individual cases or exceptions – after all, the world isn't black and white. But no, the rules were the rules and they were like sacred or something.* (p. 238)

Similarly, an environment is non-therapeutic if there is no structure. In this regard, Gunderson (as cited in Norton, 2004) identifies five key functions in an in-patient unit that can assist psychiatric nurses in establishing/creating a therapeutic environment. The five functions are: containment, support, structure, involvement and validation. My investigation explores the views of child psychiatric nurses in relation to their subjective experiences with the environment and whether they punctuate their realities as therapeutic or not. It also explores whether they reflect on the importance of their unstructured observations and how these need to be shared in order for a therapeutic environment to be created.

## **Contextual role-players: A team in context**

### ***Reflection space: On walking on the moon***

*Without individuals who live in or visit a territory (at any moment in time), there can be no explanation of a territory. I can, for example, give an explanation of what I think it is like to walk on the moon. I can base my explanation either on observed footage, or by reading the stories of the people who have been there and wrote stories about it. In my investigation, I primarily report on the constructed realities of the child psychiatric nurses, as punctuated by them. My own punctuations of the context form part of the investigation, seeing that I was once part of the context (for six months in 2003) as an intern clinical psychologist. Another part is an exploration of the literature with regards to the multidisciplinary team of which the psychiatric nurse is a part.*

Before exploring the different role-players in the context of child psychiatric nursing, I first want to draw a distinction on the context of psychiatric nursing in South Africa.

According to Kahn and Kelly (2001), there are typically three types of nurses in a South African psychiatric ward: registered enrolled (staff), auxiliary (assistant) and student. In this investigation I am exploring the lived experience of registered nurses working in an in-patient hospital setting. No role can exist in isolation. Part of my epistemology is the acknowledgement that realities are constructed socially and in relation to others.

Therefore it is important to mention the other role-players who exist in the context of the child psychiatric nurse.

In psychiatric hospital settings, the multidisciplinary team approach to treatment has long been part of the context (Mohr, 1999a). Im et al. (2004) also talk about acknowledging the importance of the multidisciplinary team approach for mentally ill children in Korea. They further state that the nurse is a key person to take care of such children. Procter and Loader (2000) also state the value of the multidisciplinary approach as a comprehensive approach to complex problems, when working with children.

Messinger (2007) urges current psychiatric practice to take a multidisciplinary team approach, where expert knowledge about patients across different occupational groups can be utilised. She says it is important to remember that disputes between these clinical perspectives have implications for the treatment of patients and for the study of psychiatric practice, and that a reflective space needs to be established where better insight into this aspect is possible, which will in turn lead to better patient care. It is important to acknowledge power relations at an in-patient setting, but more important to allow for shifts in a multidisciplinary team. In the South African context, Kahn and Kelly (2001) confirm that the general practice model is a multidisciplinary team approach as well and that the multidisciplinary team is headed by a psychiatrist and comprise of nurses, a clinical psychologist, occupational therapists, and physiotherapists.

***Reflection space: On multidisciplinary teams***

*In my experience the multidisciplinary team consisted of a psychiatrist, a psychiatrist in training (registrar), a social worker, an occupational therapist, a clinical psychologist, a registered psychiatric nurse, an intern clinical psychologist and an educational*

*psychologist. The ward rounds were also mostly attended by medical students as part of their training blocks in psychiatry. My subjective experience and explanation of the functioning of the team was that I sometimes felt that the role of the child psychiatric nurse was not constructed in the ward rounds as equal to that of, for example, the psychologist or the social worker.*

Lichtenstein et al. (as cited in Singh, Singh, Sabaawi, Meyers, & Wahler, 2006) say a therapeutic multidisciplinary team is a place where the different team members are comfortable about their roles and feel that they are able to take part in any team discussion where clients are discussed and where important decisions need to be made. This way, each member feels positive about the functioning of the team overall, and contributes in the setting of goals for the team. The naming and exploration of the context (as outlined in the above text) are not exclusive, but form part of this investigation in creating a description of the context of the child psychiatric nurse. The next section is an exploration of the role of the child psychiatric nurse as she functions and interacts within the constructed context, where the latter also in turn interacts with the meta-context of psychiatric nursing in South Africa.

### **THE CHILD PSYCHIATRIC NURSE: AN EXPLORATION OF ROLES**

With regards to the role of the child psychiatric nurse, the complementary relationship between visible/invisible; container/contained; caring/curing; attachment/detachment; good object/bad object; whole/parts of the whole; and systems thinking/object-relations theories are all part of my thinking when thinking about the role of the child psychiatric



nurse. What follows is an explanation of the way that I punctuate the role of the child psychiatric nurse (as subjectively informed by different literature about the role of the child psychiatric nurse) to allow for a reflective space to be able to integrate their own meanings of their roles, later in the investigation. This enables the creation of a double description of the role of the child psychiatric nurse in this investigation.

Huelskoetter (1991) states that no role can exist in isolation and that the psychiatric nurse firstly sees her role in relation to the expectations of what others think her role should be (preconceived ideas of others), and secondly, in relation to the way in which she sees her role (preconceived ideas of self). This in itself can form a complementary relationship in the form of preconceived ideas of self/preconceived ideas of others. The nurse's preconceived ideas of self, in her role as a nurse, are thus informed by training and both the overt and covert communication of different individuals that he/she interacts with. Embedded in the role of the child psychiatric nurse are the roles of the nurse and the psychiatric nurse. As per ecosystemic epistemology, I cannot exclude/ignore these roles, seeing that they contribute to the child psychiatric nurse's context of being and becoming.

### **The traditional role of the nurse: The person behind the uniform**

The history of professional nursing begins with Florence Nightingale. According to Haber (2000), Nightingale said that the nurse's role is to perform tasks to and for the patient and control the patient's environment to enhance recovery. In most descriptions of the traditional role of the nurse, the patient is passive and the nurse is actively involved in supporting not only the patient, but also any other individual in the medical team, to

provide a safe environment and to assist in the process of recovery for the patient.

According to the traditional role of the nurse, the nurse's role is to be visible. In addition, the nurse needs to be available. In essence, the traditional role of the nurse was that of support to doctors and patients (Marriner-Tomey & Alligood, 2002). The invisible part is the impact of this traditional role description on the child psychiatric nurse. One can argue that it might be difficult for people (and for the nurses themselves) to look *beyond* the *nursing uniform*. Part of this investigation is to explore the way in which the child psychiatric nurse defines herself, to see if there is still any *holding on* to traditional roles. The latter in itself can be a cause of the nurse not being comfortable to become visible outside of the traditional roles; to become, for example, the person behind the uniform.

### ***Reflection space: A nurse in uniform and an intern without a uniform***

*In reflecting on my own experience, I had to challenge my own thought processes in realising that it was initially difficult for me, too, to connect and see the important work of the person behind the uniform. Initially I viewed the nurse in uniform as someone whose primary role was to support the members of the multidisciplinary team and to perform medical procedures. It was only later that I started realising that they play a far more crucial part in the treatment of the children. When I left, I knew the people behind the uniforms.*

### **The role of the psychiatric nurse: A reflection on self**

Peplau can be seen as the Florence Nightingale of psychiatric nurses, and her influence can be widely seen in most of the literature that reflects on the role of the psychiatric

nurse, from 1959 to the present. According to Peplau (as cited in Haber, 2000), the most important difference between the role of the nurse and the role of the psychiatric nurse is the nature of the nurse-patient relationship. Peplau can be considered as one of the biggest voices in psychiatric nursing. Her voice can still be found in many articles relating to psychiatric nursing today and her theory of the different phases of the nurse-patient relationship is acknowledged by most literature on psychiatric nursing. Peplau's primary contribution to the field of nursing – and psychiatric nursing in particular – is her development of the frame that focuses on interpersonal relations. Haber (2000) states that, through this paradigm, psychiatric nurses can assist patients in making sense of and learning from their responses to experiences related to health and illness.

The role of the psychiatric nurse is thus not only to have an understanding of the patient and the patient's needs (the traditional role of the nurse), but to also have an understanding and awareness of the 'self' in interaction with the patient and the role that the 'self' plays in the therapeutic process. This is aligned with the shift from cybernetic thinking to a 'cybernetics of cybernetics' way of thinking, where the observer is part of that which is being observed. Haber (2000) further states that Peplau emphasised the fact that health is restored for the patient in the interactional domain, as the aim is for the interactive process to promote independent problem solving, ego building and corrective boundary setting.

Sjostedt et al. (2001) also highlight the importance of the nurse-patient relationship in psychiatric nursing. They argue that, in order for the patient to get better, the nurse must

show that she completely understands the patient's suffering. The nurse-patient encounter is an ongoing process and can be fully understood and developed only in the context of lived experience. This also forms the basis for doing my investigation, namely to see how the nurse-patient encounter is constructed/punctuated by the child psychiatric nurse. This can lead to a better understanding of the unique role that child psychiatric nurses play in patient treatment.

Within this interactional context (or as previously punctuated, the science and art of nursing), Benson and Briscoe (2003) state that one of the primary functions of the psychiatric nurse working in an in-patient setting is to provide patients with a space where they feel physically and emotionally safe. One can thus say that the nurse needs to be an advocate for safety. The creation of such a safe space can make therapeutic relationships between nurses and patients possible.

According to the visible/invisible complementary relationship, one can argue that Peplau attempted to make the invisible visible. According to Marriner-Tomey and Alligood (2002), Peplau asserts that the role of the counsellor is of the greatest importance for the psychiatric nurse. This role of the counsellor can still be seen as a relatively new term in psychiatric nursing. Boyd (2002) says that in the past, psychiatric nurses were not described as therapists; this term was used only in relation to psychiatrists, psychologists and social workers.

Another important difference between the role of the nurse and the role of the psychiatric nurse is the importance of her role in the multidisciplinary team. Robinson (1983) says that the psychiatric nurse shapes and coordinates the therapeutic milieu: she plans and implements nursing interventions to alter maladaptive behaviours observed on the ward, administers medications and treatments and observes for their effects. Even though this is an example of *visible nursing* it is important to see if this aspect of psychiatric nursing is made visible in the lived experience of child psychiatric nurses in later chapters.

Thus far we have seen that the psychiatric nurse is an advocate for safety, a counsellor and an important role-player in the multidisciplinary team. She also possesses the ability to form therapeutic relationships with patients. The multiple skills that the psychiatric nurse requires are made evident in the various literature. These skills enable the nurse to be successful in her different roles. Some of these skills include: effective communication, structuring patient activities, encouraging appropriate behaviour, leading groups, administering medication, managing crises, being an active listener, relating with family, interacting with different members of the multidisciplinary team, and being fluid in structure (Benson & Briscoe, 2003; Kahn & Kelly, 2001; Sjostedt et al., 2001).

Jackson and Stevenson (as cited in Benson & Briscoe, 2003) highlight the importance of the role of psychiatric nurses by saying that, through their flexibility and accessibility, patients are allowed to get better and the gap is bridged between intimate and professional knowledge within the mental health services. The importance of the role of the psychiatric nurse in offering good patient care needs to be made visible and

communicated more clearly in psychiatric settings. All the different functions that were punctuated in the previous section on the role of the nurse and of the psychiatric nurse are part of the role of the child psychiatric nurse.

### **The role of the child psychiatric nurse: Gatekeepers of the uncontained**

#### ***Reflection space: The Iron Gate that separates***

*Where I did my internship there is an iron gate that separates the psychiatric nurses and the children who are admitted at the children's ward from the offices where the other members of the multidisciplinary team are situated. The sister in charge has a key to the gate and in a very literal way, she is the gatekeeper. On many days when entering the ward, some of the children would cry uncontrollably at the gate, before the nurses directed them away from the gate. Many a time, while working at the unit, I observed several nurses needing to deal with raw and uncontained emotions. I further reflected on my own emotions and the impact that simply the observation of such a child had on me, often wondering what the impact of this ongoing containment of raw emotions had on the child psychiatric nurse.*

When looking at the role of the child psychiatric nurse, the importance thereof becomes visible when realising that, apart from the being gatekeepers, they are the individuals who interact most with the children. Delaney (2006) writes in her article: *Learning to observe in context: Child and adolescent in-patient mental health assessments*, that the child psychiatric nursing staff have 24-hour exposure to the behaviour of the children. The importance thereof becomes evident in Delaney's (2006) following statement:

*In-patient nursing staff experience firsthand how children take in information, organise themselves in an activity and regulate strong effects. Thus, nursing staff occupy a prime position from which to observe patterns in behaviour over time and to help others in the treatment team. (p. 173)*

According to Street (2004), the importance of having a nurse that they (the children admitted to a psychiatric hospital) could talk to and with whom they could form a meaningful relationship, was clearly apparent when looking at the role of the child psychiatric nurse. It seems that there is an even greater emphasis on the sensitivity of the nurse-patient relationship and on the specialised role of the child psychiatric nurse working in an in-patient hospital setting.

When thinking about the role of the child psychiatric nurse, it is important to mention what was punctuated in a previous chapter when reflecting on the importance of object relations, specifically Klein. She makes us aware of the inner struggles of the child that are projected onto the outer (external) world (Gunter, 1971). When thinking about the children who are admitted – at a point in their lives where there is a lot of uncertainty and little trust in the world – it needs to be remembered that this will be projected onto the people who work the closest with them. The nurse needs to have the ability to reflect more on the behaviour that she is observing, trying to make sense out of it. Clarke and Flanigan (2004) say that the ability of the nurse to share in the patients' daily lives is as important as individual therapeutic work.

The role of the psychiatric nurse is also to allow children to not only form relationships with them, but allow them to form attachments with them. Qualter and Munn (2002), in referring to the difference of emotional and social loneliness in childhood, argue that emotional loneliness is more intense and involves a psychological absence from others and an absence of a close attachment relationship. For lack of such meaningful attachments (an essential part of a child's development), the psychiatric nurse can create such a space where the child can be allowed to form such an attachment with him/her. This can be defined as a corrective experience. Eisen and Schaefer (2005) note that the characteristics of sensitivity, warmth, support and stimulation of the nurse can create such an environment that will enhance the chances for the child to form a meaningful attachment with the nurse.

The role of the nurse is not only to act as a gatekeeper to the children, but also by necessity to act as a gatekeeper for the anxieties of the families. Scharer and Jones (2004) say that, usually at the point of admission, most parents have run out of options and act out of desperation following (more often than not) a crisis. Often the child was directly involved in the crisis and was either a danger to himself/herself or others. The role of the nurse is to reflect on each set of parents; the nurse also has the unique opportunity of observing interactions between the child and the parent. These observations may not be accessible to the rest of the team. Scharer and Jones (2004) end their article by encouraging psychiatric nurses to better engage parents from the admission of the child right through to when the child is being discharged. The need for the nurse to include the families in the treatment of the children is further supported by a number of sources



(Elilla et al., 2007; Procter & Loader, 2000; Simpson, Yeung, Kwan & Wah, 2006). Ellila et al. (2007) also attribute positive outcomes in child and adolescent in-patient psychiatric treatment to the ability of the nurse to form effective therapeutic relationships with parents or other primary caregivers in the children's lives.

***Reflection space: On thinking about the roles of the child psychiatric nurse and my own role in drawing the subjective distinctions in the literature review***

*I argue that the exploration of the role of the child psychiatric nurse remains one of my main reasons/motivations for the completion of this investigation. This is in order to make the invisible more visible, by asking pivotal questions about the role of the child psychiatric nurse in relation to the overall management of the patient. The aim is to understand the impact that the suspected invisibility of the process not only has on the psychiatric nurse (as part of the whole), but also on the different role-players (child, family, mental health field). I am fully aware that the distinctions of the roles that I have highlighted are only my subjective punctuations and that there are some traditional role descriptions that I have not included in my review. I am of the belief that the above punctuations and distinctions assist me in the investigation, by allowing the subjective rich descriptions of the lived experience of the child psychiatric nurse as punctuated by them, to form a more comprehensive (double) description of the unique role of the child psychiatric nurse. I also cannot help but wonder about my own process (role) in relation to the system and how the distinctions of attachment/detachment; being/becoming and observer/observed mirrors itself in relation to my different parts and to the system as a whole. Thus, included in this investigation is my own search and struggle for meaning*

*outside the label of being a psychologist. Hence, the pain that I felt in working with these children necessitated that I, on occasion, detached in order to attach again. Part of this investigation therefore is to explore these questions and reflections between my own lived experience and the lived experiences of the child psychiatric nurses. This will further allow a double description of the research context.*

### **THE CHILD PSYCHIATRIC NURSE IN RELATIONS/RELATING**

Bion (as cited in Sprince, 2002) reflects on the complementary relationship container/contained as a constantly recurring pattern. He states that it is a relationship that is observable between one individual and another, between an individual and a group, as well as between a group and an organisation. In the processes of these interactions and through the use of language, knowledge is constructed between people. I want to take this above aspect to another level by drawing another distinction on another complementary relationship as follows: container/contained: knowledge/language.

The following section explores the nurse in relation to the child by looking at different theories that assist me in understanding the process of what happens when the nurse and the child meet. Through exploring factors that can damage such a relationship, a space is provided where the data in later chapters is integrated. I also draw conclusions on how to improve patient care, by allowing the nurse to be visible in that space. This section ends by looking at the child psychiatric nurse in relation to others, seeing that this also influences the lived world of the child psychiatric nurse and the way in which the children are assisted.

## **The child psychiatric nurse in relation to the child: Container of the good, the bad and the ugly**

In the context of psychiatric nursing, Peplau (as cited in Haber, 2000) proposes that a nurse-patient relationship “facilitates forward movement” (p. 60) for both the nurse and the patient. When integrating these two ideas it is clear that, even though the ideal is for the nurse-patient relationship to move forward together, there are many factors that influence what is contained, the ability to contain and whether the contained material is allowed to be contained. This aspect is explored in later chapters to see what factors enable/facilitates the relationship to move forward (as punctuated by the nurse and myself) and which factors disable/hinder the relationship from moving forward. In order to allow for double description, an exploration of the literature is provided. Interweaved into the above are my own subjective observations that influence my punctuations and the distinctions I draw.

The importance of the first nurse-child (patient) encounter in an in-patient hospital setting is reviewed in an article by Sjostedt et al. (2001). The authors state that a nurse has the potential to communicate her understanding of the patient’s vulnerabilities in the first encounter. This allows for a relationship where the child will feel safe and understood. Sjostedt et al. (2001) further propose that the first evaluation needs to be managed/performed by the nurse to allow the first meeting to be therapeutic. Darwish, Salmon, Ahuja, and Steed (2006) remind the reader that admission to a unit can be a traumatic experience for the child. The child experiences loss of the family system, the

community system, the school system and even a loss of the self. They further state that the success of any programme lies in the ability of the staff to be available, supportive, and consistent in their approach and to communicate clearly. A recent study on children's understanding of a psychiatric in-patient admission (Hepper, Weaver & Rose, 2005) found that children do not feel listened to and that they had inaccurate ideas about their problems and reasons for admission. This has huge implications for the establishment of a therapeutic relationship. In reviewing the above, I am of the view that the ability of the nurse to allow herself to contain that which needs to be contained in the first encounter with the child, will in return allow the relationship between the child and the nurse to be therapeutic. According to Peplau (as cited in Sloan, 2006) this facilitates growth and forward movement, for both parties involved.

***Reflection space: The storm after the silence***

*This leaves me with the need to reflect on what happens after the first meeting, after admission, after the realisation for the child that this is his/her new reality (the in-patient unit). In my observation, while working at the unit for six months, that which follows admission, is central to patient care, as this is where the nurse is most visible. This is also the space where the children become even more visible, allowing them to be seen. This is the space where anxieties are free floating and the sad reality of children facing demons at an age way too young for them, takes place. This in itself creates the space for corrective experiences where the child can be noted and heard instead of noted and hurt.*

***Reflection space within the reflection space: An intern leaving for home and then leaving for good***

*I cannot help to include my own reality at this point in time. I often felt that the above space was so intense that I needed breathing space after many therapy sessions with the children. A 50-minute session felt endless, where the pain that I felt was so real, and surreal, that I felt relieved whenever I took them back to that side of the unit. It is even difficult to reflect on this after so many years. I often felt relieved in driving home and I felt relieved after the six months. I often wondered and am still wondering about the impact of these spaces on the child psychiatric nurse who needs to interact with the children for extended periods of time. This is one of the reasons for completing my investigation, to not only find a way for myself to go back, but to also create and share an understanding/appreciation of the difficult spaces that the child psychiatric nurse is faced with on a daily basis.*

**Phases in the nurse-patient relationship**

Peplau identified different phases that occur during nurse-patient relationships, reminding the reader that the nurse-patient relationship needs to be goal centred (Sloan, 2006).

Following the initial meeting, the different phases of the nurse-patient relationship (as identified by Peplau, as cited in Sloan, 2006) allow the nurse to move from a superficial to an intimate level. “Peplau identifies three sequential phases that occur during the nurse-patient relationship: orientation, working (identification and exploitation) and termination” (p. 61). The ability of the psychiatric nurse to reflect on her own behaviour in relation to the child and on the child behaviour in relation to the context and content of

these different phases will determine the success of any intervention. Again, Peplau (as cited in Sloan, 2006) was the first nurse theorist to suggest the essential relationship between therapeutic use of the self and the outcome of patient well-being. She further states the critical idea that the nurse has the ability – through self-assessment, self-awareness and personal growth – to change and shape her own world. This is in line with ecosystemic thinking, where the punctuations of any individual affects the way that he/she draws distinctions, which in turn, enhances understanding.

#### Orientation phase

The main goal of this phase is to establish trust between the nurse and the patient. If the child psychiatric nurse demonstrates in this phase that she is a caring, nurturing, safe person, the child feels secure and safe and is able to trust the child psychiatric nurse. Huelskoetter (1991) compares this phase developmentally to that of infancy, because the client depends on the nurse. Sloan (2006) says that during this phase, the nurse and patient meet as total strangers, they orientate themselves to each other and then form a relationship. The unfortunate reality is that often, the theory and practice part of psychiatric nursing is not that easy to apply. Im et al. (2004) did some research on assessing current child psychiatric practices in Korea. They found that child psychiatric nurses identified that establishing relationships with children was the most difficult aspect of nursing, followed by fatigue, role confusion and unpredictable situations. What makes it difficult for nurses to form meaningful relationships with children is that, even though they feel great affection for the children that they work with, it is difficult to process and reflect on the negative feelings they feel towards the children at times.

Forchuk et al. (2000) looked at the development of the nurse-client relationship in a psychiatric setting. They conclude that clients who have mental difficulties and are admitted to an in-patient facility, often have orientation phases of six months or longer, whereas the duration of this phase in other hospital settings is much shorter. The authors identified that if difficulties are apparent in the orientation phase, it can often lead to both parties becoming frustrated and withdrawing from the relationship. Forchuk et al. (2000) encourage nurses to reflect on the reasons for the frustration. This implies the need for a nurse to have insight into what she observes in the relationship. There are some factors that cause the relationship to not move beyond this stage, where nurses often get trapped or stuck. This is explored in the section after the discussion of the phases. According to Peplau (as cited in Sloan, 2006), towards the end of the phase, the nurse and patient are able to clarify problems. Hence, there is agreement upon constructed realities.

### Working phase

Once a safe environment is established for the nurse-patient relationship, and the child feels that he/she is able to trust the psychiatric nurse, the relationship moves on to the next phase, the working phase. The working phase is also described as the 'action' phase of the nurse-patient relationship. Peplau (as cited in Sloan, 2006) originally subdivided the working phase into two components: the identification phase and the exploitation phase. During the identification phase, the patient reacts selectively to those professionals who can meet his/her needs. Problems are identified and the patient decides who can assist in resolving these concerns. In the exploitation phase the patient makes use of all

available services. During this phase the problem and underlying needs and dysfunctional behaviour patterns of the child are sensitively and safely explored in the nurse-patient relationship. Carson (2000) states:

*Frequently, a disturbed child has become stuck in a cycle of maladaptive behaviours that draw forth unhelpful responses from those in the family and community who have also become stuck in responding in a certain way. Thus, weaknesses and problems appear in both the child and others.*  
(p. 468)

The psychiatric nurse's challenge is to recognise ways in which these patterns of learned behaviour can be broken, in the context of a therapeutic relationship. According to Christ, Critchley, Larson, and Brown (as cited in Fagin, 1974), the nurse learns to deal not with symptoms alone, but to search for their underlying conflicts. By helping the child to deal with his/her conflict in a more satisfying and effective way, the nurse hopes to reduce his/her need for the symptom itself and to substitute it with more appropriate behaviour by suggestion or demonstration. In this 'action' phase, the child psychiatric nurse needs to be aware of the way that she sees each child and each relationship. Again, like in the previous phase, it is important for the nurse to reflect on each relationship and each child independently, in order to establish the goals of this action phase. The contribution of the multidisciplinary team can become even more meaningful if goals can be created together.



## Termination phase

This phase is the most delicate phase when working with children. The experience of being admitted at a psychiatric hospital is usually quite traumatic for the child. It takes time for them to form a trusting relationship with a nurse. For many children the safety of the relationship (that needs to be established in order to facilitate good care) is a unique experience that they have never had. It is important for the child psychiatric nurse to implement a plan well in advance, which includes talking to the child about termination, and working through the child's feelings of separation and loss. Carson (2000) says that ideally, the seeds of termination are sown in the first encounter, when the nurse informs the patient that the relationship is time-limited. When working with children it can be done in practical ways, like drawing pictures to help the child to understand. The nurse also needs to acknowledge her own feelings of anxiety and loss. Again, like in the previous phases, the ability of the nurse to reflect is important. A part of this reflection is an inclusion of the different factors that contribute to nurses or patients getting stuck in any of the phases. This can lead to a non-therapeutic environment where either or both parties withdraw and are unable to form a meaningful relationship.

## **The unspoken that leads to spilling, withdrawal and frustrated containers**

As mentioned previously, the child psychiatric nurse works with children who are victims of severe violence and abuse, or who suffer from mental disorders, every day. The psychological impact on the child psychiatric nurse of working in such an environment needs to be explored. What follows is an exploration of the unspoken, creating a

reflective space where feelings of anxiety and anger are normalised in order to encourage reflection.

Feelings of anger experienced by the child psychiatric nurse

***Reflection space: Is it ok to be angry?***

*In the six months of working at the children in-patient unit, I often experienced moments of anger towards the children. For me, the anger came from a place of not knowing and of frustration. I reflected on some of these feelings in my own supervision, but also observed that there were never any discussions with the psychiatric nurses on their own feelings of possible anger towards the children. For me, it was almost as if experiencing anger and talking about this anger towards the child in a psychiatric hospital setting, is a sign of weakness or incompetence of the child psychiatric nurse, or anybody else who talks about it.*

Carson (2000) states that acknowledging these feelings of anger are an important part of the therapeutic process for psychiatric nurses who work with emotionally disturbed children. For the nurse to be able to help a child to deal with his/her angry feelings, it is important that she understands and deals with her own response pattern to anger. This in itself encourages reflection. The psychiatric nurse must remind herself that feeling angry is normal and that the expression of this feeling can be helpful. When anger is repressed (see later discussion on defence mechanisms), there is less energy available for constructive and therapeutic interaction with the children. Coffman (as cited in Fagin, 1974) states that if feelings of anger occur in nurse-patient relationships and are not

explored and expressed, they may show up in the nurse's non-verbal behaviour. Coffman (as cited in Fagin, 1974) continues and says that there is no set rule regarding whether or not a nurse should express her anger towards a disturbed child, but expressing her angry feelings should be determined on the basis of the child's needs and not on the basis of the nurse's needs.

#### Feelings of anxiety experienced by the child psychiatric nurse

Taylor (1999) defines anxiety as follows: "Anxiety is a diffused, vague sense of impending doom and is always perceived as a negative emotion. Therefore, the person experiencing anxiety works to get rid of this feeling, often through the use of ego defence mechanisms" (p. 8). Anxiety produces discomfort in all people. Anxiety can be destructive or constructive for the child psychiatric nurse. Anxiety is destructive if the nurse fails to recognise its source and nature and acts involuntarily to relieve the discomfort. On the other hand, anxiety can be used constructively, if the child psychiatric nurse can identify the true nature of the discomfort and then alter the source of the anxiety. The child psychiatric nurse often experiences emotions in her daily interaction with emotionally disturbed children that cause high levels of anxiety. The child psychiatric nurse develops defences against difficult emotions, which are too painful or too threatening to acknowledge. The ego defence mechanisms that the child psychiatric nurse develops protect her from experiencing too much anxiety. The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) published by the American Psychiatric Association (1994) defines defence mechanisms (or coping styles) as follows:

*The automatic or psychological process protecting the individual against anxiety and from the awareness of internal or external dangers or stressors. Individuals are often unaware of these processes even though they mediate their reaction to emotional conflicts and to internal and external stressors. (p. 53)*

The disadvantage of these defence mechanisms is that they prevent the nurse from having therapeutic relationships with the children with whom she works. Owing to the workload of the child psychiatric nurse, there is often little time to identify and explore these defence mechanisms, which prevent them from offering better patient care to the children with whom they work. Brown (as cited in Gow, 1982) says that total patient care provokes emotions of such strength that psychological defences are set up, which greatly reduce the nurse's ability to engage in meaningful relationships with patients. If the nurses do not receive any support in confronting these anxieties, they do not develop a capacity to deal more effectively with these anxieties (Brown, as cited in Gow, 1982).

The following extract highlights all the ego defence mechanisms that help the child psychiatric nurse to deal with the anxiety that she experiences in the nurse-patient relationship (Taylor, 1999, p. 9): "Denial, displacement, compensation, fixation, sublimation, reaction formation, identification, introjections, isolation, rationalization, repression, regression, projection, conversion, passive aggressive behaviour, blocking, externalization, and humour". According to Johnson (1995), anxiety in the nurse can stem from several sources in a psychiatric setting. In working closely with severely traumatised children, the child psychiatric nurse is often the person who is not only

hearing about all the abuse that the children had to endure, but also seeing the effects of the abuse on the children's behaviour. Hartman (as cited in Feldman, 1995) identifies this phenomenon as vicarious traumatization:

*Vicarious traumatization is a phenomenon that recognizes that the exposure of persons, other than the victim, to the specifics of trauma material or the re-enactment of traumatic experiences transmits the emotional laden aspects of the original violence and thus is a source of emotional arousal and distress for the nurse working with victims of violence. (p. 44)*

Nurses' reactions to this trauma information often result in non-therapeutic patterns of interaction with the children. Hartman (as cited in Feldman, 1995) continues by saying that these non-therapeutic patterns are marked by behaviours that over-involve the nurse or results in the nurse's withdrawal from the patient. Another source of anxiety for the child psychiatric nurse is when the nurse experiences counter-transference in the nurse-patient relationship. Huelskoetter (1991, p. 172) defines counter-transference as "an unconscious, inappropriate emotional response to the client as if he/she were an important figure in your life, or unconsciously based in past unresolved experiences with key people in your life". If the child psychiatric nurse is unconsciously experiencing counter-transference in her interaction with a child, it leads to non-therapeutic relationships. Such interactions can be destructive for the child psychiatric nurse and for the child. The child psychiatric nurse needs to identify the existence of counter-transference in her interaction with children to deal with it more effectively. If she is aware of specific reactions to specific children, her communication is more effective and

her nurse-patient relationships are more therapeutic. Carson (2000) says that an increase in anxiety or uneasiness that is felt by the nurse in working with a child is normally an indication of counter-transference. Symptoms of counter-transference include: sudden rush of any strong emotion; persistent feeling of dislike for a child or parent; boredom or sleepiness in the absence of real fatigue; urge to argue with a child or parent; or the wish to elicit gratitude from a child or parent.

***Reflection space: Including the exclusions***

*I have often observed the nurse in relation to the child as a gentle space in my six months of working at the hospital. I can recall many excited faces when seeing the nurse at the beginning of a day. The naming of the difficulties in the above sections that can be seen as factors that can easily cause non-therapeutic relationships needed to be stated. In the same way, a space needs to be created that allows for the dialogue of the nurses in this investigation, to lead to knowledge and better care when looking at the nurse in relation to the children, and to create a space where more of the unspoken can be spoken, allowing new realities or understandings to emerge. This reflection in itself allows for observing the whole of the relationship, not only its parts.*

**The child psychiatric nurse in relation to others: Systems maintaining problems**

The different role-players in the child psychiatric nurse's context were named in the previous section. It is important to acknowledge that the nurses also construct realities with staff. Within these realities, knowledge is generated through the use of language and dialogue. Within this distinction, the nurse impacts on the team, and the team impacts on

the nurse. Together they impact on the child and the child impacts on them. Again, this is in line with ecosystemic thinking in that it proposes a non-linear way of thinking, with an acknowledgement of multiple impacts.

Lanyado (as cited in Gairdner, 2002) offers a useful perspective that is based on Bowlby's attachment theory. She argues that, as children settle into a treatment unit and begin to feel secure, the fear that the new attachments made with members of staff will go wrong. Lanyado (as cited in Gairdner, 2002) further says:

*This plays an important part in the fear of disintegration that can underlie many processes of splitting and acting out in organisational settings, as well as between professionals in outpatient settings everything feels very wobbly and this is an anxiety that runs deep and brings out the wish to place it elsewhere in the community, rather than examining it in oneself.*  
(p. 291)

This can cause lots of tension within a team. To relate back to the initial statement of Bion's theory (Bowlby, 1973), children cannot feel contained if a team is uncontained. One can argue that the role of a multidisciplinary treatment team is to provide an experience of containment in which the child's distress can be tolerated. According to ecosystemic thinking, the nurse-patient relationship cannot be viewed in isolation from the bigger context, but only in relation to it.

In an attempt to explain what sometimes does happen in a multidisciplinary team, Main (1986) wrote an article on 'The Ailment'. He focuses on the impact that some children

have on the nurse and the way it affects the team. He explains it through object-relations theory, saying that sometimes there is a child who brings out a need from the nurse to overprotect them. The nurse may in response to this, offer the child more of her time, almost as if she is giving the child special treatment. Because of the severity of these children's psychological difficulties, the special treatment does not help them to 'get better'. Rather, the process normally ends with the nurse feeling extremely exhausted, having the need to blame someone else in the team for the child's lack of improvement. The nurse is then acting out the child's inner confusion. This can cause a multidisciplinary team to split, which can have effects on the rest of the treatment, seeing that the team is now perceived by the other children as uncontained. This causes them to think that the hospital is also not a safe environment. The latter is constructed as being 'caused' by the children re-living their insecure childhood life and projecting all their insecurities onto the people with whom they interact. The effect on the child is that, when the nurse realises that the child is not getting better, she might withdraw from the child. For the child, this function is yet another example of an object rejecting him/her, which re-traumatises the child. Yet again, the need for reflection is evident. The psychiatric nurse needs to reflect on her everyday interactions with other team members, seeing that that in itself can also assist the team in thinking about the child and the best treatment for the child. This can allow for spaces where thinking about the thinking can prevail. Main (1986) ends his article by commenting on this need to reflect and to be open with each other:

*It is important for such patients that those who are involved in their treatment and management be sincere with each other, in disagreement as*



*well as agreement, that each confines himself to his own role, and that each respect and tolerate the other's limitations without resorting to omnipotence or blame. (p. 455)*

In closing I would like to return to my earlier punctuation, when reflecting on the role of the child psychiatric nurse, namely the importance of being able to interact with the family. The same anxieties, anger and ego defence mechanisms can play themselves out in the interactions with the family and is therefore important to reflect on. Influenced by 'systems thinking treatment trends' over the past 20 years, it has been a pattern to move away from the child as the 'identified patient' and sole recipient of the interventions (Mohr, 1999b). According to Mohr (1999b), the emphasis of care has expanded to include the 'family-as-client' perspective. Gross and Goldin (2008) state that engagement with families is at the heart of any successful in-patient admission for a child or young patient.

***Reflection space: On painting/artist as a complementary***

*Is the painting a result of the artist or the artist a result of the painting? If psychiatric nursing is an art, I am wondering if we have for many years focused on the science of nursing, struggling to find words to define the art and allow the paintings of the child psychiatric nurse to emerge. Is this investigation an attempt by me to define the painting or the artist, or both? According to my epistemology, it is both, and I hope that the painting and the artist can be defined and so create many more paintings of words and visible artists, to allow this investigation to be a painting of an artist drawing a painting. The description of the context of child psychiatric nursing, the role-players, the roles of*

*the child psychiatric nurse and the processes that happen when nurses interact are all punctuations of a painting that is painted by literature (different voices), with some of my own reflections embedded in that.*

## **IMPORTANCE OF SUPERVISION: THE ART OF MIRRORING REFLECTIONS**

The importance of reflection is central to this investigation and has been encouraged in most of my descriptions/constructions thus far. The ability to reflect allows you to step back and confirm, reconstruct or give alternative and more comprehensive meanings to that which was constructed. White and Winstanley (2009) define clinical supervision as follows:

*Clinical supervision provides time out and an opportunity, within the context of an ongoing professional relationship with an experienced practitioner, to engage in guided reflection on current practice in ways designed to develop and enhance that practice in the future. (p. 265)*

The literature shows that one way of providing a space for nurses to reflect on themselves in relation to others and also to reflect on the impact of others (including the patients) on them, is through clinical supervision/support groups (Griffin & Christie, 2004; Gross & Goldin, 2008; Ramritu, Courtney, Stanley, & Finlayson, 2002; White & Winstanley, 2009). Griffin and Christie (2004) say that staff groups for nurses that run on a weekly basis at an in-patient facility have proved to be highly successful on a number of levels. The groups that the psychologist facilitates have helped both the nurses and psychologist to understand each other's language (way of punctuating). Gairdner (2002) states that

group supervision for nursing staff gives them the opportunity to reflect together on the range of responses different members of the team may have to patients. What is important, however, is for nurses to move away from the traditional thinking of supervision in a nursing context, where the purpose is to examine the nurse's efficiency with regards to medical procedures. This investigation also aims to identify and explore if any of the child psychiatric nurses raise the need for supervision.

***Reflection space: The whole is bigger than the parts; the parts interact with each other***  
*According to ecosystemic epistemology, the whole is bigger than the parts, in such a way the whole of this chapter needs to be reflected on. I am aware of my own punctuations and that many of my punctuations can be included under different sections. I would like to encourage the reader to view the chapter in the same way. In the same way, this chapter is part of the previous chapter and part of the next chapter, together forming a whole. This encourages reflective thinking and allows a space for further constructions of reality.*

## **CONCLUSION**

Before I move on to the next chapter, which is the drawing of a distinction and punctuations within that distinction of the research method for this investigation, I want to apply the *stop-pause-reflect* button. The *ideal-lived-world* for the child psychiatric nurse, according to what was reflected on in this chapter, is a therapeutic space that allows the nurse to form meaningful relationships with children who are admitted to any in-patient unit, where the nurse can allow the children to project their own insecurities in

a reflective space, allowing therapeutic growth. It is a space where there are both structured and unstructured factors within the environment and where any individual in the team has the opportunity to share their understandings with each other to allow for better patient care.

The literature further showed that the ideal and the reality is differs mostly in that there are a number of factors that cause the nurse to be anxious and which, in turn, has a direct impact on the immediate environment and nurse-patient relationship. Several aims have been identified in this chapter with regards to this investigation. In the same way as outlined above, one is urged to ask whether the whole of the different aims are bigger than the different aims themselves. The whole is to establish in this investigation what the punctuated reality is of the four child psychiatric nurses. In order to create a reflective space, where I and anyone (irrespective of their profession) who interacts with the text can allow themselves to enter into that space, and to draw new distinctions about how to improve patient care for children that are being admitted to in-patient units in South Africa. It is to establish if there is a fit with what we know (the content of this chapter) to what we see in the analysis of the later chapter to allow for new *what-we-know* information.

***Reflection space: On hope through connection and unity experienced through the self***

*Archbishop Anthony Bloom (as cited in Bowlby, 1973) says:*

*People are much greater and much stronger than we imagine, and when unexpected tragedy comes ..we see them so often grow to a stature that is far beyond anything we*

*imagined. We must remember that people are capable of greatness, of courage, but not in isolation They need the conditions of a solidly linked human unit in which everyone is prepared to bear the burden of others. (p. 322)*

*This quote stands central to my own subjective observations of the nurse-patient relationship. It also serves as a reminder to me that without completing this investigation it remains yet another example of the voice of the child psychiatric nurse in isolation. It is lastly a pledge to myself, to re-enter the world of child psychiatry, acknowledging the need and the hope within that need, as mirrored in my own struggle for healing.*

## **CHAPTER 4**

### **RESEARCH METHOD**

Woolf (as cited in Rapport & Wainwright, 2006):

*The 'proper stuff of fiction' does not exist; everything is the proper stuff of fiction; whatever one honestly feels. No perception comes amiss; every good quality whether of the mind or spirit is drawn upon and used and turned by the magic of art to something little or large, but endlessly different, everlasting new. (p. 228)*

### **AN EXPLORATION OF TERRITORY**

The biggest challenge for me is to align this investigation to ecosystemic thinking, where the whole is bigger than the different parts of the whole. This is a challenge because of the unique learning experiences I have already had while interacting with the different chapters thus far. The challenge therefore is to avoid seeing each chapter in isolation. Therefore, I need to remind myself (and the reader) of the realities that have been punctuated thus far, when looking at the lived world of child psychiatric nursing. These distinctions and punctuations assist me in entering this chapter, allowing this chapter of the investigation to unfold. It is thus a cybernetic complementary of *Chapter 4/Chapters 2 and 3* (the it/the process leading to the it). This punctuation in itself is a reflective space of learning and assists me in the distinctions that are to be drawn in this chapter. I am reminding myself and the reader of my earlier punctuation of Hoffman (1993), that there is a possibility for something new to be created at each point of interaction and reflection about interaction.

Maggs-Rapport (2001) describes qualitative research as being founded on four levels of understanding. The *first level* is *ontology*, defining reality. This is reflected in my investigation in exploring the lived reality of child psychiatric nurses. The *second level* is about *epistemology*, looking at how knowledge is gained. Different lenses were identified to describe the different ways in which I view the world and the territory of child psychiatric nursing in particular. These lenses included: ecosystemic thinking, cybernetic complementarities (contact lenses), post-modern lenses (sunglasses) and psychodynamic lenses (reading glasses). These lenses all inform the way in which I explore and reflect on the territory of child psychiatric nursing. Keeney (1993) states that the observer distinguishes first, and then describes. All of these lenses are tools that assist me in my interactions with this investigation and with this chapter, and are referred to accordingly. As Doherty (1999) explains, the different lenses assist me in the search for essence, allowing something new to evolve, rather than predetermining what is real and valid in the world. The territory was further explored through different maps of the territory (Chapter 3). These maps punctuated different ways of looking at the same territory, of child psychiatric nursing, allowing for thinking about the thinking of child psychiatric nursing through reflection. The different role-players who share the territory with the child psychiatric nurse were identified and the importance of the nurse interacting with these role-players was identified. The aim was thus to familiarise myself and the reader with the territory. The *third level*, according to Maggs-Rapport (2001), is about *methodology* and ways in which the realities of the psychiatric nurses are explored under the umbrella of descriptive phenomenology. This forms the basis of this chapter. The

*fourth level* (and last) focuses on *specific methods* of how data is collected in a process of developing understanding, and is also punctuated in this chapter and the ones that follow.

One can thus say that for the purpose of this investigation, it is a universal territory, reminding the reader that this universal territory is different to the universal territory of another researcher, because of the freedom to punctuate and draw distinctions. This can be linked to Hoffman (1993) and her views on self-referentiality. She postulates it as an essential feature of ecosystemic thinking, in that it enables a researcher to become more aware of the manner in which one's own relationship to the operation influences the operation. Self-referentiality refers to the manner in which the researcher, who proposes the *reality*, remains aware of it being just that: his/her own punctuation of his/her own creation. In addition, the researcher acknowledges the recursive influence that he/she has on the observed system and the observed system on him/her (Keeney, 1993). Within this context I am aware that the emotional distance that I had (in the form of time) plays a significant role in the drawing of the distinctions, and in what is punctuated in the analysis of the data. This aspect of the investigation is included in the data analysis section of the dissertation, enabling a double description.

## **A TERRITORY WITHIN A TERRITORY**

Within the context (territory) of child psychiatric nursing, I am drawing another distinction that forms the basis of the remainder of this investigation, specifically in this chapter and the next. This distinction is on the lived world of four child psychiatric nurses working at a psychiatric hospital. The aim is to explore the unique ways in which these



individuals punctuate their realities, to allow for reflection and to look for essences that are constructed through language in order to allow for a space where new realities can be created. Embedded in that is my own experience of being in the world and being part of the constructed reality, both during my six-month internship and during this investigation. I am of the belief that this will, in turn, allow anyone who interacts with the text to ask meaningful questions about current realities and the way forward. This is the entry point for the chapter to follow.

I am using the analogy of a mine for this specific territory. Seeing that I also believe that caring for children is a unique field, I compare it to a diamond mine. The aim of this investigation is thus to search for diamonds (essence) in this territory, by looking at the ways in which the different miners (child psychiatric nurses) punctuate their realities to develop better understanding. The process of understanding is “the process of immersing ourselves in the other’s horizon” (Anderson, 1999, p. 39). The end product of this investigation is to construct a description of diamonds (essences) that were discovered. Reminding myself and the reader that Hoffman (1993) says that within this epistemology the emphasis is on meaning. It is also to discover the template theories of people, what they believe about the world, because they act according to these templates.

Before this can happen, it is important to first understand the way in which I am going to interact with the observed realities of the different miners. Aligned with the different lenses that were punctuated in previous chapters and my epistemology, I chose descriptive phenomenology as the method for analysing the data. I am punctuating from

within this methodology, seeing that I am of the firm belief that this method underpins my epistemology and complements the way in which I view the world. What follows is an exploration of phenomenology as a science and then as a methodology, specifically as it relates to the territory as punctuated above. This can be seen as the map that assists me in the drawing of distinctions on the territory.

The aim of the investigation is for me to describe, as accurately as possible, the phenomenon (lived experience of child psychiatric nurses) and to gain a deeper understanding of the essence and the meaning that these nurses attach to their everyday experiences of practising child psychiatric nursing. According to Aquino-Russell (2006) phenomenological research is seen as a co-creation between researcher and participant rather than as observations of objects or behaviours. It is important to understand that the word *phenomenology* can refer to a research method, a philosophy or an approach (Aquino-Russell, 2006). Aligned with ecosystemic thinking, for me, it is not an either/or, but rather a method, philosophy and approach that assists me in this investigation.

### **DESCRIPTIVE PHENOMENOLOGY AS A PHILOSOPHY**

According to Kleinman (2003), phenomenology is the study of consciousness and was first introduced as a philosophy in the early twentieth century by Edmund Husserl. Kleinman (2003) states that the focal point of Husserl's formulation of phenomenology is that truths rely on the things themselves. Husserl describes this aspect as "going back to the things themselves" (p. 9). Wertz (2005) states that phenomenology emphasises the importance of returning to the psychological subject matter with an open attitude and

“evoking fresh, detailed descriptions that capture the richness and complexity of psychological life as it is concretely lived” (p. 176). According to Lopez and Willis (2004), Husserl believed that a scientific approach, in the form of phenomenology, was needed to bring out the essential components of the lived experiences specific to a group of people. Descriptive phenomenology can thus be seen as Husserl’s method of describing essence, punctuating from a qualitative research perspective. Rapport and Wainwright (2006) refer to this as a descriptive moment, which reveals the way things are (currently); any future punctuation with regards to that specific context will then happen against this backdrop of what was constructed/ punctuated. In order to achieve the above, I need to acknowledge the difference between a positivistic (scientific) way of thinking and a way of thinking that encourages human reflection in relation to others. The above is not always as easy as following a specific scientific formula. Husserl developed and explained key concepts to allow for the descriptions of essence (consciousness), also referred to as descriptive phenomenology (Ladkin, 2005). These concepts are discussed next.

### **Intentionality**

Husserl says that consciousness is always intentionally directed towards an object, and that that needs to be the aim of the researcher, to describe consciousness as it appears to perception (Lopez & Willis, 2004). Husserl refers to this as intentionality, where man is intentionally conscious of things. According to Giorgi (as cited in Rapport & Wainwright, 2006), intentionality refers to the fact that consciousness is always directed.

### **Universal essences**

Lopez and Willis (2004) say that the concept of universal essences underlies Husserl's philosophy of studying human consciousness, in that certain features to any lived experience of a group of people are common (shared) to all persons who have the same experience.

### **Transcendental subjectivity**

When punctuating from a descriptive phenomenology perspective, Husserl in his later works (Wojnar & Swanson, 2007) presented an ideal of transcendental subjectivity. He said that this is a condition of consciousness and is achieved if a researcher is able to successfully abandon his/her own lived reality and describe the phenomenon in its pure, universal essence. This is aligned with the earlier identification of the voice of Braten (as cited in Hoffman, 1993) when referring to post-modernism, where he speaks about a space individuals carry by their sides for the virtual other, this space allowing for another view. Husserl further says that this process of transcendental subjectivity may be accomplished through the process of bracketing (Wojnar & Swanson, 2007). The concept of bracketing is further explored later in this chapter.

### **Phenomenological reduction**

According to Husserl (Rapport & Wainwright, 2006), phenomenological reductions assist the researcher in exploring phenomena exactly as they are experienced by the people in a specific context. The purpose is not to confirm or deny what is being experienced. Wertz

(2005) says that this process allows the researcher to reflect and describe the meanings behind lived-through situations of individuals.

### **Free imaginative variation**

According to Wertz (2005), free imaginative variation is a process that allows a researcher to know or discover essences of phenomena. This process entails that the researcher imaginatively varies an aspect of a phenomenon under study in any possible way, in order to distinguish essential features. Rapport and Wainwright (2006) refer to this aspect as a moment of true arrival for the researcher, when discovering essences of people as they appear to consciousness.

## **DESCRIPTIVE PHENOMENOLOGY AS A METHODOLOGY**

The punctuation of phenomenology as a philosophy can be seen as an explanation of the territory (lived experience of four child psychiatric nurses) within the territory (lived experience of child psychiatric nurses in general). Within this territory, a map is described that informs the reader of the methods that were used in the planning, gathering and analysing of data for this investigation. It is the way of knowing about the knowing within descriptive phenomenology as a methodology. This section draws distinctions on several important aspects of this process. Firstly, I start with an explanation of the goals of descriptive phenomenology. Secondly, I describe the four key aspects of following such an approach. I also explain the process of this investigation, under the headings of the role of the researcher; sampling; ethical considerations; measuring instruments; and

data analysis. I end the section by looking at the trustworthiness of qualitative analysis and this investigation, specifically.

### **The goals of descriptive phenomenology**

A phenomenologist seeks to understand the nature of a phenomenon, rather than to predict or control it (Wojnar & Swanson, 2007). The aim of this investigation of descriptive phenomenology is to describe and explain the everyday lived world of four child psychiatric nurses working in an in-patient hospital setting in a way that expands my own understanding and the understanding of everyone who interacts with the written text. The goal is thus to understand the phenomenon from the viewpoint of those who have lived (are still living) it. After reflecting and interacting with it, the goal is to describe a structure of meaning that reflects the essence of the phenomenon under study. Drummond (2007) reminds us that, within this frame of reference, the description needs to be purely descriptive rather than explanatory and that the phenomenologist is not concerned with developing a model explaining why things are the way they are. Instead, the goal is to identify and describe the intentional structures of meaning as it appears to consciousness.

### **The four key aspects of a descriptive phenomenological approach**

I am reminding myself and the reader that there is not an either/or approach in this investigation and that certain punctuations might overlap with earlier punctuations, yet each of the punctuations are important in the broader understanding or territory of this investigation. For this reason I deemed it necessary to include these four key components

of the phenomenological methodology as outlined by Giorgi (1997), who was a student of Husserl:

- Firstly, phenomenology “thematizes the phenomenon of consciousness; it is the medium of access that is given to awareness, since nothing can be spoken about or referred to without implicitly including consciousness” (Giorgi, 1997, p. 236). This consciousness is unique to the four psychiatric nurses who took part in this investigation.
- Secondly, Giorgi (1997) reminds us that the word ‘experience’ refers to a broader range than that of objects as presences in space and time; this includes the term intuition. In such a way a psychiatric nurse can, for example, experience isolation even though she is between people.
- Giorgi’s (1997) third point rests on the precise meaning of phenomenology. He defines phenomenology as “the presence of any given precisely as it is given or experienced” (p. 237).
- The fourth key component of phenomenology is intentionality. “The very meaning of subject implies a relationship to an object, and to be an object intrinsically implies being related subjectively” (Giorgi, 1997, p. 237.). Intentionality is how I am aware of the world of the child psychiatric nurse, and how it presents itself to me.

In order to be open to achieving the above principles in this investigation, I need to be able to reflect and correct if needed to. One tool in assisting the researcher to reach these objectives is through bracketing and this will be part of the analysis process, as achieved through self-reflection.

### **The role of the researcher**

The main role of any researcher is to collect data in a way that will encourage the reliability and the credibility of the study. Aligned with descriptive phenomenology the role of the researcher is further to focus entirely on the participants' experiences as constructed through language and to interpret these punctuated realities later in a descriptive way, capturing the essence of the lived world of child psychiatric nurses. The role of the researcher is also to identify a methodology that he/she feels best fits the investigation and to explain/apply that method. I explore this further in the data analysis section of this chapter. Doherty (1999) adds that the researcher needs to be resilient in order to allow something new to evolve.

### **Sampling**

I have used a case study method for gathering raw data. This data is in the form of spoken words gathered from interviews with the research participants. Sampling was purposeful (i.e., non-random) in that I selected four research participants who qualified as *cases* of the *target population* (Terre Blanche & Durrheim, 1999). Suitable individuals for this study were any registered child psychiatric nurses who have worked for a longer period than one year in the hospital setting. To get an in-depth picture of the hospital functioning, I interviewed two day-staff nurses and two night-staff nurses, the chief child psychiatric nurse being one of these. Maggs-Rapport (2001) mentions that with descriptive phenomenology, sample size is dependent on the depth of the dimension that is tapped into. Wertz (2005) also says that the number of participants for a study in



phenomenology differs from one to up to 20 individuals, and that it is more important that the quality of the data is of such a nature that it can assist the researcher in constructing essential structures of the phenomena under study.

### **Meeting the participants**

Please allow me to, at this point, introduce the four participants of this investigation. The next chapter primarily focuses on the analysis of the data and on the search for meaning/essence without connecting the rooms (as referred to in the next chapter) to the different participants, in this way protecting their confidentiality. I have also attached names to them subjectively, as follows: the strong voice, the assertive voice, the friendly voice and the quiet voice. I feel these names capture the nurses as I got to know them, bearing in mind that this is a punctuation and not exclusive or only inclusive as such. In addition, these distinctions were drawn at the time of the interview and might not be reflective of their current realities.

#### The strong voice

She is an African female in her early thirties, married, with one child. She has worked at the unit for three years. She is currently the head of the nurses at the unit. She worked at an adult ward before starting to work with children.

#### ***Reflection space***

*I got to know the strong voice as a natural leader, soft-spoken but with ample inner strength. She is well-organised and her fellow colleagues and other members of the*

*multidisciplinary team have great respect for her and her opinions. She always strives for better patient care. In my interaction with her she always made me feel safe and I never questioned her decisions.*

#### The assertive voice

She is an African female, in her late thirties, married with two children. She has worked at the unit for four years. She is currently the second in charge at the unit. She has been working as a psychiatric nurse for more than 10 years.

#### ***Reflection space***

*I got to know the assertive voice as someone who is not scared to show her emotions and share her opinions in ward rounds. She was not always the most popular in the multidisciplinary team because of that, but she has an unbelievable passion for children and for her work. In my interaction with her, it took some time before she felt safe with me and I was always aware that she would fight for what she believes in.*

#### The friendly voice

She is an African female, in her mid-twenties, married and with no children. She has worked at the unit for three years, and she worked at the forensic ward at the hospital prior to that.

### ***Reflection space***

*I got to know the friendly voice as someone who is always warm and friendly in nature and who has an ability to connect with the children in a very special way. She was very involved with the children, but according to what I have observed, she was mostly quiet in the ward rounds with the multidisciplinary team. In my interactions with her, I realised that her insight was significant yet not voiced.*

The quiet voice

She is an African female in her late twenties, married with one child. She has been working at the unit for two years and worked in other adult wards prior to this.

### ***Reflection space***

*I got to know the quiet voice as someone who did not show that much emotion when working with the children or in her interactions with other members of the team. The children did form very close relationships with her and I could always find a child next to her.*

### **Ethical considerations**

Participants, who freely agreed to participate in the proposed activities of the investigation and for the proposed duration, were involved in the data gathering process.

Participants were able to view examples of questions with regard to the research interviews to determine whether they were prepared to discuss the subject matter.

Withdrawal from the research project was voluntary and at the participants' own

discretion at any time during the study, as suggested by Terre Blanche and Durrheim (1999). Other ethical considerations included assurance of participant anonymity. Voluntary and informed consent were considered adequate for their inclusion in the study as further suggested by Terre Blanche and Durrheim (1999). Patients' confidentiality is further assured in that their identities remain anonymous. Possible identifying aspects are omitted. Only I work with the raw data of the study, and my supervisors and external examiners have access to the typed, verbatim texts of these interviews.

### **Measuring instruments**

An informal, unstructured interview was used to gather the descriptions of the lived experience of child psychiatric nurses. The qualitative method used was an undirected conversation with the participants; the process of the discussion itself directed and constituted the information created. The interview incorporated questions around the researcher's own assumptions, and hypotheses from the literature, regarding the lived experience of child psychiatric nurses. A tape recorder and notebook were used in the interviews to exactly record the portrayals given by the interviewees. Terre Blanche and Durrheim (1999) describe a conversation (or interview) as a process wherein the subject's presenting narrative always introduces the interviewer to the next question.

The method that was used around the unstructured interview needs a more detailed description here. I approached this question from a phenomenological point of view in that rich descriptions of different individuals' immediate experiences of working in a child psychiatric unit were sought. This study examines the individuals' relationship

with, and reaction to, the *real-world situations* (the in-patient unit) in terms of their internal meanings, be they positive, neutral or negative. The focus is on active listening. Giorgi (as cited in Smith, 2003) also describes the process of unstructured qualitative research interviews as “more rambling and disorganized but more spontaneous” (p. 245). My questions were generally more broad and open-ended, seeking a detailed description of the subject’s own lived experience, as suggested by Terre Blanche and Durrheim (1999).

### **Data analysis**

The objective of data analysis, in phenomenological research, is to make sense out of the information obtained in a way that captures the essence of the phenomenon that is studied. This is the step that needs to be taken to ensure that the researcher is enabled to reflect on the essence of the templates of the four psychiatric nurses who took part in the investigation. The steps that are consistently outlined as essential in the descriptive phenomenological method of inquiry are followed and include the following: bracketing; analysis; intuiting and structural synthesis (Wojnar & Swanson, 2007).

### **Bracketing**

According to Wall et al. (as cited in Wojnar & Swanson, 2007), bracketing is a researcher’s attempt to achieve a state of transcendental subjectivity (neutrality) by putting aside prior understandings about that which is being observed (preconceptions). This is crucial in order for me to ‘immerse’ myself in the lived world of another. Aligned with ecosystemic thinking, it can be seen as a cybernetic complementary in that it is the

subjective experience of child psychiatric nurses/ bracketing of the perceptions of the intern psychologist. Bracketing is also referred to as phenomenological reduction. Gearing (2004) says it is “the scientific process in which a researcher suspends or holds in abeyance his or her presuppositions, biases, assumptions, theories, or previous experiences to see and describe the phenomenon” (p. 1430). Phenomenological reduction (bracketing) assists me in going back to that what is important (going back to the things themselves). Wall (2003) also says that bracketing is an important part of descriptive phenomenology and reminds the researcher that it is a continuous process.

Ahren (1999) says that bracketing and reflexivity are similar, that one must be reflexive in order to bracket, and that both activities require time to reflect. She further mentions that bracketing happens through the whole process of doing research. What is important for me is the importance of bracketing while analysing the data. I need to remind myself that each interview is of equal importance. I also need to be sensitive towards my feelings in reading through the interviews and try to bracket that as I work through the interviews. I (as in previous chapters) include my reflections/feelings as reflective spaces, as such creating bracketing spaces within the text.

The ecosystemic thinking concepts of recursion, dormitive principle and cybernetic complementarities (Keeney, 1993) are all part of the process of phenomenological reduction. According to the dormitive principle (Keeney, 1993), I need to bracket all abstract words when thinking about the child psychiatric nurse and her interactions on a daily basis and I need to be aware of not including such descriptions. For example, I

cannot assume that a nurse is withdrawn if she says in the interview that she normally prefers not to interact with the multidisciplinary team. The cybernetic complementary of attached/detached is also applicable. In order for myself to be attached to the descriptions of the psychiatric nurses in an 'open way', to subjectively transcend myself into their horizons and allow the essence of their experiences to emerge, I need to first detach myself from my own preconceived ideas of what I need to see in the analysis of this investigation. I also need to detach myself from ways in which I have constructed the child psychiatric nurse, which is based on my own experiences in the six months that I worked at the unit. The bracketing is punctuated at the beginning of the next chapter, as well as throughout the chapter, as I need constantly to remind myself of the effects of preconceived ideas on the research.

## Analysis

Colaizzis' (as cited in Wojnar & Swanson, 2007) method is used to guide the analysis in the following ways:

- Read and reread all of the subjects' descriptions of their experience to acquire a sense of them.
- Extract significant statements that directly pertain to the investigated phenomenon.
- Try to formulate the meaning of each significant statement – this involves a leap from what subjects say to what they mean and results in the formulation of second-degree constructs or themes.
- Organise the formulated constructs or themes into clusters of related themes.

- Refer the theme clusters back to the original descriptions to validate them, thereby determining if the original description contains anything that is not accounted for in the theme clusters and whether the theme clusters propose anything not implied in the original descriptions.
- Integrate the results into a description of the investigated topic.
- Achieve a final validation, by asking someone who is familiar with the environment, how the themes and theme clusters compare with her experiences and by incorporating any new data into the exhaustive description of the situation.

***Reflection space: The art of making a recipe your own***

*What makes qualitative research the most exciting, but also the most challenging, is to incorporate methods of thinking/analysing into it. It is a way of conforming or standardising data in a meaningful way, enabling people that interact with the data to understand how a person reached certain conclusions. It is like following a recipe. The recipe that I am going to follow is Collaizzis' method for analysing data, and it can be found in the Phenomenological Cookbook (Wojnar & Swanson, 2007). Inasmuch as I realise that certain products are essential for the recipe (the seven steps that need to be followed), I also realise that there is a freedom in choosing the spices that I add. This is my unique flavour that I add to the recipe. Even though I have resistance against the following of rules or specific recipes (challenge), I am equally excited about adding unique spices to it, producing an end product (constructions of essences) that will hopefully stimulate the senses and encourage readers to challenge their own thoughts about the recipes they use in constructing realities about the child psychiatric nurse.*



## Intuiting

This concept of intuitive thinking stands central to phenomenology and also forms the basis of many of the ecosystemic thoughts and ideas. This is where the researcher reflects on the commonalities between the reflections and asks himself what it must be like to be a nurse working in a child psychiatric hospital setting.

## Structural synthesis

According to Wojnar and Swanson (2007), the end point of a descriptive phenomenology investigation is to present a theoretical model representing the essential structures of the phenomenon under study. Wojnar and Swanson (2007) say that, consistent with the Husserlian tradition, if the true structure of the phenomenon is identified, then anyone who has experienced the phenomenon should be able to identify his/her own experience in the proposed description. The structural synthesis is thus the major finding of the descriptive phenomenological inquiry (Kleinman, 2003). Rapport and Wainwright state: “It is the articulation, based on intuition, of a fundamental meaning without which a phenomenon could not present itself as it is” (p. 232). It is thus the way in which the life-world of the four child psychiatric nurses manifests itself as a structural whole to my consciousness through interacting with the data. Within the framework of ecosystemic epistemology and my earlier punctuation of comparing this part of the investigation to a search for ‘diamonds’, it means that I will describe the uniqueness (that is shared) of the methods that the four miners use in looking for ‘diamonds’, creating a description of the

territory and the maps that they used. This process, in itself, is the construction of a 'diamond', almost like taking several 'diamonds' and making them one.

## **RESEARCH PRODUCT**

Too frequently qualitative research is evaluated against criteria appropriate to quantitative research. Qualitative researchers contend that, because the nature and purpose of the quantitative and qualitative traditions are different, it would be erroneous to apply the same criteria of merit (Krefting, 1991). Therefore, different language is needed to fit the qualitative view: terms that would replace reliability and validity with terms such as credibility, accuracy of representation and authority of the writer (Krefting, 1991).

Credibility refers to the probability that truthful findings will result in the study (Krefting, 1991). A qualitative study is credible when it presents such accurate descriptions or interpretation of human experience that people who also share that experience would immediately recognise the descriptions. This is accomplished by prolonged engagement with the data, allowing for reflection. As the author of this investigation, I can only reflect on that which resonates with me, in the background of my own experiences and drawing subjective distinctions. In this way my reflections and findings are truthful from my own lived reality and from my personal engagement with the data. I can further guarantee that I only use the direct spoken words of the child psychiatric nurses that I have interviewed as the foundation of the findings, reminding the reader that, within this context, punctuations are unique. Instead of reliability, the qualitative researcher can talk of dependability, which refers to the degree with which the reader can be convinced that

the findings did occur as portrayed (Kruger, 1979). Rich and detailed descriptions that acknowledge the contextual nature of all interpretations, work towards this goal.

Finally, I would like to remind myself and the reader that study findings based on the qualitative, descriptive experiences of a few purposively selected case studies can, besides, not be generalised to a broader population because they will not be representative of a population. They should, instead, be understood for what they are: detailed, subjective illustrations of individuals' experiences. Such qualitative findings should be transferred to new contexts and other studies, where they can serve as frameworks for understanding new meanings (Kruger, 1979). Transferability is promoted by the creation of rich descriptions, which are, furthermore, detailed as to context and participant characteristics.

I will share the final product with the psychiatric nurses at the hospital who work in Ward 1 (the children's ward) and with the multidisciplinary team who work at the hospital. In so doing, I am creating another space for reflection and more importantly, allowing for the visibility of the child psychiatric nurse. I also have a further passion to share the findings with the Western Cape Department of Health (with whom I have been working in the past three years) to allow for better/deeper understanding and more reflection when looking at the lived world of psychiatric nurses. I have had discussions with them and have their permission to do so.

***Reflection space: On finding voice through acknowledging the voices between people***

*The key to qualitative work is to learn from the participants. In reflecting on the process up to this point in time, I know that those who I have noted speak strongly to me. Their voices are reflected in the voicelessness of the children, whom I have observed, and in my own voicelessness – I am humbled by the experience of writing this investigation and by life. I have the deepest respect for the psychiatric nurses of the hospital.*

And now I will enter into the essence of this investigation. I am inviting you, the reader, to first create a space of reflection by reading the nurses' pledge of service, allowing the connection and creating further context for the evolvement of the next chapter.

The Nurses' Pledge of Service (card handed out at International day for nurses, no author, 2009):

*I solemnly pledge myself to the service of humanity and will endeavour to practice my profession with conscience and with dignity.*

*I will maintain by all the means in my power the honour and the noble traditions of my profession.*

*The total health of my patients will be my first consideration.*

*I will hold in confidence all personal matters coming to my knowledge.*

*I will not permit considerations of religion, nationality, race or social standing to intervene between my duty and my patient.*

*I will maintain the utmost respect for human life.*

*I make these promises, solemnly, freely and upon my honour.*

## CHAPTER 5

### ANALYSIS

#### ON ENTERING AN AUTHENTIC SPACE

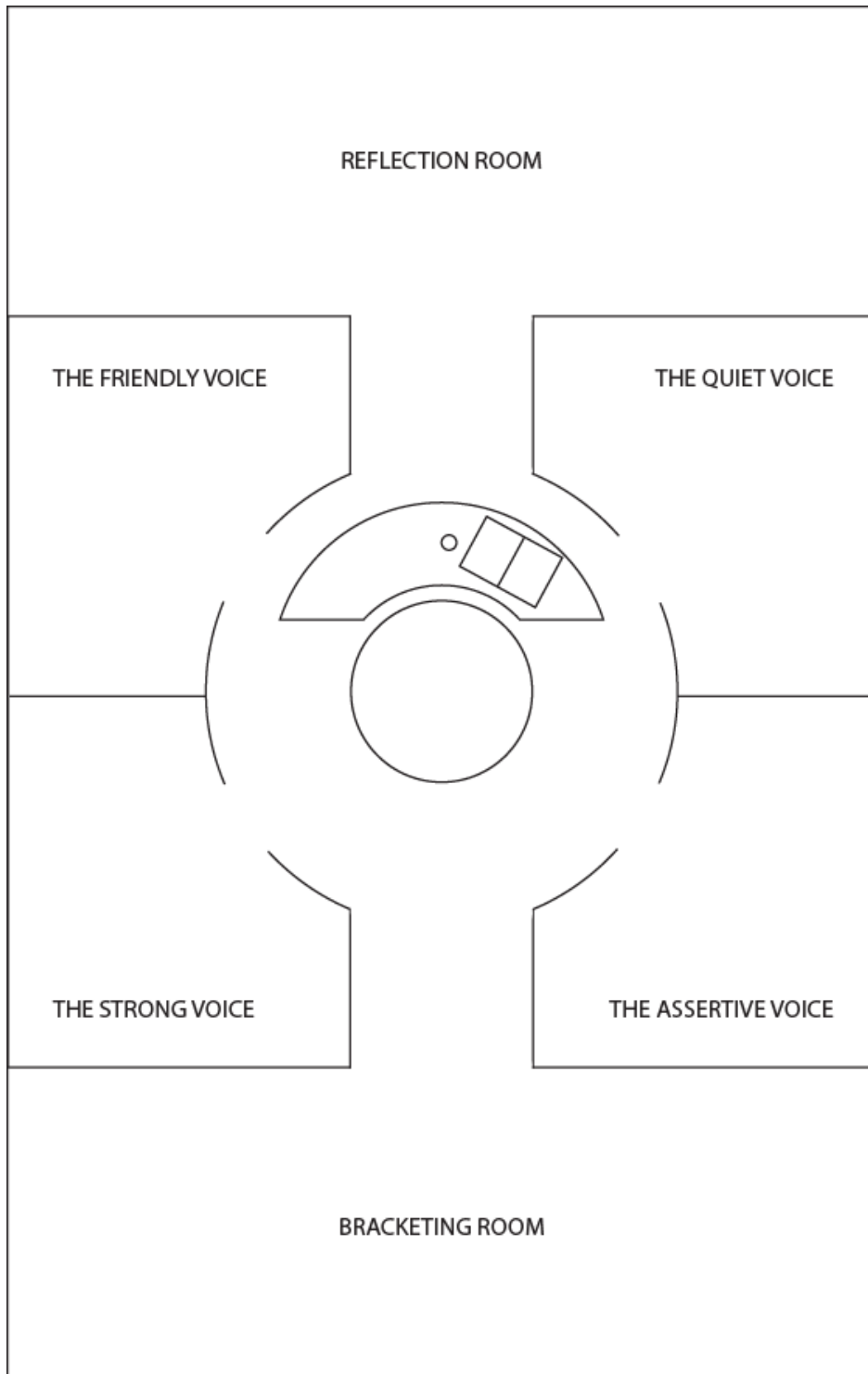
The importance of language and dialogue has been confirmed in previous chapters and remains central to the rest of my investigation. According to an ecosystemic epistemology, what we know affects what we see and affects new levels of knowing (Hoffman, 1981). This happens in a recursive manner and is punctuated as the *process of living*. It is therefore with hesitancy, vulnerability, eagerness, anticipation, anxiety and much appreciation for life that I am entering into this space and this part of the investigation. Fully realising that even though the whole is bigger than the sum of the different parts, at this punctuated moment, the whole of this chapter feels bigger than the sum of the previous chapters. I am starting this chapter with a reflective space on being/becoming, on attachment/detachment, on voice/voicelessness, on visibility/invisibility, on change/stability, and on transformation/conservation. All of these are currently in my awareness and need to be punctuated; all of these cybernetic complementarities form part of my thinking about myself, the psychiatric nurses and the children who are admitted to psychiatric units in South Africa, as well as those who are never admitted and are in need of help.

In descriptive phenomenology, Husserl (Wojnar & Swanson, 2007) refers to the ideal of transcendental subjectivity, where the researcher abandons his/her own lived reality in order to try to explain the phenomena in its pure, universal essence. Acknowledging the

importance of this, I have allowed myself to be alone in a small town for five days in an attempt to achieve this. This serves as a reminder that it is important to discover the essences of the lived experience of the child psychiatric nurse and to then give a fresh, detailed description as it appears to my consciousness.

## **THE ARCHITECTURAL MAP TO THE TERRITORY**

I first want to draw distinctions on the architectural map of this chapter before visiting the territory. I am going to refer to the map as an architectural map of a house. It is within this house that this chapter is constructed, applying the research methods as outlined in the previous chapter, in the form of descriptive phenomenology. This house is thus the authentic space for this investigation. Husserl says that transcendental subjectivity can also be achieved through the process of bracketing (otherwise referred to as phenomenological reduction) (Wojnar & Swanson, 2007). Through this process I attempt to 'bracket' or 'put aside' any preconceived ideas, theories or beliefs I have in relation to the phenomenon under study. On the map of the house (Figure A) you see that there is first an area that allows for bracketing, before entering the house. This area is connected to the house but also separate. This is the first part of the exploration of the territory.



**Figure A: Architectural map of the house**

***Reflection space: On facing my own fears, naming them and bracketing them***

*The putting aside of preconceived ideas, thoughts and theories is explored in the next section. I realised that it was essential to the completion of this investigation to bracket some of my own fears about visibility, not being good enough, being unable to succeed and the acknowledgement that these exact fears were holding me back in my process of becoming. After naming them, I needed to visualise how I leave them in the bracketing room, too. This allows for insight into my own process, perhaps also making me wonder about the fears that the nurses carry within them and the impact it has on their functioning.*

On entering the house you find a public area with a fountain in the middle. Next to the fountain is a table with a book and a candle next to it. This is where the universal essence of the participants is constructed, in the form of the *structural synthesis* at the end of this chapter. The fountain symbolises birth, life and serenity, and the candle is a reminder of the calling of anyone who works as a healer, in an effort to bring light to dark places. The different templates of the four rooms are first organised through a process of *free imaginative variation* into different themes. The different themes are used to allow the punctuation of the structural synthesis at the end of this chapter, and are written in the book next to the fountain. As punctuated in the previous chapter, the structural synthesis is the end product of descriptive phenomenological research (Wojnar & Swanson, 2007). The essence of this chapter is integrated and constructed in an attempt to describe the everyday lived world of the child psychiatric nurse. This is done in a way that any



individual who works in the field can connect to the data and engage with it and, most importantly, see reflections of themselves in the data.

Connected to the public area are the four private rooms. These four rooms represent the four interviews of the study. I explore the ways in which they punctuate their realities in each of the rooms. Then I reflect on the data, *extract meaningful statements*, and organise the meaningful statements into *clusters/themes* through a process of *imaginative variation*. The *clusters/themes* form the template of each of these rooms and is punctuated accordingly (Colaizzis, as cited in Wojnar & Swanson, 2007). Aligned with ecosystemic epistemology, I want to remind the reader that Hoffman (1993) says that at each point of interaction and reflection, there is the possibility of *something new* to be discovered. I include a last room to the house. It is an empty room with many windows and ample light. This is punctuated as the meditation room and is a room for reflection, where knowing about the knowing can happen and can be visited at any point in the chapter to reflect on learning, or to bracket that which is revealed to consciousness.

## **AN EXPLORATION OF THE TERRITORY**

### **The bracketing room: A connection to that which temporarily needs to be left behind**

The following are all items that came to my awareness that I need to bracket, before entering the house for the purpose of this investigation. In my initial contact with the psychiatric nurses and in the six months that I worked with them, I subjectively constructed them as a group of people who need to be made more visible in caring for

children. I see them as not having enough voice in the functioning of the child psychiatric unit. I see them as resilient human beings with a passion for children. I further see child psychiatric nurses in need of more support. I also feel that their work is central to patient care, and that their interactions with the children – and the families of these children – are sometimes not accurately reflected on in the ward. After engaging with the different literature in this investigation, I also need to bracket all preconceived ideas about the literature and the work of child psychiatric nurses around the world. I need to bracket the idea that I have, that all nurses strive for therapeutic client-patient relationships and that all nurses feel that they are not acknowledged enough. I need to bracket my own punctuations on how the cybernetic complementarities are reflected in the nurses as referred to in earlier chapters. According to the dormitive principle, I need to bracket all psychological and psychiatric terms before entering the house (Keeney, 1993). Lastly, I need to bracket the names of the participants as punctuated in the previous chapter, namely: *the strong voice, the assertive voice, the friendly voice and the quiet voice*. I want to encourage the reader to also allow a few moments of reflection on what they may need to bracket before entering the house. The bracketing room is, lastly, not a place that can only be visited before entering the house. I need to remind myself and the reader that the bracketing place allows and encourages multiple visits.

### **Template themes discovered in room 1**

#### ***Reflection space: On the discovery of the themes***

*The themes were discovered through a process of reading and re-reading the verbatim text of the four different interviews to really familiarise myself with that what was*

*reflected on, or punctuated by the nurses. Before extracting the themes, I went to the beach and read through each of the interviews a final time and allowed myself to connect with them again in the way that I remembered them.*

#### Theme 1: Diagnose and treat accordingly

The importance of diagnosing and treatment is clearly reflected in several statements in the interview, and can be seen as an essential tool for functioning within the ward:

“I have learned a lot in this ward, you learn about different behaviours in children and how to diagnose accordingly”.

“You learn how to identify, diagnose and treat at an early age”.

“If you can make the right diagnosis, the child can get the right treatment”.

The disadvantage of diagnosing children is also reflected on in the interview and is punctuated in the following two statements:

“You start seeing disorders instead of children”.

“You start diagnosing people outside as well”.

#### Theme 2: The difficulty in defining the role of the child psychiatric nurse

The diversity of the role and the difficulty in punctuating is reflected on:

“My role is many things; it is a very important role. I don’t think everyone understand how important our role is”.

“My role is to also help my community. In our black community we have to inform them of different conditions and educate them”.

### Theme 3: Experiencing close connections in daily interactions

The intensity of the connection that the child psychiatric nurse is having as part of her functioning is punctuated in the data:

“We had such a close connection”.

“He would greet me in the mornings, gave me a hug and when I go he would say goodbye”.

“I was going to cry, I loved her so much”.

“We had such a personal close connection, he even knew my name”.

“I couldn’t even look at him to say good bye, I wanted to say thank you”.

### Theme 4: Availability of the nurse

The availability of the nurse is punctuated as an important aspect:

“You see the children every day”.

“We understand, we really understand the children, we are with them for 24 hours a day”.

### Theme 5: Feelings of helplessness

Feeling helpless in different situations is something that surfaced at different points of punctuations within this room:

“Some days you feel so helpless- you don’t get any answers”.

“When someone is aggressive, I ask “What have I done to this child? Why does he hate me?” You ask a lot of questions”.

“There are a lot of things in your head, you can’t think clearly”.

“When you disagree, they do not take your view seriously, you feel bad, there is nothing you can do, you just wait, but you get depressed”.

“Sometimes when I come to work, I thought, no- I can’t go on”.

“Sometimes I would scream and say, no- I can’t do this, when I go home I feel exhausted”.

“Even the parents, I get so angry with them even thinking about them at home”.

“But then you just sit, with all the emotions”.

Theme 6: I am here for the kids

The commitment towards the children is punctuated:

“What can I say? I am here for the kids”.

“I am here for the children”.

“But then I just tell myself, I have to go on, for the children, you just go on, even tomorrow”.

“I really wanted to help this child”.

Theme 7: The need to be acknowledged

The value of been acknowledged is punctuated:

“The psychiatrist takes our views seriously”.

“She understands our situation and the kid’s and would come to us and say: Sister what do you think?”

“Helped us when you and another psychologist, once, would ask us about our views”.

“Its good to know that there are people who want to know how a nurse feels”.

Theme 8: Connections with the family of the children

The value of engaging with the family of the children is punctuated:

“The mother was a little bit close to me, I would talk a lot to her, I would answer all her questions, we had a good connection”.

“The grandmother and I had a good connection, she would ask me to talk to the whole family”.

Theme 9: Feeling angry, then guilty

The anger that the nurse sometimes feels in her daily work is reflected in the data, and is immediately connected to feelings of guilt:

“He would grab you and hit you. I would get so angry. Then I feel guilty and think that I am not doing what I am supposed to do”.

“We were so frustrated. Then we would become impatient, but when you see that you have hurt the child, you feel bad”.

***Reflection space: Visiting the meditation room***

*After each of the interviews were analysed, I tried to take at least a two-hour break in an attempt to keep the information of the different rooms separate. This can be seen as visits to the meditation room where I cleared my head. I never went back to any of the rooms until I had visited each of the four rooms and extracted themes from them.*

## **Template themes discovered in room 2**

Theme 1: The important role of the child psychiatric nurse

The valuable role of the child psychiatric nurse in the ward is punctuated:

“Nurses spend 24 hours with the children; they know the patient better than the whole of the team”.

“If you want to know anything about the patient, they (the nurses) can tell you the whole story”.

Theme 2: Advocate for child psychiatric nursing

Within this data one can clearly see that the importance of child psychiatric nursing is punctuated through different statements:

“I am fulfilling my role as a nurse, taking care of children”.

“I am trying to make people aware of this place; I have referred two people from my community”.

“I want our people to be able to know about the child and family unit”.

“I don’t want to work in any other ward”.

“It has been a good experience to work in this psychiatric unit. As a nurse, it opened my eyes”.

“The children we are working with are the mothers and presidents of tomorrow. You need to take good care of them, they are our assets”.

### Theme 3: Facing challenges in the multidisciplinary team

The struggle to find a voice within the multidisciplinary team is punctuated and most of the issues that are reflected on in the raw data are continuously felt:

“How come did the doctor discharge the child?”

“We are facing challenges of racial issues within the team. They use Afrikaans to conduct some of the sessions; if you don’t get the whole story nursing care will not be fulfilled”.

“It is not easy to work with this team. It is frustrating: the lack of communication”.

“Maybe people in the team just don’t take child psychiatric nursing seriously”.

“I would like to not worry about people not taking us seriously, when I am not seen as a valid person in the multidisciplinary team”.

“I want our children to have the chance not to be only treated for two weeks and then they are discharged, like other children are given six weeks. Sometimes our children come here, being discharged without finding the real problem of what brought the child here”.

### Theme 4: The need to be acknowledged

The need to be acknowledged as someone who makes a difference is punctuated:

“Without Doctor X, we will not survive. She takes our story and supports us. She believes in us. She listens”.

“Maybe we are not being taken seriously”.



#### Theme 5: The ability to form meaningful relationships with children

The essential ability to form meaningful relationships with children is reflected in the data:

“Even now, I ask myself, how is X doing?”.

“Working in this ward, you really need to listen to each child”.

“I like to work with children. I like to reach them, see what affects them and help them to overcome”.

“One day I was shopping, she came to me, ‘Hi sister, how are you?’. She still remembered me”.

#### Theme 6: Feeling frustrated

Feelings of frustration are punctuated in relation to the daily life of the psychiatric nurse:

“It was frustrating nursing him”.

“We neglect our health. Even with that that frustrates us, we do not go for counselling”.

“Sometimes you would get so frustrated, you would be short-staffed and you would have five conduct disorders in the ward”.

#### Theme 7: Feeling anxious

The impact of working in the unit becomes evident when looking at the following punctuations of the nurse feeling anxious:

“Sometimes I feel burnt out”.

“When you arrive at home, you are so stressed; you don’t even want to talk. When your family wants to talk, they are stressing you. It really affects me, it makes me irritable”.

“We think we are strong, but it will catch up with us”.

“I thought of my older daughter, if one day my husband will rape her, how would I feel? I don’t want this thing to happen to my child”.

#### Theme 8: Feeling helpless

The intense feelings of helplessness are punctuated through some of the statements in the data, with the nurse wanting to do more, but not having answers:

“How can a father rape a child and get away with it? How can a father do this? A father should love his children”.

“You can’t even reach a child with conduct disorder, because they can come to you and say: “Sister, this and that”. And then they can go to X and change the story”.

“He made me feel helpless”.

“What can you do? You just carry the emotions”.

“I don’t want to work in any other ward, I am stuck here”.

#### Theme 9: Being affected by the nurse-patient relationship

The way that the nurse-patient relationship can affect the nurse is punctuated here:

“The other one I loved too much was X”.

“I was affected by the whole situation of X. I went deep. I said to the mother: “Come to my house and I can help you.” The father is now in jail and the child is free”.

“It affected me- I still have their telephone numbers”.

### **Template themes discovered in room 3**

#### Theme 1: Feeling lost

The initial reaction to child psychiatric nursing is punctuated in a number of statements in the data:

“The first few months I was lost. I didn’t believe that a child can be like this. I was never exposed to this”.

“Seeing problems that were so severe, was like, no, this is not true”.

“I was having problems in managing. Can I manage a small child like an adult?”

#### Theme 2: Searching for answers

Throughout the data, several questions are asked as a way of reflecting on the difficulties in the field of child psychiatric nursing:

“I had questions that were unanswered”.

“I wanted to know what happened to those children’s lives that can be the cause of them turning into young criminal adults”.

“Wow, what is happening here?”

“Why is this child so aggressive?”

“When you see a patient with specific problems, you want to know, where is he coming from?”

“Why this poor child. Why him?”

“What wrong did they do to the child?”

“Most of the times I would wonder did we even do enough for the children who get admitted here”.

“Why are you so isolated? What is happening?”

“When she came here she was sad, now angry, why the change?”

“Why was she only relating to younger children?”

“Why would a child protect his parents, even though they have hurt him so bad?”

### Theme 3: Experiencing child psychiatric nursing

The experience of being a child psychiatric nurse is punctuated as well as some of the emotions that are felt as a result of the experience:

“This is an experience, I was learning a lot, but you become emotionally affected and you take some of the problems home”.

“I experienced sadness”.

“I was enjoying child psychiatric nursing, trying to prevent problems from getting worse”.

“That day I was so affected. I was angry. I didn’t know what to say”.

“It was scary”.

“I was hurt”.

“It was one of the most difficult experiences I have ever had”.

“It was exhausting”.

“I would go home and just want to be alone with my sadness and anger”.

“At times I got angry; I wanted to do something that is not right”.

“Sometimes when there is difficult children and conflict in the team you feel that you want to run away”.

“Emotionally it is taxing”.

“There are tough times, I don’t know how tough, when you come with all your skills and they don’t work”.

#### Theme 4: Questioning the work of the child psychiatric unit

The nurse questions the efficiency of the unit in a reflective space:

“I feel that children are being admitted and the way we personalise a problem and you end up missing the need of the child and at the end it is like we didn’t deliver. Most of the times I wonder if we even did enough for children that get admitted here”.

#### Theme 5: The important role of the child psychiatric nurse

The important work that the child psychiatric nurse fulfils is punctuated through several statements:

“I play a major role, the way we spend time with the children, you get to know the child better than any other team member”.

“You are with them every minute and every hour”.

“You understand better, you can give information to other people that can benefit the child more”.

“The children are comfortable with us”.

“They trust us more”.

“She knew that I was there for her”.

“It feels like home, we are there for them”.

“It’s like becoming a mother for them”.

“You become an advocate for them when they cannot speak”.

“I am here for the children, dedicating yourself to it, facing the challenges”.

#### Theme 6: The need to be acknowledged

The need to be acknowledged is evident in the punctuation of two statements about interactions with members of the multidisciplinary team:

“We were so impressed with the way that you acknowledged us, we would give you feedback”.

“Even with doctor X, she would acknowledge us, it gives us strength”.

#### Theme 7: The impact of not being acknowledged in the multidisciplinary team

The impact of being dismissed or not taken seriously in the ward rounds of the hospital is punctuated:

“There are situations where you are not acknowledged in ward rounds”.

“Your opinion is put aside”.

“You feel like why am I here?”

“Why is nobody listening to what I am saying?”

“You feel belittled as if your role is not important”.

“That makes me negative so that I feel, why bother. So you end up not acknowledging some of the situations that you have observed, because they don’t listen. Then the child is not benefiting”.

#### Theme 8: Walking the extra mile in building a relationship

The dedication of the child psychiatric nurse to be there for the child is evident in the data and following statements specifically:

“I made sure that I build a one-on-one relationship with her. I interviewed her. She was reserved. She was very quiet and you could see her silence. I never gave up. She was pushing me away, I was more interested”.

“Let’s give her time, she will tell us”.

“The relationship was solid, she trusted me. She started crying”.

#### Theme 9: Observing the whole

The ability of the nurse to view the whole system in order to better patient care is punctuated:

“In this ward, you even work with the parents and then you understand more”.

“His (the father’s) eye contact was poor, he didn’t show any concern. But the mother said that the relationship was close, so why this?”

“You could see that the relationship was influenced by the dad”.

#### Theme 10: The little things

The importance of how small things can make a difference is punctuated:

“The little comments make us feel important, it gives me strength”.

“There are times when you look for the little things. It is the little things in the ward that counts the most”.

### Theme 11: Feeling helpless

The punctuation of not having answers in reaction to some of the situations that the nurse is faced with is reflected in the following sentences of the data in this room:

“It made me feel helpless. We went through all the effort, for what?”

“I couldn’t get through to her. She was oppositional and physically abusive”.

### Theme 12: The nurse as a change agent

The role of the nurse in allowing a child to see a different view of him-/ herself is punctuated:

“We assured her that life is worth it and not ending here”.

“We gave her compliments”.

“We built her self esteem. Then she changed”.

### Theme 13: The need to protect

Apart from always being there for the children, the need to protect them even after discharge is punctuated:

“I wanted to protect her then, even more”.

“I wish that with each child I had a weapon to give to them, and say that you will be ok”.

### Theme 14: Finding strength on difficult days

The resilience of the nurse is punctuated through the following statements with regards to facing difficult days and challenges:

“I will say, it’s gonna pass, it will pass”.



“I tell myself to be strong, there will be avoidance, but you are just working”.

“I tell myself that I am coping, if I don’t tell myself that I can’t cope”.

“There are days where you ask God for strength”.

“Then you feel all the strength coming from the little voice of a child”.

#### **Template themes discovered in room 4**

##### Theme 1: Impact of the environment on children

The punctuated reality of the impact of the environment on the child who gets admitted is reflected on, through the lived experience of the nurse in room 4:

“I became aware of the impact that parenthood has on children”.

“It is the environment that lands the children here”.

“Most of the parents of the children who get admitted have problems to begin with”.

“It is the socio-economical impact that brings them here”.

##### Theme 2: Developing as a person and as a parent

The direct result of growing as an individual and as a better parent, in working as a child psychiatric nurse, gets punctuated here:

“It is a positive experience, as a nurse, as a person and especially as a mother, I have learned a lot from my experience in working here”.

“I am a lot wiser; I use to take things for granted”.

“Working here has opened my eyes, I am passionate about parenting”.

“It gives me fulfilment. I am able to be all these different roles”.

“I began to grow as a person and as a therapist”.

### Theme 3: Feeling lost

The impact of the work of a psychiatric nurse is punctuated through the reflections of initial feelings that the nurse had when she started to work at the ward:

“In the beginning, working here was too much for me”.

“As a parent it was too much for me”.

### Theme 4: Confusion of roles

The complex nature of the different roles of the child psychiatric nurse is punctuated here:

“It is difficult to draw the distinction of being a therapist, a disciplinarian and a mother”.

“At times you have to be only a mother, they are so deprived. They just need somebody to hold them or kiss them”.

### Theme 5: Availability of the nurse

The lived reality of always being there for the children is punctuated:

“As a nurse you are with them all the time”.

“All the negative things that a child presents with, you will experience it”.

### Theme 6: Feeling helpless and frustrated

The inability of the nurse to be in control and the impact thereof is punctuated here:

“It is frustrating to treat the same patient over and over”.

“The time children spend here is too little to change the impact of the negative environment on the child”.

“They leave too soon. They go back to the same environment, go back to the same negative experiences”.

“Then you see that the same child is being readmitted again”.

“This has a negative impact because you feel that all your efforts have been wasted”.

“Their problems might even be worse”.

#### Theme 7: Frustrations with team membership

The difficulty of being acknowledged as a valid team member is punctuated and the impact thereof:

“As a nurse, on the face of it, you are being seen as part of a multidisciplinary team, but that is not how the reality is”.

“I don’t feel as if I am part of a team most of the time”.

“There are people more senior than you whose decisions count more than yours to begin with”.

“It is frustrating to work and to then give input which nobody appreciates or listen to”.

“Sometimes your opinion is just discarded in the ward rounds”.

“That is something that I have noticed in the multi disciplinary team, the one member would think that his role is more important than the other members’ role”.

“At the end of the day the child suffers”.

## Theme 8: Reflecting on emotions

The impact of working in the ward is punctuated through the reflections of the nurse on her emotions:

“I began to separate my emotions, I try to treat a child as they are presenting at a specific moment. I can be angry at a child and 10 minutes later he will ask for a hug, so within 10 minutes I move from being angry to giving him a hug”.

“In the beginning, when a child is aggressive towards you, I would be angry for the whole day”.

“I connected with him on an emotional level; maybe it was the mother in me that wanted to protect him”.

“There are days that drain you physically and emotionally, to the extent that when you go home you don’t even want to listen to what your child is saying”.

## Theme 9: The ability to be an agent of change

The awareness of the possibility of showing a child a different experience is punctuated:

“You must be able to step back and say: ‘How can I help this child differently from what he is used to?’”.

“Maybe the child was an aggressive child and if he interacts with his parents he would get more punished... But then it comes for the child as somewhat of a surprise, if you don’t punish him and you are able to give him a positive reward instead, so you give him a different experience”.

#### Theme 10: Disadvantage of being a nurse

The frustration of the nurse to be seen as only a nurse gets punctuated:

“People even tell you to do this or that”.

“That is the disadvantage of being a nurse, you are always under somebody”.

“I feel that we just get labelled as nurses at times, then you take things personally and you can’t act in the best interest of the child”.

#### Theme 11: The need to be acknowledged

The need to be seen is punctuated through the following statements:

“Dr. X has a greater appreciation for my role as a nurse, she listens to me”.

“She realises the impact that we have on the children”.

#### Theme 12: Special connections with marginalised children

The ability of the nurse to work with some of the more difficult children is punctuated:

“I enjoyed working with him, he was mentally retarded”.

“Maybe I like the underdog”.

“I had to go after him, wiping him, but he was loveable”.

“We had a special connection”.

“When he was hurting himself, I was also hurting”.

“My heart bled for him”.

“I was the only one that developed a special trust with him, he would always ask for me”.

Theme 13: A nurse in need of assistance

The need for support is punctuated:

“We definitely need a support system; the methods that they are currently using are failing us”.

“We only see supervisors where there are problems in the ward; we need to sit with someone to talk about our difficulties”.

### **A TIME TO REFLECT ON THE CHAPTER THUS FAR**

True to recursiveness of the ecosystemic epistemology I want to apply the ‘stop-pause-reflect button’ to reflect on the process of this chapter as it appears to my consciousness thus far. A distinction was drawn between a map and a territory. The architectural map outlined the territory of a house that consists of a bracketing room, a public area, four private rooms and a reflection room. The reader was informed on what to expect when visiting the territory. Each of the punctuated areas of the map was visited and constructed. The interplay between what we know and what we see, defined earlier as the process of living, is recursively changing again in that the territory of the four different rooms now become the map that leads to the territory of the *structural synthesis*. The different themes guide me in the punctuation of the structural synthesis, being true to the nature of descriptive phenomenology, in that *we go back to the things (the core) themselves*. It is an authentic space within an authentic space. It is the writing of a story in the book on the table, in the house.

**A DISTINCTION OF A BOOK WITHIN A CHAPTER WITHIN A  
DISSERTATION**

**Structural synthesis of the lived experience of child psychiatric nursing:**

**Introduction**

According to Keeney (1993), one can only fully understand an individual’s lived experience by observing how his/her social context is punctuated. Hoffman (1993) speaks about taking a position that is a step removed from the operation (investigation) itself, so that one can perceive the operation more holistically – views about views. The essence of post-modernism is in allowing something new to evolve, rather than predetermining the rules for what is real and valid in the world. This requires resilience on the part of the researcher (Doherty, 1999). It is within this context that I have decided to create this metaphorical book within this chapter. The data that is used for this book (the map) is the 45 themes/clusters that were punctuated in the four different rooms of the house. Table 1 below shows the different themes organised in different clusters and guides the structural synthesis (the numbers in brackets refer to the rooms of the house in which the themes appeared).

**Table 1. Themes in the four different rooms of the house**

<b>Feelings of the child psychiatric nurse</b>	<b>The role of the child psychiatric nurse</b>	<b>The importance of the nurse-patient relationship</b>	<b>Functioning of the child psychiatric nurse in the multidisciplinary team</b>	<b>The ability of the child psychiatric nurse to reflect</b>
Feelings of helplessness (1)	Diagnose and treat accordingly (1)	Experiencing close connections in daily interactions (1)	The need to be acknowledged (1)	Connections with the family of the children (1)
Feeling angry, then guilty (1)	The difficulty in defining the role of	The ability to form meaningful	The need to be acknowledged (2)	Searching for answers (3)

	the child psychiatric nurse (1)	relationships with children (2)		
Feeling frustrated (2)	Availability of the nurse (1)	Being affected by the nurse-patient relationship (2)	Facing challenges in the multidisciplinary team (2)	Observing the whole (3)
Feeling anxious (2)	I am here for the kids (1)	Walking the extra mile in building a relationship (3)	Questioning the work of the child psychiatric unit (3)	Impact of the environment on children (4)
Feeling helpless (2)	The important role of the child psychiatric nurse (2)	The need to protect (3)	The need to be acknowledged (3)	Developing as a person and as a parent (4)
Feeling lost (3)	Advocate for child psychiatric nursing (2)	Special connections with marginalised children (4)	The impact of not being acknowledged in the multidisciplinary team (3)	Disadvantage of being a nurse (4)
Experiencing child psychiatric nursing (3)	The important role of the child psychiatric nurse (3)		The little things (3)	A nurse in need of assistance (4)
Feeling helpless (3)	The nurse as a change agent (3)		Frustrations with team membership (4)	
Finding strength on difficult days (4)	Confusion of roles (4)		The need to be acknowledged (4)	
Feeling lost (4)	Availability of the nurse (4)			
Feeling helpless and frustrated (4)	The ability to be an agent of change (4)			
Reflecting on emotions (4)				

The content of this book is thus the territory. It is punctuated in the form of a story about the lived experience of a child psychiatric nurse working in an in-patient unit, and is told in the first person. The aim of this book is an attempt to try to, as accurately as possible, describe what it is like to work as a child psychiatric nurse. All of the names that are used in this book are pseudonyms.



**I am here for the kids: Personal reflections on the experience of being a child psychiatric nurse**

Let me begin by introducing myself. I am a child psychiatric nurse. I work at an in-patient unit where children who are either a danger to themselves or to the people around them are admitted. Severely traumatised and abused children are also admitted to this hospital. *\*As I am writing this book I cannot help but wonder if Skosana will be safe tonight – I had to leave her there while she was very upset. It breaks my heart when she hurts herself so badly. How can a five-year-old child have the need to end her own life?* I have been working at this ward for the past three years and it has been an experience that has, and is, changing my life every day. So I want to try to explain to you, the reader, what it is like to work as a child psychiatric nurse.

Let me start by defining, or by trying to define, my role. My training as a nurse and as a psychiatric nurse helps me to understand the diagnosis and treatment of child psychiatric disorders. I will never forget my first two weeks at the unit. Nothing could have prepared me for the sad reality of working with severely traumatised children or children with psychiatric disorders. I felt lost, confused and helpless. I felt angry at the world and at parents that can hurt their children so badly. It just didn't make sense. This is essential for my functioning in the ward, seeing that I have to ensure that the children get their medication on time and in order for me to manage their physical health in the ward. My knowledge also assists me in trying to understand the behaviour that the children display and to give feedback to the different role-players who work with me at the unit. I feel that

my role in the ward is one of the most important (if not the most important) roles in the ward. My colleagues and I are on a 24-hour basis with the children. We see all of their symptoms. For example, the one day Nozipho started scratching her teeth against a wall, banging her head, screaming at the top of her voice. By the time I got to her, she had already broken a tooth; my heart broke in little pieces as I felt her sadness and pain. If anyone wants to know what is happening with a child they can come and ask us. I see if a child is sad, withdrawn, aggressive or even psychotic.

Within this aspect of always being available lies the biggest challenge as well, in that you allow yourself to get very close to the children. That is where confusion in roles can happen. Sometimes I get confused in my role as a parent, a counsellor, a nurse and a disciplinarian. *\*I cannot help but think of James – he felt like my own son. I felt helpless when I realised that he was going to be discharged and I knew that he was going back to the same environment. I could not even say goodbye to him and just left for home that afternoon. Every night I pray for him.* I take my role very seriously and realise that I am here for the kids. The unit becomes their home and their future lies within our hands. My role is also to be an advocate for child psychiatric nursing in my community. I also need to protect the children – their families leave them with us and we are responsible for them while they are under our care.

The biggest reason why I keep on working at the unit is because of the meaningful relationships and close connections that I can form with the children. It does make me feel that I make a difference and that there is hope. There are always the ones that stand

out, that define your work at the unit and change your life. *\*I was so deeply affected by Carol, an 11-year-old girl, who was at the unit for six weeks. Our relationship was solid; she trusted me and allowed me into the deep secrets that no one knew. Only after that, she got better. It was like she was a different person. Working with her reminded me of why I do the work that I do.* According to Hildegard Peplau (cited in Sloan, 2006), who can be seen as the mother of psychiatric nursing, psychiatric nursing is unique in that it focuses on the relationship between the patient and nurse and that one must always try to keep moving forward in the relationship. I always try to remember that. The difficulty is when you are not able to connect with a child or when a child is aggressive and oppositional. *\*The one weekend I was alone in the ward for night shift; there were only two children. The one was an 11-year-old boy, Simon. He was a strong, physical boy and was angry at life after many years of abuse that he had to endure. I could understand his anger but I couldn't understand why he kept on hitting me and swearing at me. I was really scared.* Then I sometimes feel helpless and like a failure.

I suppose that every job has difficulties or challenges. One of the more challenging areas for me is to work in the multidisciplinary team. It is extremely frustrating. I know how important the work is that I do, but sometimes, when I am attending a ward round, it seems difficult to even speak. I suppose that is one of the disadvantages of being a nurse: there will always be people who are 'higher' than you. I become very discouraged when I want to share something important with the team and it is almost like they are not listening. I take that very personally and my biggest concern is that the child will suffer at the end of the day when you become discouraged. *\*I hope that my husband is not too*

*upset about my silence tonight. It's just that I was so upset about the incident at the ward today that I didn't have the energy to even listen to him or engage. I know that this is wrong and I feel guilty about me not being there for him.* The one doctor does take me seriously and I feel that she does understand the importance of the work that I do. If only people would know what a difference it makes in my day when someone acknowledges what I do or asks for my opinion. Just the other day, the social worker came to see me and asked me for input on one of the children. I cannot begin to describe what a difference those five minutes made to my day.

So how do I cope? Working as a child psychiatric nurse is one of the most challenging, yet rewarding, things that I have ever done. Some days I don't know how I will get through the day, or I will wake up and feel that I don't have energy to even start the day.

*\*Just two months ago, we were understaffed and there were five conduct disorders in the ward. I felt helpless and wanted to run away.* I learn to cope by trying to reflect on my emotions as much as possible. I try to see the whole picture and I constantly remind myself that the children's intentions are not bad and that I need not react in a negative way towards them. I do wonder about my own emotional well-being and realise that I need to take better care of myself when I become short-tempered or even depressed at times. The difficulty is that there is not a structure in place for us to reflect with someone professional and just talk. *\*After Peter was readmitted and I saw his sadness and I saw that his symptoms were worse than ever, I just wanted to cry. I told myself that I need to cope and that tomorrow will be different. I couldn't show weakness; the other children*

*needed me.* As nurses, we do support each other. We listen to each other. My family is also very supportive.

I am strong. I am a fighter. *\*Maybe the fact that sometimes I feel like the underdog in the ward rounds, makes me fight even harder for the children, especially the underdogs that no one wants to work with.* You may ask: “What makes you stay?” It is the little things that give me strength. Like getting a hug in the morning and someone telling you: “Sister, today you look beautiful.” Or in the voice of a parent, doctor, or any other person who shows appreciation for the work that I do.

I often wonder if we ever do enough. Whether I didn’t miss something, or could have done more. What can I say? I am stuck here. I am here for the kids. *\*I hope that I will be able to sleep tonight and that Skosana is feeling better in the morning...*

**\* Refers to thoughts of the psychiatric nurse while constructing the story, allowing for richer/double descriptions to emerge, within the structural synthesis (book).**

## **CONCLUSION**

According to an ecosystemic epistemology the whole is bigger than the sum of the different parts. Such is this chapter. In this chapter I chose to draw distinctions and punctuate in a specific way. It is not an either/or approach. What is important is to allow a space for reflection about the lived experience of the child psychiatric nurse. I started this chapter by acknowledging the importance of it for me, on a personal level. I hope

that it allows for important spaces of reflection on being/becoming and on voice/voicelessness for anyone who interacts with this chapter and the rest of the investigation as a whole. In the next chapter the analysis of this chapter is discussed and interpreted in relation to the other chapters.

## **CHAPTER 6**

### **FINDINGS AND RECOMMENDATIONS**

#### **THE MAP OF THE FINDINGS**

Keeney (1993) refers to the stepping-back action (reflection) of the researcher, where he/she examines what he/she has done. I simultaneously acknowledge that there are other ways of interacting with the same data, which can lead to different distinctions and punctuations. What follows is thus my punctuation of the findings of this investigation, also referred to as the map of the findings, or the drawing of a distinction in which the findings are punctuated (territory). Allowing for knowing about knowing and double descriptions, the following cybernetic complementary is drawn as part of the process: the findings (Chapter 6)/the map to the findings (Chapters 2, 3, 4, and 5). Included in the findings is my own subjective punctuated reality (that what was bracketed in the data analysis chapter) in relation to the lived experience of the child psychiatric nurse.

Keeney (1993) supports this and says that, when an observer allows his/her own observations to be included in what is being observed, it points to recursiveness and allows for richer descriptions. In this chapter, I thus allow my own views to interact with that which was observed and constructed in previous chapters. As mentioned before, the luxury of working in an ecosystemic frame of reference is that there is space for double description when trying to understand or describe that which is being observed.

Also, at the core of post-modern thought (as part of my epistemology) is the importance of reflection. The content of this map is punctuated and is explored in the next section under the following headings: the role of the child psychiatric nurse; the nurse-patient relationship; a therapeutic environment; the membership of the nurse in the multidisciplinary team; and the need for supervision or support groups.

## **AN EXPLORATION OF THE TERRITORY OF THE CHILD PSYCHIATRIC NURSE**

The following section can be seen as an integration of punctuations and distinctions. The aim is not to look for the presence or absence of data, but to describe what is seen as it is revealed to my current awareness and to reflect on that, in order to enter new spaces of knowing, also referred to as the process of living.

### **The role of the child psychiatric nurse**

*'My role is many things; it is a very important role. I don't think everyone understands how important our role is'.*

The importance of the role of the child psychiatric nurse is reflected through many personal statements of the nurses with regards to the availability of the nurse and the way that they experience daily interactions with the children. They punctuate a great awareness of the central role that they play in the ward. Central to the care of children's mental health is the child psychiatric nurse, especially when looking at the role of the nurse in an in-patient psychiatric setting. Delaney (2006) says that:



*In child/adolescent psychiatric units, nursing staff have 24-hour exposure to patients' ongoing milieu behaviour. This vantage point affords them the unique opportunity to develop an understanding of hospitalised children and adolescents and their cognitive, regulatory, and emotional processes. (p. 170)*

The literature review punctuates psychiatric nursing as both an art and a science (Haber, 2000). The different templates of the interviews punctuate the role of the child psychiatric nurse as needing to be able to diagnose and treat (science), but also as an art in the way that each child is approached differently. Most of the interviews emphasised the role of the nurse as being able to create a safe space for the children (art). Benson and Briscoe (2003) say that one of the primary functions of the psychiatric nurse working in an in-patient setting is to provide a patient with a space where they feel physically and emotionally safe. One can thus say that the nurse needs to be an advocate of safety.

Another aspect of the child psychiatric nurse that can be seen as an art is the ability to allow herself to act as a surrogate mother for the child who is admitted, which is also punctuated in the reviewed templates. According to Haber (2000), Peplau asserts the surrogate role of the psychiatric nurse, and that the nurse's function is to help the patient recognise similarities between the nurse and the person recalled by the patient. The impact of the different roles on the nurse is reflected on the struggle that is punctuated with regards to role confusion – not knowing when to be a parent, counsel or discipline, for example.

***Reflection space: Finding a voice through punctuating the loss of it***

*I want to remind the reader that the above are two of the findings that stand out for me and that I choose to punctuate as part of this investigation. When I reflect on the way that I view the role of the child psychiatric nurse, I punctuate the distinction of voice/voicelessness and the interplay between the two. Huelskoetter (1991) states that no role can exist in isolation and that the psychiatric nurse is seeing her role in relation to the expectations of what others think her role should be (preconceived ideas of others) and secondly, to the way in which she herself sees her role (preconceived ideas of self). In my experience and in the different interviews of the child psychiatric nurses, the nurse is aware of the importance of her own role and is able to voice it accordingly, but is not sure about the way in which others see her role. This is reflected in statements about the label of being a nurse and the fact that there will always be people who are 'above them'. The paradox inherent in this investigation, however, is that it is the very voicelessness of nurses that I have observed that has allowed the voice of the nurse to be recorded and analysed.*

According to Haber (2000), Peplau states that the role of the counsellor is of the greatest importance for the psychiatric nurse. This role of the counsellor can still be seen as a relatively new term in psychiatric nursing. This is also reflected in the interviews in that only one of the four nurses drew the distinction of being a counsellor, whereas the therapeutic nature of the work all of them do is clearly reflected in the interviews.

The need for the nurse to include the families in the treatment of the children is supported by a number of resources (Ellila et al., 2007; Procter & Loader, 2000; Simpson et al.,

2006). The interviews also indicate the acknowledgement of the role of the nurse to be able to work with the family in that it leads to better patient care and a more complete understanding of the problem.

***Reflection space: The nurse in the role of a family advocate***

*I cannot recall any evidence of a nurse talking about the way that they observe the family or interact with them in any of the ward rounds, yet the importance of that is reflected in the interviews.*

**The nurse-patient relationship**

***‘I like to work with children. I like to reach them, see what affects them and help them to overcome’.***

Sjostedt et al. (2001) highlight the importance of the nurse-patient relationship and says that the nurse must show that she completely understands the patient’s suffering in order for the child to get better. There is an even greater emphasis on the sensitivity of the nurse-patient relationship and on the specialised role of the child psychiatric nurse working in an in-patient hospital setting in the literature. There are many examples under the templates of the nurses about the ability to understand and reflect on the children’s suffering and that it affects them. It is in the nurse’s ability to allow herself to form a meaningful attachment with the child, that the understanding of the suffering takes place. Qualter and Munn (2002) say that, in the absence of meaningful attachments for the child (that plays an essential role in their development), the psychiatric nurse can create a space where the child can be allowed to form such an attachment with her. This can be defined

as a corrective experience. This corrective experience is also acknowledged in one of the interviews. What is further reflected in the interviews is the impact of these 'close' relationships on the child psychiatric nurse. There is much punctuation of feelings of anxiety, anger, helplessness, exhaustion, frustration and guilt when referring to relationships with the children in the ward. Carson (2000) states that acknowledging these feelings of anger are an important part of the therapeutic process for psychiatric nurses who work with emotionally disturbed children. For the nurse to be able to help a child to deal with his/her angry feelings, it is important that she understands and deals with her own response pattern to anger.

***Reflection space: Revisiting the psychodynamic voice***

*I need to reflect on the earlier distinction of attachment/detachment when reflecting on the nurse-patient relationship. It was something that I observed within, when I worked as an intern, in that my reaction to the above feelings was that I needed to detach – it was just too much. In retrospect I remind myself of the value of object-relations theory; it is proposed that most of those feelings are feelings that the child projects onto any individual with whom they form a meaningful attachment. Most of the children did not have an available mother as an infant so they have never had the experience of going through a process of separation-individuation. I further observed in my interactions with the nurses and with the interviews of the nurses that these exact feelings trigger defence mechanisms in the form of denial, avoidance or suppression of feelings. When any of these mechanisms are at play, it causes less energy and less space for reflection.*

The resilience of the nurse is noticeable in that, in spite of many of the negative emotions that they feel, they still put their own needs aside and punctuate the importance of needing to be there for the children and needing to protect the children. When looking at Peplau's four sequential phases (as mentioned in Chapter 4) that occur during the nurse-patient relationship (orientation, working (identification and exploitation) and termination), all of the nurses who were interviewed displayed the ability to form meaningful, trusting relationships with the children (orientation). More difficult is the second and third phases. There were, however, some instances where all four phases were experienced.

***Reflection space: It's not time to say goodbye yet***

*What is reflected in the interviews is the difficulty of the termination phase, which I can strongly connect with. This is part of the attachment/detachment distinction and the difficulty of 'letting go' is clearly evident. The helplessness the nurses feel is further reflected in their awareness of the challenging socio-economic situation that the child goes back to, which is often seen as being a part of the problem. I am reminded here of Hoffman's (1993) description of the system that creates the problem. The denial and avoidance of saying goodbye is punctuated in the one interview where the nurse could not even tell the child (who she was very close to) that she was not working the next day when he was going to be discharged – she was scared that she would cry in front of him.*

## **A therapeutic environment**

**‘Maybe the child was an aggressive child and if he interacts with his parents he would get more punished. But then it comes for the child as somewhat of a surprise, if you don’t punish him and you are able to give him a positive reward instead, so you give him a different experience’.**

Kolko (1992) says that parent participation, a therapeutic atmosphere, individual psychotherapy, somatic therapies, education and medical services are the elements of a therapeutic environment in an in-patient milieu. The elements that are punctuated the most in the interviews and template statements of the four nurses are individual psychotherapy and the therapeutic environment of the ward. They all feel that it is a place where children feel safe and where they can enter into therapeutic relationships with the children. One interview mentioned the education of parents and the community; the medical services were also punctuated in one interview. Benson and Briscoe (2003) further mention that both structured and unstructured components play a part in the creation of a therapeutic environment. The nurses showed appreciation for the structured programme, specifically when referring to the ‘difficult children’. There seems to be a flexibility that is punctuated in some of the stories of specific relationships.

### ***Reflection space: Am I a counsellor or not?***

*Important to note is that, even though all of the nurses punctuated the therapeutic relationships that they are able to form with the children and the importance of it, only one nurse referred to herself as a counsellor. In my interaction with the nurses I also constructed them as meaningful role-players, but not as counsellors.*

What is mentioned as a challenge – when referring to the therapeutic environment in both the literature and the reflections of the psychiatric nurses – is the fact that children are discharged too soon and that there is a definite need for longer admission periods. This is especially true for children where the source of the problem is the home environment. Another challenge that affects the therapeutic environment is conflict within the multidisciplinary team. Two of the nurses punctuated the conflict in the team and the effect of that on them but also, in the longer term, on the children. Lanyado (as cited in Gairdner, 2002) offers a useful perspective that is based on Bowlby's attachment theory. She argues that, as children settle into a treatment unit and begin to feel secure, they fear that the new attachments made with members of staff will go wrong. To relate back to the initial statement of Bion's theory, children cannot feel contained if a therapeutic team is uncontained. The multidisciplinary team is discussed in greater detail in the next section.

***Reflection space: See no evil; hear no evil; speak no evil***

*In reflecting on my own experience, what was interesting for me as an intern psychologist, is that the one thing that I felt impacted most negatively on the therapeutic environment was not mentioned in any of the interviews. That is the effect that sedation, or being put in the seclusion room, has on the children. In my belief, it impacted negatively on the whole environment. I do, however, feel that the rest of the programme at the unit is well structured and that there is enough space for unstructured activities too.*

## **Membership in the multidisciplinary team**

*'If you want to know anything about the patient, they (the nurses) can tell you the whole story'.*

Baldwin (2002) says that it is of concern that psychiatric nurses are not able to define what is unique about their roles in the multidisciplinary teams. The voicelessness of the psychiatric nurse – or more the struggle to find a voice – in the multi disciplinary team, is clearly punctuated in all of the interviews when referring to the weekly ward rounds. The effect is punctuated through feelings of not being acknowledged, feeling belittled, being dismissed or having opinions rejected. Mohr (1999b) warns of the dangers of that, in that it can impact negatively on the child if there is conflict within a team. This aspect is also reflected in two of the interviews, where the nurses say that they feel discouraged to mention what they have observed in the ward and their concern is that it affects the child.

The importance of the effective functioning of the multidisciplinary team for patient care in an in-patient unit is further reflected in a number of articles (Im et al., 2004; Procter & Loader, 2000; Sutton et al., 1974). Sutton et al. (1974) urge psychiatric nurses to take a strategic position in the total treatment milieu and remind them of their unique competence in working with children. Robinson (1983) says that an important difference between the role of the nurse and the role of the psychiatric nurse is the importance of her role in the multidisciplinary team. The one psychiatric nurse punctuated her struggle in this in saying that, even though it looks like they are part of the team, they do not feel part of it at all. The interviews also showed that they feel uncomfortable in the ward rounds. They do, however, acknowledge the value of the connection they have with one



of the psychiatrists and that they feel that she understands them. The positive effect of affirmation by any of the team members was also punctuated in the interviews.

The literature does offer an explanation for conflict in the team in the article on 'The Ailment' and evidence thereof can also be found in the interviews where nurses explain how they form very close connections with some children, and how they then have the urge to protect them. They even punctuate that the relationship sometimes feels too close for them. According to Main (1986), 'The Ailment', through object-relations theory, sometimes manifests as a child who brings out a need from the nurse to overprotect him/her. The nurse may, in response to this, offer the child more of her time, almost as if she is giving the child special treatment. Because of the severity of these children's psychological difficulties, the special treatment does not help them to 'get better'. Rather, the process normally ends with the nurse feeling extremely exhausted and needing to blame someone else in the team for the child's lack of improvement. The nurse then acts out the child's inner confusion. This can cause a multidisciplinary team to split, which can have effects on the rest of the treatment, seeing that the team is now perceived by the other children as uncontained. This causes them to think that the hospital is also not a safe environment. The latter is constructed as being 'caused' by the children re-living their insecure childhood life and projecting all their insecurities onto the people with whom they interact. The effect on the child is that, when the nurse realises that the child is not getting better, she might withdraw from the child. For the child this function is yet another example of an object rejecting him/her, which re-traumatises the child.

***Reflection space: The psychiatric nurse being a nurse***

*I have observed in the weekly ward rounds that the nurses took an administrative role, speaking usually to confirm compliance or side effects of medication. They did sometimes mention if there were difficulties with some of the children. However, I observed that this was mostly content feedback and that there were seldom interpretations by the nurses or new ideas brought to the table with regards to the treatment of the children. I have further noted the value that I got from engaging with the nurses about what they observed in their interactions with the children and the appreciation that they felt.*

**The need for support and supervision**

***‘We definitely need a support system; the methods that they are currently using is failing us’.***

The literature shows the need for a space for nurses to reflect on themselves in relation to others and also to reflect on the impact of others (including the patients) on them. This need can be met through clinical supervision/support groups (Griffin & Christie, 2004; Gross & Goldin, 2008; Ramritu et al., 2002; White & Winstanley, 2009). The interviews punctuate the struggle of the nurses to understand supervision as it is constructed in psychology. For them, the understanding of supervision is more someone ‘checking’ your work or someone that is approached if there is a complaint, or if something goes wrong with a patient. The need for such support is punctuated and by reflecting on the data it can clearly be seen.

## REFLECTIONS AND RECOMMENDATIONS

### *Reflections: Thoughts about the thoughts*

Once again, I find myself in the meditation room, reminding myself of the important punctuation of Hoffman (1993) where she speaks about taking a position that is a step removed from the operation (investigation) itself, so that one can perceive the operation more holistically – views about views, or thoughts about the thoughts. I again become aware of my own fears that need to be acknowledged, realising that even though an attempt was made to leave some of my fears in the bracketing room, the complexities of life and of us as human beings need to be noted as shadows following us. My fears of failure and not doing enough in relation to this investigation are evident, yet through punctuating it, I bring a sense of relief and it enables me to reflect holistically. I leave this house with a great appreciation for being fortunate enough to have been granted the opportunity in life to work with people and to find meaning through the interactions of those I meet – more specifically, the child psychiatric nurses who have been part of my journey in life for six months, and are still part of it.

The following distinctions stand out for me and form part of reflecting on myself, the psychiatric nurse and the children who are admitted to a psychiatric hospital: voice/voicelessness; being/becoming; stability/change; caring/curing; and attachment/detachment. These reflections allow me to arrive at the most important distinction, namely the cybernetic complementary of beginnings/endings. The ending of this investigation allows for a new beginning, for me personally, in that it can be seen as my passport for entering back into the world of psychology. Within an ecosystemic

epistemology there is no either/or. In the same way, the beginning is the end and the end is the beginning.

### **Recommendations**

One of the aims of the study was to allow anyone who interacts with this text to create spaces within themselves when thinking about the child psychiatric nurse. Even though I have drawn distinctions on the specific field of child psychiatric nursing, I feel that spaces can also be allowed for reflecting on the important work of any nurse, working in any hospital setting. I am ending this chapter by punctuating some subjective personal areas of interest that might form part of future studies; I encourage the reader to do the same.

Possible future studies that can benefit, or add more value to, the important work of the child psychiatric nurse in order to better patient care:

- Termination phase as punctuated by Peplau (cited in Sloan, 2006). What is the effect of termination on the child psychiatric nurse? What is the impact if the same child is re-admitted? What is the role of the nurse after termination?
- Functioning of the multidisciplinary team in working with specific child psychiatric disorders. Is there a difference in approach?
- The experience of anxieties within the child psychiatric nurse and the effect on patient care.
- The surrogate role of the child psychiatric nurse when working with children in in-patient hospital settings.

- The need for supervision for the child psychiatric nurse.
- Cross-cultural studies in South Africa in looking at perceptions of child psychiatric disorders and nursing.
- Families' experiences of child psychiatric nurses.
- Studies on the nurse-patient relationship in an in-patient hospital setting.
- Children's perceptions of child psychiatric nurses.

## **PERSONAL REFLECTIONS ON ATTACHMENT AND DETACHMENT**

There have been pivotal moments in this investigation – which I believe contributed to the success of this investigation – that I want to include. More importantly, I feel that this has allowed for deeper understanding when connecting to the concept of holism, specifically the concepts of attachment and detachment. I have realised that it is not an either/or approach, but that the beautiful ‘dance’ between these two concepts that has allowed me to complete this investigation.

I formed meaningful attachments with everyone in the multidisciplinary team and with the children that I interacted with in the six months in 2003 when I worked as an intern psychologist. The reality of being a clinical psychologist was felt through the pain of working with the children who have endured great suffering because of psychiatric disorders. The causes of these disorders are debatable, but in my experience, many a times they came about as a result of environmental factors that can only be described as unfair and uncalled for. My interactions with the child psychiatric nurses were of such a nature that I got to know them quite well. This allowed me to start asking questions about the importance of their work that does not get acknowledged. Internalising the pain that I felt, it also connected with some of the pain that I have had as a child. The pain was felt unconsciously at the time. In reaction to this pain that I felt in attaching, I needed to detach. I did this by moving away from the field of psychology completely.

I moved to Cape Town in 2006, started a beautiful process of personal long-term counselling, which allowed me to attach again to the importance of being a psychologist,

without even realising it. This came to my awareness when I went overseas in 2009, detaching from my current environment, in the form of several dreams that I have had in relation to being a psychologist. When I arrived back in South Africa, in August 2009, I made contact with Unisa again, exploring the possibility of completing my studies. At the time, the task felt enormous, but I trusted the bigger process.

In the months that followed, I started embarking on the completion of my investigation and through these months I, again, observed the process of attachment and detachment when interacting with each of the different chapters. I also observed my detachment in a physical sense from my current environment. Two of the chapters were constructed in Pretoria, which is meaningful in itself, seeing that this is where the process started. The last two chapters were constructed in Struisbaai, a beautiful setting next to the coast, where I spent a week in silence, reflecting on that what needs to be said through the words of the psychiatric nurses that I interviewed.

In reflecting on the concepts of attachment and detachment, I have realised that it is not either/or, but both, where the detachment from this investigation allows for attachment to my future career as a clinical psychologist. It is to allow a holding space for both. I will constantly need to remind myself of this in my future life path in connecting with individuals again on a therapeutic level.

I want to conclude with the following quote, as cited in Williamson (2002), which is also widely known as part of Nelson Mandela's inauguration speech in 1994:

*Our deepest fear is not that we are inadequate.*

*Our deepest fear is that we are powerful beyond measure.*

*It is our light, not our darkness, that most frightens us.*

*We ask ourselves, who am I to be brilliant, gorgeous, talented and fabulous?*

*Actually, who are we not to be?*

*You are a child of God.*

*Your playing small doesn't serve the world.*

*There is nothing enlightened about shrinking so that other people won't feel insecure around you.*

*We were born to make manifest the glory of God that is within us.*

*It is not just in some of us, it's in everyone.*

*And as we let our own light shine, we unconsciously give other people permission to do the same.*

*As we are liberated from our own fear, our presence automatically liberates others.*



## REFERENCES

- Ahren, K. J. (1999). Ten tips for reflexive bracketing. *Qualitative Health Research*, 9(3), 107-111. Retrieved October 6, 2009, from <http://qhr.sagepub.com/cgi/content/abstract/9/3/407>
- Anderson, H. (1999). *Conversation, language and possibilities: A post modern approach to therapy*. New York, NY: Basic Books.
- Anderson, H., & Gehart, D. (2007). *Collaborative therapy: Relationships and conversations that make a difference*. New York, NY: Basic Books.
- Anderson, H., & Goolishian, H. A. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process*, 24(4), 371-393.
- Aquino-Russell, C. E. (2006). A phenomenological study: The lived experience of persons having a different sense of hearing. *Nursing Science Quarterly*, 19(4), 339-348. Retrieved October 6, 2009, from <http://nsq.sagepub.com/cgi/content/abstract/19/4/339>
- Baldwin, L. (2002). The nursing role in out-patient child and adolescent mental health services. *Journal of Clinical Nursing*, 11, 520-525.

- Bateson, G. (1979). *Mind in nature: A necessary unity*. New York, NY: E. P. Dutton.
- Becvar, D., & Becvar, R. (2000). *Family Therapy: A systemic integration*. Massachusetts, ND: Allyn & Bacon.
- Benson, W. D., & Briscoe, L. (2003). Jumping the hurdles of mental health care wearing cement shoes: Where does the inpatient psychiatric nurse fit in? *Journal of the American Nurses Association*, 9(4), 123-128. Retrieved from October 8, 2009, <http://jap.sagepub.com/cgi/content/abstract/9/4/123>
- Bowlby, J. (1973). *Separation, anxiety and anger*. New York, NY: Basic Books.
- Boyd, M. A. (2002). *Psychiatric nursing: Contemporary practice*. Philadelphia, PA: Lippincott.
- Buckley, P. (1986). *Essential papers on object relationships*. New York, NY: University Press.
- Carruthers, A. (2007). Psychotherapeutic effectiveness and social discourse: An *ecosystemic* exploration. Unpublished doctoral thesis. University of South Africa, Pretoria, South Africa.

Carson, V. B. (2000). *Mental health nursing: The nurse-patient journey*. Philadelphia, PA: W. B. Saunders.

Clarke, L., & Flanigan, T. (2004). *Institutional breakdown: Exploring mental health nursing practice in acute inpatient settings*. Wiltshire, England: APS Publishing.

Darwish, A., Salmon, G., Ahuja, A., & Steed, L. (2006). The community intensive therapy team: Development and philosophy of a new service. *Clinical Child Psychology and Psychiatry*, *11*(4), 591-605. Retrieved October 6, 2009, from <http://ccp.sagepub.com/cgi/content/abstract/11/4/591>

Delaney, K. R. (2006). Learning to observe in context: Child and adolescent inpatient mental health assessment. *Journal of Child and Adolescent Psychiatric Nursing*, *19*(4), 170-174.

Diagnostic and Statistical Manual of Mental Disorders. (1994). Fourth Edition (DSM-IV), published by the American Psychiatric Association, Washington, DC.

Doherty, W. J. (1999). Post-modernism and family theory. In M. Sussman, S. K. Steinmetz, & G. Peterson (Eds.), *Handbook of marriage and the family* (pp. 205-217). New York, NY: Plenum Press.

Drummond, J. J. (2007). Phenomenology: Neither auto- nor hetero- be. *Phenomenology Cognitive Science*, 6, 57-74.

Eisen, A. R., & Schaefer, C. E. (2005). *Separation anxiety in children and adolescents: An individualized approach to assessment and treatment*. New York, NY: The Guilford Press.

Ellila, H., Valimaki, M., Warne, T., & Sourander, A. (2007). Ideology of nursing care in child psychiatric inpatient treatment. *Nursing Ethics*, 14(5), 583-596.

Fagin, C. M. (1974). *Readings in child and adolescent psychiatric nursing*. St. Louis, MO: Mosby.

Feldman, H. R. (1995). *Nursing care in a violent society: Issues and research*. New York, NY: Springer.

Forchuk, C., Westwell, J., Martin, M. L., Bamber-Azzopardi, W., Kosterewa-Tolman, D., & Hux, M. (2000). The developing nurse-client relationship: Nurses' perspectives. *Journal of the American Psychiatric Nurses Association*, 6(1), 3-10.  
Retrieved October 6, 2009, from <http://jap.sagepub.com/cgi/content/abstract/6/1/3>

- Gairdner, W. (2002). The Ailment: 45 years later. *Clinical Child Psychology and Psychiatry*, 7(2), 288-294. Retrieved October 7, 2009, from <http://ccp.sagepub.com/cgi/content/abstract/7/2/288>
- Gearing, R. E. (2004). Bracketing in research: A typology. *Qualitative Health Research*, 14(10), 1429-1452. Retrieved October 6, 2009, from <http://qhr.sagepub.com/cgi/content/abstract/14/10/1429>
- Giorgi, A. (1997). The theory, practice and evaluation of the phenomenological method as a qualitative research procedure. *Journal of Phenomenological Psychology*, 28(2), 235-260.
- Gow, K. M. (1982). *How nurses' emotions affects patient care: Self studies by nurses*. New York, NY: Springer.
- Griffin, A., & Christie, D. (2004). Trials and triumphs, stories and solutions: using systemic therapy techniques to facilitate paediatric and community nurses' groups. *Journal of Child Health Care*, 8(1), 59-68. Retrieved October 8, 2009, from <http://chc.sagepub.com/cgi/content/abstract/8/1/59>
- Gross, V., & Goldin, J. (2008). Dynamics and dilemmas in working with families in inpatient CAMH services. *Clinical Child Psychology and Psychiatry*, 13(3), 449-

461. Retrieved October 6, 2009, from  
<http://ccp.sagepub.com/cgi/content/abstract/13/3/449>

Gunter, H. (1971). *Psychoanalytic theory, therapy and the self*. New York, NY: Basic books.

Haber, J. (2000). Hildegard E. Peplau: The psychiatric nursing legacy of a legend. *Journal of the American Psychiatric Nurses Association*, 6(2), 56-62. Retrieved October 6, 2009, from <http://arj.sagepub.com/cgi/content/abstract/6/2/56>

Hepper, F., Weaver, T., & Rose, G. (2005). Childrens understanding of a psychiatric in-patient admission. *Clinical Child Psychology and Psychiatry*, 19(4), 557-573. Retrieved October 6, 2009, from <http://cgi.sagepub.com/cgi/content/abstract/19/4/557>

Hoffman, L. (1981). *Foundations of family therapy*. New York, NY: Basic Books.

Hoffman, L. (1993). *Exchanging voices: A collaborative approach to family therapy*. London, England: H. Karnac (Books) Ltd.

Huelskoetter, M. M. W. (1991). *Psychiatric mental health nursing: Giving emotional care*. Norwalk, CA : Appleton and Lange.

Im, S., Kim, J., Ju, S., Kwon, M., Kim, J., Kwon, J., & Lee, S. (2004). Development of child and adolescent psychiatric nursing practice in Korea, 1980-2000. *Journal of Child and Adolescent Psychiatric Nursing, 17*(2), 56-65.

Johnson, B. S. (1995). *Child, adolescent & family psychiatric nursing*. Philadelphia, PA: J.B. Lippencott.

Kahn, M. S., & Kelly, K. J. (2001). Cultural tensions in psychiatric nursing: Managing the interface between western mental health care and Xhosa traditional healing in South Africa. *Transcultural Psychiatry, 38*(1), 35-50. Retrieved October 6, 2009, from <http://tps.sagepub.com/cgi/content/abstract/38/1/35>

Keeney, B. P. (1993). *Aesthetics of change*. New York, NY: The Guilford Press.

Kleinman, S. (2003). Phenomenology: to wonder and search for meaning. *Phenomenological Research, 11*(4), 7-19.

Kolko, D. J. (1992). Historical overview. In V. B. van Hasselt & D. J. Kolko (Eds.), *Inpatient behavior therapy for children and adolescents* (pp. 3-21). New York, NY: Plenum Press.

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *American Journal of Occupational Therapy, 45*(3), 214-222.

- Kruger, D. (1979). *An introduction to phenomenological psychology*. Johannesburg, South Africa: Juta.
- Ladkin, D. (2005). 'The enigma of subjectivity': How might phenomenology help action researchers negotiate the relationship between 'self', 'other' and 'truth'? *Action Research*, 3(1), 108-126. Retrieved October 8, 2009, from <http://arj.sagepub.com/cgi/content/abstract/3/1/108>
- Lopez, K. A., & Willis, D. G. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative Health Research*, 14(5), 726-735. Retrieved October 6, 2009, from <http://qhr.sagepub.com/cgi/content/abstract/14/5/726>
- Maggs-Rapport, F. (2001). 'Best research practice': In pursuit of methodological rigour. *Journal of Advanced Nursing*, 35(3), 373-383.
- Main, T. F. (1986). The Ailment. In M.D. Buckley (Ed.), *Essential papers on object relations* (pp. 419-446). New York, NY: New York university press.
- Marriner-Tomey, A., & Alligood, M. R. (2002). *Nursing theorists and their work*. St. Louis, MO: Mosby.



- Maturana, H., & Varela, F. (1980). *Autopoiesis and cognition: The realisation of the living*. Dordrecht, the Netherlands: D. Reidl Publishing.
- McDougal, T. (2005). Child and adolescent mental health services in the UK: Nurse consultants. *Journal of Child and Adolescent Psychiatric Nursing*, 18(2), 79-83.
- McDougal, T. (2006). Defining the terms. In T. McDougal (Ed.), *Child and adolescent mental health nursing* (pp.1-13). Oxford, England: Blackwell Publishing Ltd.
- Messinger, S. D. (2007). Representation of the patient: Conflicts of expertise in a psychiatric emergency department. *Qualitative Health Research*, 17(3), 353-363.  
Retrieved October 6, 2009, from  
<http://qhr.sagepub.com/cgi/content/abstract/17/3/353>
- Middleton, A. B., & Pothier, P.C. (1974). The nurse in child psychiatry- An overview. In M. Fagin (Ed.), *Readings in child and adolescent psychiatric nursing* (pp. 9-19). London, England: Mosby.
- Mohr, W. K. (1999a). Beyond cause and effect: Some thoughts on research and practice in child psychiatric nursing. *Journal of Child and Adolescent Psychiatric Nursing*, 12(3), 118-127.

Mohr, W. K. (1999b). Discover a dialectic of care. *Western Journal of Nursing Research*, 21(2), 225-245. Retrieved October 6, 2009, from <http://cgi.sagepub.com/cgi/content/abstract/21/2/225>

Norton, K. (2004). Re-thinking acute psychiatric inpatient care. *Internal Journal of Social Psychiatry*, 50(3), 274-284. Retrieved October 6, 2009, from <http://isp.sagepub.com/cgi/content/abstract/50/3/274>

Procter, E., & Loader, P. (2000). Getting it right: A dilemma of multidisciplinary working in a paediatric liaison team. *Clinical Child Psychology and Psychiatry*, 5(4), 491-496. Retrieved October 8, 2009, from <http://ccp.sagepub.com/cgi/content/abstract/5/4/491>

Qualter, P., & Munn, P. (2002). The separateness of social and emotional loneliness in childhood. *Journal of Child Psychology and Psychiatry*, 43(2), 233-244.

Ramritu, P., Courtney, M., Stanley, T., & Finlayson, K. (2002). Experiences of the generalist nurse caring for adolescents with mental health problems. *Journal of Child Health Care*, 6(4), 229-244. Retrieved October 3, 2009, from <http://chc.sagepub.com/cgi/content/abstract/6/4/229>

Rapport, F., & Wainwright, P. (2006). Phenomenology as a paradigm of movement. *Nursing Inquiry*, 13(3), 228-236.

Robinson, L. K. N. (1983). *Psychiatric nursing as a human experience*. Philadelphia, PA: Saunders.

Scharer, K., & Jones, D. S. (2004). Child psychiatric hospitalisation: The last resort. *Issues in Mental Health Nursing*, 25, 79-101.

Seed, M. S., Torkelson, D. J., & Karshmer, J.F. (2009). The clinical nurse leader: Helping psychiatric mental health nurses transform their practice. *Journal of the American Psychiatric Nurses Association*, 15(2), 120-125. Retrieved October 6, 2009, from <http://jap.sagepub.com/cgi/content/abstract/15/2/120>

Simpson, P., Yeung, F. K. K., Kwan, A. T. Y., & Wah, W. K. (2006). Family systems nursing: A guide to mental health care in Hong Kong. *Journal of Family Nursing*, 12(3), 276-291. Retrieved October 6, 2009, from <http://jfn.sagepub.com/cgi/content/abstract/12/3/276>

Singh, N. N., Singh, S. D., Sabaawi, M., Meyers, R.E., & Wahler, R.G. (2006). Enhancing treatment team process through mindfulness-based mentoring in an inpatient psychiatric hospital. *Behavioral Modification*, 30(4), 423-441. Retrieved October 6, 2009, from <http://bmo.sagepub.com/cgi/content/abstract/30/4/423>

Sjostedt, E., Dahlstrand, A., Severinsson, E., & Lutzen, K. (2001). The first nurse-patient encounter in a psychiatric setting: Discovering a moral commitment in nursing. *Nursing Ethics*, 8(4), 313-327. Retrieved October 8, 2009, from <http://nej.sagepub.com/cgi/content/abstract/8/4/313>

Sloan, G. (2006). *Clinical supervision in mental health nursing*. Chichester, West Sussex, England: Wharf Publishers Limited.

Smith, J. A. (2003). *Qualitative Psychology: A Practical Guide to Research Methods*. London, England: SAGE Publications.

Sprince, J. (2002). Developing containment: Psychoanalytic consultancy to a therapeutic community for traumatized children. *Journal of Child Psychotherapy*, 28(2), 147–161.

Strayhorn, J. (1992). Medical aspects of psychiatric treatment of children. In V. B. van Hasselt & D. J. Kolko (Eds.), *Inpatient behavior therapy for children and adolescents*. (pp. 53-89). New York, NY: Plenum Press.

Street, C. (2004). In-patient mental health services for young people- changing to meet new needs? *The Journal of the Royal Society for the Promotion of Health*, 124(3), 115-118. Retrieved from <http://rsh.sagepub.com/cgi/content/abstract/124/3/115>

- Sutton, H., Maas, C. S., & Krug, O. (1974). Child psychiatric nursing in the comprehensive residential treatment of emotionally disturbed children. In M. Fagin, *Readings in child and adolescent psychiatric nursing* (pp. 25-32). London, England: Mosby.
- Taylor, C. M., (1999). Introduction to psychiatric mental health nursing. In P. G. O'Brien, W. Z. Kennedy, K. A. Ballard (Eds.), *Psychiatric nursing: an integration of theory and practice* (pp. 3-24). New York, NY: McGraw-Hill.
- Terre Blance, M., & Durrheim, K. (Eds). (1999). *Research in practice: Applied methods for the social sciences*. Cape Town, South Africa: University of Cape Town press.
- Varela, F. J. (1979). *Principles of biological autonomy*. New York, NY: Elsevier, North Holland.
- Von Foerster, H. (1981). *Observing systems*. Thousand Oaks, CA: Inter systems Publications.
- Von Foerster, H. (2002). *Understanding: Essays on cybernetics and cognition*. New York, NY: Basic Books.
- Von Glasersfeld, G. (1984). An introduction to radical constructivism. In P. Watzlawick (Ed.), *The invented reality*. New York, NY: W.W. Norton.

- Wall, C. (2003). Using a reflective diary to develop bracketing skills during a phenomenological investigation. *Phenomenological Research, 11*(4), 20-29.
- Wertz, F. J. (2005). Phenomenological research methods of counseling psychology. *Journal of Counseling Psychology, 52*(2), 167-177.
- White, E., & Winstanley, J. (2009). Clinical supervision for nurses working in mental health settings in Queensland, Australia: A randomized controlled trial in progress and emergent challenges. *Journal of Research in Nursing, 14*(3), 263-276.  
Retrieved October 6, 2009, from  
<http://jrn.sagepub.com/cgi/content/abstract/14/3/263>
- Williamson, M. (1992). *A Return to Love: Reflections on the principles of courses of miracles*. New York, NY: Harper Collins Publishers.
- Wojnar, D. M., & Swanson, K. M. (2007). Phenomenology: An exploration. *Journal of Holistic Nursing, 25*, 172-180. Retrieved October 6, 2009, from  
<http://jhn.sagepub.com/cgi/content/abstract/25>