GUIDELINES FOR PSYCHIATRIC NURSES TO ASSIST IN THE CARE OF FEMALE PATIENTS WITH BIPOLAR DISORDER DURING THEIR ADMISSION AND STAY IN A TERTIARY LEVEL PSYCHIATRIC FACILITY IN THE EASTERN CAPE, SOUTH AFRICA

By

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DECLARATION

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

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DEDICATION

TO MY MOTHER

THANK YOU, THANK YOU, THANK YOU.

Thank you for your bright idea, initiating this study. If it was not for your continual support, motivation and encouragement, this study would not have seen the light.
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ABSTRACT

Bipolar disorder is the sixth leading cause of disability in the world among people aged 15-44. Bipolar disorder is a chronic psychiatric disorder with a significant impact on patients’ social, occupational, and general functioning well-being. Patients who are diagnosed with bipolar type 1 disorder are usually admitted to a psychiatric hospital as an involuntary patient which means that they will be cared for in a closed unit. In a critical analysis of the literature it was noted that not much is known of the experiences of patients in psychiatric wards.

The researcher used a qualitative approach, with a phenomenological research strategy. An explorative, descriptive and contextual design was utilized to gain more insight into female patients’ lived experiences during their admission and stay in a tertiary level psychiatric institution. The research population was female patients who were diagnosed with bipolar disorder and who had recently experienced being admitted to and treated at a tertiary level psychiatric facility where they were treated for this condition. Purposive sampling was utilised to obtain the sample for the study.

A pilot study was conducted before the study commenced to ensure the trustworthiness of the findings. The researcher obtained the data via semi-structured interviews as well as field notes and reflective journals. Data was analysed by using Tesch’s method as adopted by Creswell. Once the data had been analysed, a literature control was done in accordance with the findings. Guba’s model of trustworthiness was utilized to ensure that this study was trustworthy and credible. The researcher implemented ethical principles to ensure that no harm was done to the participants during the research study. Finally, guidelines were developed to assist professional nurses to manage patients optimally during their admission and stay in a closed unit of a tertiary psychiatric facility.

Keywords: Admission process, Bipolar Disorder, Closed unit, Hospital stay, Psychiatric nurse, Tertiary level psychiatric facility.
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CHAPTER ONE

OVERVIEW OF STUDY

1.1 INTRODUCTION

Female patients diagnosed with bipolar disorder have reported a variety of positive and negative experiences during their admission and stay in a state tertiary psychiatric facility. Bipolar disorder is a mood disorder that may have a sudden onset. Therefore it can manifest itself as a change in mood such as becoming either euphoric or depressed, or it can present itself as a mixed episode. Mixed episodes refer to patients experiencing both depression and euphoria (Svindset, Dahl & Hatling, 2007:47; Moosa & Jeenah, 2008:110; Johansson, Skärsäter & Danielson, 2009:501).

The researcher has worked in various acute female psychiatric wards and has developed a passion for working with female patients diagnosed with bipolar disorder. During her time in practice the researcher noted that the psychiatric nurses did not seem have a clear concept of how to care for these patients according to their needs. In addition, the researcher experienced difficulty obtaining information regarding the experiences of female patients diagnosed with bipolar disorder during their admission and stay to a tertiary level psychiatric facility in South Africa. Most of the information that was found was obtained from international journals. Therefore, in this study the researcher aims to investigate the experiences of female patients diagnosed with bipolar disorder who were admitted to a state tertiary psychiatric facility in the Eastern Cape, South Africa.

Chapter 1 discusses the background, followed by the problem statement, together with the research questions and objectives. Thereafter, certain key concepts in the study will be defined. The paradigmatic perspective of the study will be presented and then the research design and methodology will be explained to ensure that the reader understands the research process of the study. Furthermore, the ethical standards that were upheld throughout the study will also be discussed.

1.2 LITERATURE REVIEW AND BACKGROUND

In the literature review a brief description of bipolar disorder will be presented, followed by a discussion of the prevalence of bipolar disorder. Thereafter, an overview will be
given to assist the reader in gaining a clear perspective of the term bipolar disorder and the meaning thereof. This will be followed with reasons why bipolar patients are admitted into a tertiary level psychiatric facility as well as the environment that these patients will stay in during their admission period. A discussion of the experiences of patients diagnosed with a mental illness during their admission and stay in a psychiatric facility in other countries will follow. In addition, the importance of applicable legislation, specifically the Mental Health Care Act no 17 of 2002 (MHCA), which guides the health care professional to assist patients appropriately with a mental illness, will be presented. Discussions will then follow of previous studies on how the patients experience their illness and stay in a psychiatric facility. The pharmacological treatment, multi-professional involvement and environmental approaches of patients diagnosed with bipolar disorder will be discussed so that the reader can gain an in-depth understanding of the process of admitting a patient to a state tertiary level psychiatric facility and the environment to which the patient is admitted. Lastly, an overview will be given on the role that the psychiatric nurses has in the care of patients diagnosed with bipolar disorder.

The American Psychiatric Association (2008:382) states that an essential component of bipolar disorder is the incidence of one or more manic episodes or mixed episodes during the course of the illness. In order to be diagnosed with bipolar disorder a person must have experienced at least one manic and one depressive episode in the past (Cochrane, Barkway & Nizette, 2010:149). The patient’s mood may also fluctuate between these two extremes.

The Centers for Disease Control and Prevention (CDC) (2012) in the United States of America reported that bipolar disorder is more common in woman than in men, with a ratio of 3:2. The inpatient hospitalization rate of bipolar disorder (39.1%) was higher than the 4.5% of all the other patients with behavioural diagnoses (CDC, 2012). The South African Depression and Anxiety Group (SADAG) states that over four million South Africans have been diagnosed with bipolar disorder (SADAG, 2012). According to Sadock and Sadock (2007:528), the lifetime prevalence rate of bipolar disorder type 1 is about 2.4% in a population. Statistics for mood disorders from a tertiary state level psychiatric facility in the Eastern Cape were obtained and these indicated that about 953 cases were treated in 2011.
Bipolar disorder is a well-known mood disorder and is the sixth leading cause of disability in the world amongst people aged 15-44 years (Zupancic & Gonzalez, 2012:1). Bipolar disorder is not always obvious in individuals, as patients experiencing mild euphoria may come across as very social, talkative and can be the “life and soul of the party”. However, euphoric feelings can quickly escalate into aggression (Kniesl & Trigoboff, 2009:427). During the euphoric phase of the condition these patients often present with behaviours that endanger themselves or others, such as being intrusive and demanding (Jarvis & Middleton, 2010:401), making sexual advances or acting in a promiscuous manner towards strangers (Antai-Otong, 2008:269). Kek, Hill, Sundram, Graham, Dean, Opeskin, Dorissa and Copolov (2009:504) state that during the depressive phase the patients may present with suicidal ideation. The suicide rate in patients diagnosed with bipolar disorder is approximately 20 times higher than in the general population. Patients diagnosed with bipolar disorder may experience an emotional rollercoaster ride where their behaviour and emotions may fluctuate throughout the day. However, patients diagnosed with bipolar disorder who are compliant with treatment may function well in the community and live a well-balanced lifestyle, maintaining a satisfactory level of work performance and functioning in all spheres of life (Russell & Brown, 2005:187).

A reason for being admitted to a state psychiatric facility may be that the patient became non-compliant with treatment (Hopko, Averill, Cowan & Shah, 2011:91) or that she experienced a stressful event in her life. For example, prior to admission while experiencing symptoms in a euphoric phase, these patients may have been on spending sprees, plunging themselves and their families into an excessive amount of debt. A response to this debt may be to haphazardly sell household items, even prized objects that have great value to themselves or certain family members. This behaviour demonstrates a diminished ability to make sound decisions based on sound judgement. The patient may also experience aggressive outbursts and thought pattern disturbances which may include delusions or even hallucinations. Furthermore, these patients have limited to no insight into their behaviour (Kumar, Kumar, Khan & Mishra, 2013:186)

Patients with bipolar disorder, who display the above tendencies, may be admitted to a psychiatric facility. In South Africa, psychiatric facilities may be old and not always
environmentally or therapeutically friendly. Patients who are diagnosed with bipolar disorder, type 1 are usually admitted as involuntary patients, meaning that the patients will be cared for in a closed (locked) unit (Johansson, et al., 2009:501). A literature review undertaken by Johansson et al. (2009:501) showed that patients who were hospitalised in a closed unit had negative experiences regarding the impact on their own autonomy and safety, which may lead them to act aggressively. In a critical analysis of the literature, Määttä (2009:177) notes that not much is known of patients’ experiences of being cared for in a closed unit.

The manner in which patients experience the admission process may have an influence on the outcome of care (Johansson et al., 2009:501). Therefore, it is important to understand how the patient experiences her admission and stay in a psychiatric facility. Svindset et al., (2007:47) state that patients may experience humiliation during the admission process. Although patients are admitted to psychiatric facilities to be cared for and treated for a mental illness, they do not always have the insight to realize the necessity of being admitted (Moosa & Jeenah, 2008:109). To them they are feeling wonderful and the mental health professionals want to take their good feelings away. Patients may experience the admission process as causing them to feel “emotionally castrated” (Svindseth et al., 2007:61). Ruchlewska, Mulder, Smulders, Roosenschoon, Koopmans and Wierdsma (2009:2) note the importance of crisis plans for patients with bipolar disorder. In a randomised control trial conducted in the Netherlands by Ruchlewska et al. (2009), approximately 50% of patients who were admitted involuntarily experienced the admission process as traumatic.

There are different ways of being admitted to a psychiatric facility. Each admission procedure has its own steps that should be followed (Madela-Mntla, 2010:106). Two types of admissions will now be discussed. A person over 18 years and who presents with a serious mental illness can be admitted as an assisted admission; this means the person is not necessarily against being admitted, but does not have insight into the seriousness of her condition or does not fully understand her condition to be able to apply for admission herself. A complication that may occur is that as this patient cannot decide by herself to leave the facility, she has to abide by the rules of the Mental Health Care Act no17 of 2002 (MHCA). This implies that a patient who feels she can be released into the community as she is once again mentally healthy cannot request
to be discharged. If this patient becomes aggressive and a danger to herself or others, an involuntary admission is arranged against the patient's own free will. Therefore, this means that the patient is against the admission and has no insight into the reason for her admission. Hence, mental health legislation is necessary for protecting the rights of people with mental disorders, who are a vulnerable population group in society (World Health Organization, 2003:2). The main reason for admitting the patients using the involuntary admission process is to ensure their safety as they may pose a physical and or emotional threat to themselves as well as to others (Moosa & Jeenah, 2008:109; Madela-Mntla, 2010:108). Both types of admission follow more or less the same admission procedure and the patient will be involuntarily detained in a closed unit (Madela-Mntla, 2010:107).

Once a patient is a danger to herself or others and displays signs and symptoms of a mental illness she is taken to the emergency department. Here the patient is physically examined, laboratory tests are obtained and then the patient is referred to the 72 hour admission unit. In the 72 hour unit a complete mental assessment is conducted and the patient's behaviour is observed. Behavioural and mood problems may be displayed by bipolar disorder patients in this unit. They may be irritable, uncooperative or even exhibit hostile and aggressive behaviour. These patients may need to be admitted for more than 72 hours to safeguard themselves from either hurting themselves or others (Stuart, 2013:309). Therefore, they are transferred to a tertiary level psychiatric facility to be treated. It is important that the care and treatment is effective to decrease these types of behaviour (Peuskens, Kasper, Arango, Bandinelli, Gastpar, Keks, Mitchell, Oral, Timdahl & Vieta, 2007:61).

Hughes, Hayward and Finlay (2009:155) report that some of the participants in their study maintained their locus of control during their time in hospital even though they were admitted involuntarily. However, some participants experienced negative changes in self-concept and loss of identity, which they blamed on their experiences of involuntary hospitalization. Hence, the use of physical restraint was seen as leading to a loss of dignity and self-respect. On the other hand, some participants stated that the support they received from friends and family affected their stay in a positive manner. In contrast, some participants reported that their relationships were affected in a negative manner due to stigmatisation. Therefore, it was concluded that the
participants’ future perceptions of were related to how they experienced their period of hospitalization (Hughes et al., 2009:155).

A study by Hem, Nortveldt and Heggen (2008:63) focused on boundaries and how they are set in a psychiatric facility to help maintain respect and dignity in the human being. Hem et al. (2008:63) state that the issue of respect for “private life” must be a high priority for nurses when they interact with mentally ill patients. A female patient in Hem et al.’s study reported that during her stay in hospital she felt she was not listened to and that no one believed her. This patient was in the depressive phase of bipolar disorder when this emotion was recorded. During the manic phase she described the staff as “...very, very nice...they brighten my existence, and in fact make this place quite habitable”. Hence, it depends on the patient’s mood how she will experience her intrapersonal world.

Pharmacological treatments that may be given to patients with bipolar disorder are mood stabilizers which may include lithium carbonate, valproate or carbamazepine. These drugs will be given throughout the patient’s stay in the hospital. Sedatives, such as Benzodiazepam (clonazepam and lorazepam), are used during acute mania, agitation, insomnia, aggression and panic to control the patient’s behaviour. Antipsychotics may be used in some patients who present with psychosis or aggression (Sadock & Sadock, 2007:560). Although psycho-tropical drugs start the process of normalizing cognitive and affective functioning, it usually takes at least 10 days before an improvement will be noticed (Antai-Otong, 2008:895). Pharmacological treatment is initially used to stabilize the patient’s mental health. In order for the patient to stay symptom free, she has to stay on lifelong treatment. After the patient has been stabilized various forms of therapy are utilized to ensure that the patient is cared for in a holistic manner. A variety of therapies may be used to ensure holistic care, such as cognitive behavioural therapy, relaxation exercises, group therapy and family therapy by the multi-professional team based at a psychiatric facility. All members of the multi-professional team participate in the care of the patient, when such a team is available (Uys, 2010b:40).

The multi-professional team may include a psychiatrist who will clinically diagnose the patient and prescribe the appropriate psycho-tropical treatment. The clinical psychologist uses therapeutic sessions which focus on the psychodynamic pattern of
the patient. These sessions may include discussions of the patient’s sense of self, use of defence mechanisms, cognitive mechanisms and coping strategies. The occupational therapist focuses on patterns of work or occupational behaviour, while the social worker focuses on the use of resources and family relationships (Uys, 2010b:39). Stuart (2013:12) supports this statement and furthermore focuses on three primary domains, namely direct care, such as assisting in the patient’s basic needs, ensuring the patient’s mental safety and also for the patient’s physical safety. Psychiatric nurses are responsible for the physical care a patient receives such as ensuring hygiene, nutrition and sleep. The psychiatric nurse is in the patient’s environment for prolonged periods, as well as in different situations, therefore she is in a unique position to counsel the patient. Indeed Uys (2010b:20) states that the main focus of the psychiatric nurse working in a psychiatric environment, is counselling. Communication is of the utmost importance as already stated.

The South African Nursing Act(33 of 2005:25) state that the registered nurse (psychiatric nurse) needs to be able to address all types of behaviour that may be displayed, such as manipulative, dependant, and aggressive behaviours. The psychiatric nurse also acts as an advocate for the patient at all times to ensure that the patient receives effective care and treatment during the admission period. The psychiatric nurse is the contact person between the family and patient as well as with the rest of the multi-professional team. Other responsibilities entail providing psycho-education to the patient and family as well as implementing activities in the unit to occupy and create opportunities where the patients can gain insight into their illness. During these interactions with the patient, the psychiatric nurse will have the opportunity to observe the patient’s behaviour more directly, thereafter feedback to the multi-professional team is essential in order to deliver appropriate care to the patient. Stuart (2013:12) notes that the psychiatric nurse initiates activities with the patients and coordinates the patient’s care. The psychiatric nurse works with patients with multiple needs and should be able to utilize a variety of resources to assist the patient at all stages of care.

1.3 PROBLEM STATEMENT AND RESEARCH QUESTIONS

According to the WHO report entitled Mental health and development: Targeting people with mental health conditions as a vulnerable group, patients diagnosed with a
mental illness, such as bipolar disorder, are identified as a vulnerable population (WHO, 2010:vii). These patients display various signs and symptoms associated with the condition that may have an influence on their daily functioning, depending on their symptoms. During a euphoric phase the thought processes of these patients may be affected, such as impaired judgement or poor decision making abilities. Psychotic symptoms such as delusions or hallucinations may also confuse how they perceive their reality (Kniesl & Trigoboff, 2009:409). Such symptoms may influence the patient’s sense of reality and her understanding of what is happening to her. During a depressive phase patients may exhibit suicidal ideation. Patients diagnosed with bipolar disorder may not always have control over their emotions and behaviour and therefore it may be necessary to admit them to a state tertiary psychiatric facility in an attempt to control their behaviour and to ensure their safety. The physical aspects of a tertiary level psychiatric facility may be experienced as an unfriendly physical environment. The buildings are old and patients are kept in enclosed environments behind large steel gates.

In a study conducted by Hem et al. (2008:63) the researchers sought to determine how patients with bipolar disorder experienced the care received during their hospitalization. A female participant stated that during her depressive phase she felt that no one listened or believed her. On the other hand, during her manic phase she stated “…very very nice, the staff brighten my existence and made the place quite habitable”. During both phases patients may not have the necessary insight to understand and accept that their behaviour is out of control and that it is necessary to be hospitalised. The patients may experience their hospitalization as traumatic as they are admitted to a locked unit, curtailing their movement. The patients’ cognitive functioning may decline and worsen the confused state that they are experiencing. Therefore behaviour and emotions may be displayed that are unpredictable. Psychiatric nurses are aware that these patients present with behaviour and emotions that are not under the patient’s control, but the nurses do not really understand how patients experience the process of admission and stay in a tertiary level psychiatric facility.

The study aims to answer the following two questions:
• How do female patients diagnosed with bipolar disorder experience their admission and stay in a tertiary psychiatric facility during a manic phase?
• What can psychiatric nurses do when caring for these patients during their admission and stay to a tertiary psychiatric facility during a manic phase to optimise the care they receive?

1.4 OBJECTIVES

The objectives of this study will be:

• To explore and describe how female patients diagnosed with bipolar disorder experience their admission and stay in a tertiary level psychiatric facility during a manic phase.
• To develop broad guidelines to assist the psychiatric nurse to optimally manage female patients diagnosed with bipolar disorder during their admission and stay in a tertiary level psychiatric facility when admitted during a manic phase.

1.5 CONCEPT CLARIFICATION

Certain concepts used in this study will now be discussed and clarified to ensure that the reader has a sound understanding of the terminology used in this study.

• Admission process: In this study, admission process refers to the legal pathway of obtaining involuntary care, treatment and rehabilitation at a psychiatric facility for patients diagnosed with bipolar disorder. The patient may exhibit either euphoria or depression, but is in need of care in an environment where the patient’s safety can be ensured. An application for this admission process may only be made by a spouse, next of kin, partner, associate, parent, and guardian or in exceptional circumstances by a mental health professional. The legal processes prescribed by the Mental Health Care Act no 17 of 2002 will then be followed (South Africa, 2002:34).

• Bipolar disorder: This term refers to patients who experience mood disorders. Such mood disorders include manic episodes, hypomanic episodes, mixed episodes, depressed episodes, and cyclothemic episodes (Kniesl & Trigoboff, 2009:408). In this study, the participants were patients who had been formally diagnosed by a psychiatrist with bipolar disorder and exhibit emotional, cognitive
and behavioural symptoms associated with a manic or depressed episode. Being formally diagnosed means that the person must meet the DSM-IV-TR (American Psychiatric Association, 2008), diagnostic criteria. In this study, this concept refers to female patients diagnosed with bipolar disorder who were admitted to a state tertiary level psychiatric facility during a manic episode.

- **Bipolar disorder type I**: Patients with this form of bipolar disorder experience one or more manic or mixed episodes with or without a depressive episode (Kniesl & Trigoboff, 2014:340).

- **Bipolar disorder type II**: Patients with this form of bipolar disorder experience one or more major depressive episodes accompanied by at least one hypomanic episode (Kniesl & Trigoboff, 2014:340).

- **Closed unit**: A closed unit also referred to as a locked unit is described as a unit with a locked door which prevents the patient from leaving the unit without permission (Nijman, Bowers, Haglund, Muir-Cochrane, Simpson & Van der Merwe, 2011:614). Therefore, a closed unit in a tertiary psychiatric facility is an area where the patients eat, sleep and engage in recreation. Patients may only enter or leave through locked doors when accompanied by a staff member or else when discharged.

- **Hospital stay**: In this study, this term refers to the period that the patient spends in a state tertiary psychiatric facility from the time of admission until discharge. All basic needs and activities of daily living take place under the care of staff members. In order to assist the patient to recuperate and to be able to fulfil her responsibility in the community once again, therapeutic interventions are implemented.

- **Psychiatric nurse**: This term refers to a professional nurse who implements an interpersonal process to support and facilitate a healthy lifestyle for the patients in a psychiatric facility (Uys, 2010a:17). All the psychiatric nurses who are referred to in this research study had at least a nursing qualification in psychiatric nursing science at the time of data collection. They were also employed in a psychiatric facility and were members of the multi-professional team.

- **Tertiary level psychiatric facility**: Such a facility is a health establishment that provides specialized psychiatric services. The work is undertaken by a multi-professional team that aims to stabilize the mental condition of psychiatric patients
with a view to placing them back into the community where they came from, or transferring them to a long term institution, where they do not need specialist care (Uys, 2010b:72). The research for this study was conducted at a state-run, tertiary level psychiatric facility situated in the Eastern Cape, South Africa. The female patients who participated in this study were patients who had been admitted to a closed unit in a tertiary facility and were discharged and placed back into the community after they had been stabilized and no longer displayed any manic behaviour.

1.6 PARADIGMATIC PERSPECTIVE

A nursing theory was chosen to guide this study, namely Kotzé’s Nursing Accompaniment Theory (Kotzé, 1998:3). Accompaniment forms part of nursing and is viewed as a purposeful systematic intervention by the psychiatric nurse to assist the patient to overcome the need for help and support. A step by step intervention is undertaken by the patient with the assistance of a psychiatric nurse through recovering self-reliance and accepting the responsibility of attaining meaning in his or her personal life, even in terminal situations. The following concepts assist in understanding Kotzé’s theory more clearly:

- **Man, human being or person:** Man is a unique three dimensional total being, with body-psych and spirit. This person has a dynamic relationship with world, time, fellow-being/s and God (Kotzé, 1998:4). In this study, a human being will be viewed as the female patient diagnosed with bipolar disorder or the psychiatric nurse who is in a relationship with the patient with bipolar disorder.

- **World:** Refers to the world in which man exists, namely the objective world and the subjective world (Kotzé, 1998:4). According to Kotzé (1998:6), the world can also be seen as the personal world, the inner or intrapersonal world, the world of co-existence and the world of objects, social and cultural activities and work. The researcher is interested in how the patient experiences her personal world as well as how the patient experiences the surrounding world of the closed unit.

- **Health:** Refers to the state of wellness or illness of an individual. This is viewed as a dynamic process relating to the degree of ability or inability of a person on all three levels, namely body-psych and spirit (Kotzé, 1998:4), to function independently. The female patient’s state of mental illness and wellness is always...
varying and influences her ability to function. When she is mentally ill she is in need of care to help her recover her mental health.

- **Nursing:** Is an interpersonal comprehensive service to all mankind at all stages of life during illness or wellness. This service entails a dynamic systematic process of management, clinical care, and teaching. Teaching is seen as an important part, so as to promote change that would assist with the prevention of illness, disability and suffering, promotion and regaining of wellness, and where this is not possible, would facilitate a peaceful dignified death (Kotzé, 1998:4). Nursing is the psychiatric nurse’s main duty and this should be done at all phases of the patient’s illness.

Accompaniment is seen as the nursing care provided to the patient by the nurse. It is defined by Kotzé (1998:10) as follows: “accompaniment in nursing is the planned deliberate intervention by the nurse to enable the patient to overcome his/her need for help and support by

- Accepting responsibility,
- Identifying the norms of a new lifestyle,
- Regaining self-reliance,
- Finding and giving meaning to his/her life even on the death bed. It is a systematic process based on the identified need of the patient for help and support and occurs within a relationship of co-operation in which both nurse and patient are actively involved.”

According to Kotzé (1998:9), the psychiatric nurse should work with the patient, but not in an autocratic manner. The patient should actively partake in the assessment period, brainstorming together with the psychiatric nurse what interventions would suit her best. Therefore, the implementation of such an intervention is more likely to have a positive outcome. When the patient’s views of her own intervention are taken seriously and considered to be a valuable contribution by the psychiatric nurse, the patient may feel respected and thus a member of the multi-professional team. The researcher was interested in gaining knowledge of how female patients with bipolar disorder were assisted and cared for at a psychiatric health care facility based on their personal experiences.
As discussed by Kotze (1998:3), nursing and accompaniment goes hand in hand and is seen as a purposeful systematic intervention to assist the patient to regain her optimal health. The researcher wanted to gain an insight into the participants’ experiences of accompaniment by the psychiatric nurses during their admission and stay in a tertiary psychiatric facility.

1.7 RESEARCH DESIGN

Burns and Grove (2011:253) state that a research design is a “blue print” for conducting a study. It starts with an idea which is then formulated on paper as research methodology. Before building a house a structured plan is required. This plan entails specific details as how to go about erecting this house. The same basic principles are necessary to plan a research study. A variety of research designs are utilized in nursing research, for example, descriptive, correlational, quasi-experimental, and experimental (Burns & Grove, 2011:256). The researcher will use a qualitative research strategy, utilizing a phenomenological approach. An exploratory, descriptive and contextual design will be utilized and these concepts will be discussed, in more depth in chapter 2.

1.8 RESEARCH METHODS

The research methods used in a study are intertwined with the outcome that the researcher envisages for the specific study (Mills & Birks, 2014:34). It focuses on the steps that the researcher will take objectively to gain the necessary information (Mouton, 2008:56). When a variety of methods are used they enhance the quality of the study and describe the observations that were made in a meaningful manner, therefore enhancing validity and reliability (Babbie & Mouton, 2001:275). The research study will be done in two phases namely:

- Phase 1: Empirical study
- Phase 2: Developing broad guidelines

1.9 PHASE 1: EMPirical STUDY

The researcher made use of a variety of strategies to answer the research questions. The following aspects will briefly be stated as a detailed discussion of these concepts.
will follow in chapter 2. The concepts that were utilized were the research population, data collection, data analysis, literature control, pilot study and ensuring the quality of the study.

1.9.1 Sampling and research population

Population refers to individuals who meet the inclusion criteria of a study (Kerlinger & Lee (2000) as cited by Burns and Grove (2011:51)). Furthermore the term “population” refers to all the individuals who meet the specific inclusion criteria of a research study (Burns & Grove, 2011:290). The research population that was used were female patients who were diagnosed with bipolar disorder and who had recently gone through the experience of being admitted to and treated at a tertiary level psychiatric facility. Therefore a sample is a subsection of the population that is carefully chosen for a study (Burns & Grove, 2011:51). Purposive sampling was used when the participants were chosen. Polit and Beck (2012:724) state that the participants chosen are those who will be the most informative for the purpose of the research study. In purposive sampling, the participants need to adhere to a certain set of criteria (inclusion and exclusion criteria) to be able to participate in this research study.

Sampling continued until data saturation was reached. The researcher contacted the designated psychiatric nurses working at four psychiatric clinics in the Eastern Cape. The psychiatric nurses were asked to assist with the purposive selection process as they knew which participants would suit the criteria.

1.9.2 Data collection

The data collection method indicates how the researcher will gather the necessary data for the research study. Careful planning and execution of the plan will increase the validity of the study (Maxwell, 2013:102). In-depth, semi-structured interviews will be conducted until data saturation is achieved. According to Brinkmann and Kvale (2015:327), the semi-structured interview is a planned, flexible interview, the goal of this interview type is to obtain descriptions of the life experiences of each participant after which the researcher interprets the meaning of the described phenomena. Mills and Birks (2014:56) state that a qualitative interview involves the researcher conducting a face-to-face interview with the participant. The interviews that the researcher conducted took place where the participant felt the most comfortable.
Privacy was preserved to ensure confidentiality. A therapeutic milieu was created to form a comfortable setting.

The importance of observations and taking field notes during the data collection phase should not be underestimated. Polit and Beck (2012:548) state that field notes are categorized according to the purpose that they will serve during the analysis and integration of the data. The researcher made use of field notes to ensure that the work was as objective and reliable as possible. In these notes the researcher not only jotted down what she actually saw externally (observational notes), but she also reflected on her own emotions and experiences (personal notes) whilst conducting the interview. These notes were made one to two hours after each interview to ensure that all important information was written down and not lost.

After the interview the researcher left a reflective journal with each participant in which she could write her thoughts and feelings (Badenhorst, 2010:170). Each participant was encouraged to write about her experiences over the period that she was admitted to a mental health care facility. It may have happened that she forgot to mention something important to the researcher during the interview. By leaving the journal with her she was able to write down such thoughts, which could be used in the data analysis period. The researcher aim to collect the reflective journals from the participants a week after each interview.

1.9.3 Data analysis

Once the data was collected the data was analysed. The semi-structured interviews were recorded with the participant’s permission and transcribed verbatim. Tesch’s method, as adopted by Creswell, identifies specific themes that will be made use of in the data analysis phase (Creswell, 2009:186). The themes generated will be used to describe the findings (Tesch (1990) cited in Creswell (2009:176)). Themes are recurring ideas or experiences mentioned by the participants. Themes and sub-themes were derived from the data.

The themes were then verified by an independent coder. The coder was provided with a clean data set and a guide of how the analysis was to be undertaken. The coder was asked to go through the same transcribed data to independently identify themes. After
a discussion between the coder and the researcher to reach consensus, the final themes were identified and described. This was done in an attempt to ensure that the research study was conducted in a trustworthy manner.

1.9.4 Literature control

A literature control is undertaken after the data analysis has been completed. Munhiall (2006) cited in De Vos, Strydom, Fouché and Delport (2011:91) states the importance of explaining and supporting the generated theory by conducting a literature control. Fouché and Delport (2011:134) support the use of a literature control, because it assists the researcher to have a clearer understanding of the nature and meaning of the interviews that were conducted. The themes and sub-themes that were identified in this study were compared to the available literature to verify findings or to assist with the identification of unique themes.

Once the themes were analysed the researcher used them to develop guidelines for the management of female patients diagnosed with bipolar disorder. These guidelines were developed in order to assist the psychiatric nurse in managing female patients' diagnosed with bipolar disorder. Kotzé’s conceptual model of Nursing Accompaniment was used as a theoretical framework when the guidelines were developed (Kotzé, 1998:3).

1.9.5 Pilot Study

A pilot study was conducted prior to the data collection phase. A pilot study is conducted to improve and identify problems with the design (Burns & Grové, 2011:49). During the pilot study the researcher utilized her interviewing skills to collect data. The researcher’s interview skills as well as the effectiveness of the interview questions to generate appropriate data were tested.

Opportunities for improving the interview schedule arose after the pilot study interview had been analysed. Polit and Beck (2012:195) state that the outcomes of the pilot study are lessons learnt to assist the researcher in gaining important knowledge of how to conduct the study in order to not make unnecessary mistakes.
1.9.6 Ensuring the quality of the study

To ensure the quality of this study, Guba’s model of trustworthiness was followed. Lincoln and Guba (1985), cited in De Vos et al. (2011:419), suggest that the criteria of credibility, transferability, dependability and confirmability will generate information that ensures trustworthiness. These concepts will be discussed in detail in chapter 2.

1.10 PHASE 2: DEVELOPING GUIDELINES

The main aim of this study was to develop guidelines to assist the psychiatric nurse in delivering optimal care to ensure that the patient will experience a favourable stay during her period of admission and stay at a psychiatric hospital. Guidelines are a written guide to provide guidance for a specific problem which focuses on improvement of care (Finkelman, 2012:481). According to Kelly (2008:337), one advantage of guidelines is that they will improve the care of the patient and shorten the length of stay for a patient. Kelly (2008:337) states that guidelines assist new personnel in guiding them how to care for the patient and thus saves time in the process of care.

Guidelines do not only improve care but they also provide a consistent approach to care. Guidelines identify outcomes and support best practices (Finkelman, 2012:481). The importance of understanding how patients respond to care for specific problems can assist in preventing similar problems. It is important to obtain knowledge of patient satisfaction and outcomes prior to the development of guidelines so that this could be considered when developing the guidelines (Finkelman, 2012:481).

Finkelman (2012:228) states that it is important for the multi-professional team members to be involved when developing guidelines. Members who take part in these discussions must be willing to openly discuss issues. They should be receptive to change and lastly be committed to assist in the development of such a guideline. The researcher involved the multi-professional team prior to the development of the guidelines. Individual appointments were made with willing multi-professional team members who discussed the findings of the study, the analysis thereof and how it could be implemented so that the female patients diagnosed with bipolar disorder could receive the best possible care.
Four steps adapted from the National Institute for Health and Clinical Excellence (NICE) were adapted and utilized to assist the researcher in developing the guidelines to best suit the patients’ specific needs (National Institute for Health and Clinical Excellence, 2012:101):

1. Interpreting the evidence to make recommendations
2. Wording the recommendations
3. Prioritising recommendations for implementation
4. Formulating research recommendations – (evaluating the outcome)

Regarding the last point, Stuart (2013:63) presents aspects that should be taken into consideration when evaluating whether or not the outcomes have been achieved, namely: Applicable, acceptable, practical, integrity and sensitive to change (Stuart, 2013:63). The researcher utilized these aspects to ensure that the quality of the required outcomes was of a high standard.

1.11 ENSURING ETHICAL STANDARDS

The most important rule of social research is that no harm must be done to the participants. In social research, the harm that is referred to is focussed more on emotional harm, although physical harm can never be ruled out (Strydom, 2011:115). Therefore, the following three fundamental principles were adhered to: the principle of respect for persons, the principle of beneficence and the principle of justice (Brink, van der Walt, and van Rensburg, 2006:31). An in-depth discussion of these three principles will follow in chapter 2.

1.12 CHAPTER DIVISIONS

Chapter 1: Overview of study

Chapter 2: Research design and methods

Chapter 3: Discussion of findings

Chapter 4: Guidelines, limitations and conclusions
1.13 CONCLUSION

In this chapter an overview was provided on what the researcher planned to do in her research study. The problem statement, research questions and objectives were shared with the reader. Thereafter the concepts were clarified. A brief discussion followed on the specific paradigmatic perspective that the researcher utilized. A short description was provided on the research design and methods the researcher planned to use after which the literature control as well as the three ethical standards that the research adhered to was discussed. These concepts will be discussed in more depth in chapter 2. Lastly, the proposed method for developing guidelines for psychiatric nurses to manage female patients diagnosed with bipolar disorder was presented.

In chapter 2 a rationale will be provided on the background of this study and the problem statement. Once again a brief overview will be given on the objectives of this study. The following concepts will be shared in more detail as stated in chapter 1: the research design and methods and the data gathering process. Thereafter a discussion concerning the data analysis, trustworthiness as well as the ethical principles of the study will be presented.
CHAPTER TWO
RESEARCH DESIGN AND METHODS

2.1 INTRODUCTION

In the previous chapter an overview was given on how the researcher planned to implement the research. Chapter 2 provides a rationale on the background of the study and the problem statement followed by a presentation of the objectives. The following concepts will be shared in more detail: the research design and method, and data gathering. Thereafter a discussion will be provided on the data analysis, trustworthiness as well as the ethical principles that were adhered to during this study.

2.2 RATIONALE

Bipolar disorder is a mood disorder that may have a sudden onset. Therefore, it can manifest itself as a change in mood such as becoming either euphoric or depressed, or it can present itself as a mixed episode. Mixed episodes refer to patients experiencing both depression and euphoria (Svindset et al., 2007:47; Moosa & Jeenah, 2008:110; Johansson et al., 2009:501). These mood fluctuations can distort reality and thus their experiences of reality and can influence their ability to make sound judgements.

Patients diagnosed with bipolar disorder who were admitted to state tertiary psychiatric facilities reported their lived experiences during the period that they were admitted and hospitalised. They described being frightened, felt misunderstood and in retrospect felt that their experiences were traumatic. The researcher investigated the experiences of female patients diagnosed with bipolar disorder who were admitted to a state tertiary psychiatric facility in the Eastern Cape, South Africa. The reason for this was to understand how they perceived their stay in a state tertiary psychiatric facility, to enable psychiatric nurses to accompany patients during their stay in a tertiary psychiatric facility, in order to make it as comfortable and acceptable for them. Furthermore, limited studies were obtained within the South African context.

2.3 OBJECTIVES

The objectives of the study were:
• To explore and describe how female patients diagnosed with bipolar disorder experience their admission and stay in a tertiary level psychiatric facility during a manic phase.

• To develop broad guidelines to assist the psychiatric nurse to optimally manage female patients diagnosed with bipolar disorder during their admission and stay in a tertiary level psychiatric facility when admitted during a manic phase.

2.4 PHASE I: EMPIRICAL STUDY

Researchers seem to have different perceptions into what a research design is, a few will now be briefly mentioned. The most common description of a research design is a blueprint for conducting a study. The purpose is to establish control over aspects that may interfere with the validity of the study findings (Burns & Grove, 2011:253). Maxwell (2013:3) states that a research design is an interactive model with a definite construction. This model has five components namely: goals, conceptual framework, research questions, methods and validity. These components form a whole for the research design. On the other hand, de Vos et al. (2011:323) describe a research design to be like “buying a dress from one shop, shoes from another and a handbag from yet another.” The emphasis should be the research question and the suitability of the research design to explain the purpose and view of the study. The researcher used a qualitative, phenomenological research approach in this study, as well as an exploratory, descriptive and contextual design. These concepts will now be discussed.

2.4.1 Research design

A qualitative study is an orderly, subjective method utilised to describe meaningful life experiences, and is not a new concept in the social or behavioural sciences (Burns & Grove, 2011:73). It is used when the researcher wants to answer questions of a complex nature regarding a certain phenomenon. The goal of this type of research is that the researcher will explain the understanding of the phenomena from the participant’s lived experiences (De Vos et al., 2011:64). The researcher interviewed female patients who were diagnosed with bipolar disorder in an effort to try and understand their lived experiences during their admission and stay in a psychiatric facility while they experienced a manic phase. The researcher also attempted to
understand the meanings that they attributed to their lives during their stay in the psychiatric facility.

2.4.2 Phenomenological approach

A phenomenological approach is a cautious and systematic reflective study of lived experiences (Mills & Birks, 2014:259). Furthermore, de Vos et al. (2011: 316) state that a phenomenological design attempts to understand people’s perceptions, outlook and understanding of a specific situation. It is a description of a phenomenon viewed through other peoples lived experiences. The researcher aims to identify any unusual occurrence or experience of a person in a specific situation. The study focussed on female patients who were diagnosed with bipolar disorder who were experiencing mania and their personal lived experiences during their admission and stay in a closed unit in a tertiary level psychiatric facility.

2.4.3 Exploratory design

An exploratory design is used to gain an insight into a phenomenon (Botma, Greeff, Mulaudzi & Wright, 2010:50). Polit and Beck (2012:727) state that this type of a design explores the dimensions of a phenomenon. This research study was exploratory in nature, especially as it dealt with an under researched population, namely female patients in an Eastern Cape tertiary level psychiatric facility. The researcher found a limited amount of literature dealing explicitly with this topic for this reason this study can be seen to be a baseline study it aimed to add new knowledge to the existing literature.

2.4.4 Descriptive design

Descriptive studies require the researcher to firstly observe the phenomenon and thereafter describe what was observed (Babbie & Mouton, 2001:257). An accurate, detailed description of the patients’ lived experiences during the admission process and stay in a state tertiary psychiatric facility will be provided later in this study. In practice, exploratory and descriptive research may blend. A rich description of the methodology will also be provided to add value and rigour to the study.
2.4.5 Contextual design

A contextual design takes into consideration where the research takes place, as well as the context/environment (external and internal attributes of the study), which could have a positive or negative influence on the outcome of the study (Neuman, 2011:154). Qualitative studies are always contextual, as the data is only valid in a specific context (Botma et al., 2010:195). The researcher focussed on the experiences of female patients with bipolar disorder during their admission and stay in a closed unit in a tertiary level psychiatric facility. A closed unit in a tertiary psychiatric facility is an area where the patients eat, sleep and engage in recreation. Patients can only enter or leave through locked doors when accompanied by a staff member or else when discharged. The patients were admitted during the manic phase of bipolar disorder and therefore they may not have interpreted reality in the same manner as the staff. The patients who participated were admitted to a closed unit as they could have caused harm to themselves or even to others. The interviews took place with patients who were discharged from a state tertiary psychiatric facility and who had been re-integrated into the community.

2.5 RESEARCH METHODS

The research methods focus on the research process which requires an understanding of a unique language and involves use of a selection of research methods (Burns & Grove, 2011:547). Maxwell (2013:87) states that the methods used in a qualitative study depend on the matter and specific setting of the study to assist in obtaining the goal. Four main concepts are of importance namely: the research relationships that are established in the study, the selection of the setting, the participants involved, and way the data is collected and analysed (Maxwell, 2013:90). In other words, the methods that the researcher uses, focuses on the steps that the researcher will take to gain the necessary information as objectively as possible (Mouton, 2008:56). De Vos et al. (2011:327) state that the qualitative design is flexible and therefore the full description of the method used can only be provided once the study is completed. Burns and Grove (2011:83) state that the following methods are used in qualitative studies: a topic must be identified, identify sources of data, gain access to those sources, recruit participants, gather data, describe, analyse and interpret the data and lastly write a written report of the findings. In addition, Maxwell
(2013:102) states that when a variety of methods are used the conclusions are more credible than if only one method is utilised.

The researcher utilized a variety of strategies to assist in answering the research questions. The following aspects will now be discussed, namely the research population, the research sample, the methods that were used to gather the data, the way the data was analysed, the literature control process, the pilot study and the trustworthiness of the findings. Thereafter, the development of the guidelines to assist patients during their admission and stay in a closed unit of a state tertiary psychiatric facility will be explained. The ethical principles will also be discussed.

### 2.5.1 Research population

The term “population” refers to all the individuals who meet the specific inclusion criteria of a research study (Burns & Grove, 2011:290). The inclusion criteria indicate the participants’ relevance to the research study (Botma et al., 2010:200). The research population for this study was female patients who were diagnosed with bipolar disorder and who had been recently admitted to and treated at a tertiary level psychiatric facility. The interviews were conducted approximately two weeks after the participants were discharged from the tertiary level psychiatric facility. The inclusion criteria for the study required the participants to:

- Have been diagnosed with bipolar disorder according to the DSM-IV-TR criteria
- Have experienced a manic phase before admission
- Be at least 18 years of age but not older than 65
- Have spent at least two weeks in a tertiary level state psychiatric facility
- Have been admitted as involuntary patients

Exclusion criteria:

- During the data collection period no participant should exhibit symptoms associated with being manic, hypo-manic, depressed, psychotic, or be experiencing excessive stress.
2.5.2 Sampling method

Purposive sampling was used to choose the participants. Babbie (2010:193) states that it is sometimes appropriate to select a sample on the basis of one’s knowledge of a population, its elements and the purpose of the study. Maxwell (2013:97) prefers the term purposeful selection instead of purposive sampling. He defines purposeful sampling as a strategy that is used to handpick a specific setting and possible participants to provide relevant information for the aim of the study. During the study, the researcher experienced difficulties in finding suitable participants to take part. The reasons for this was that some of the potential candidates stayed out of town and did not have an effective means of communication, with some not even having a telephone. Other possible participants relapsed before they could be interviewed and therefore did not fit the criteria in order to be included in the study. One of the proposed participants indicated that she could not speak or understand English very well therefore an interpreter (who is a psychiatric nurse at a psychiatric clinic acted as the interpreter) was utilized during the interview. The researcher utilized purposive sampling to prevent a re-occurrence of the researcher not being able to communicate with a participant. With purposeful sampling the researcher selected the possible participants to ensure that the patients chosen, suited the inclusion criteria and were available to communicate in Afrikaans or English. Sampling was continued until data saturation occurred, as no new information was obtained (Burns & Grove, 2011:317).

Designated psychiatric nurses working at four psychiatric clinics in the Eastern Cape were contacted to assist with the selection process. These clinics were selected using convenience sampling, as there were designated psychiatric nurses working in these clinics and the clinics were situated not too far from where the researcher lived. Convenience sampling was utilized to select the specific clinics that assisted the researcher in selecting the participants. According to Burns and Grove (2011:305), convenience sampling refers to participants who are available and in the right place at the right time. Furthermore, Burns and Grove (2011:305) stated that convenience sampling is inexpensive and accessible, which suited the researcher.

After the necessary permission was granted by the relevant authorities, appointments were made to meet the psychiatric nurses of the designated psychiatric clinics. They were informed of the research that was to be undertaken and the process was
explained to them (see Annexure A). The researcher asked them if they could assist with names and contact details of possible participants and act as gatekeepers for the study. Neuman (2011:387) describes a gatekeeper as “someone with the formal or informal authority to control access to a site and persons”. A designated psychiatric nurse acted as a gatekeeper at each clinic. The role of a gatekeeper is to assist the researcher to obtain permission from the unit where the research will be conducted. Green and Thorogood (2011:285) defined gatekeepers, as people who work in the field where the research is planned to be implemented. These people facilitate or give permission to the researcher to enter the field. They also may approach potential participants to request participation in a study.

After the psychiatric nurses of the selected clinics made the initial contact and received permission from the participant that they were prepared to take part in the research, the contact details of the potential participants were given to the researcher. The researcher then contacted the participants telephonically and discussed in broad terms the expectations and objectives of the study. Thereafter an appointment was scheduled to meet face-to-face with the participants if they were still willing to take part.

During the contact sessions that the researcher had with each participant, written consent was obtained from the participants after a detailed explanation was provided and understood about the research (see information letter, Annexure B). After consent was obtained the researcher then began the interview. After the eighth interview the researcher in conjunction with her supervisor, decided that data saturation had occurred, as most of the participants repeatedly verbalised the same lived experiences.

2.5.3 Data collection method

The aim of data collection in this study was to generate an understanding into the lived experiences of participants in a specific setting. The most common form of data collection is the audio-taped interview, but other forms of data collection may also be utilised (Mills & Birks, 2014:188). Careful planning and execution of the plan increases the validity of the study (Burns & Grové, 2009:429). Three methods were utilized, namely: interviews, field notes and entries in a reflective journal.
Before each interview, the researcher explained the purpose of the study to each of the participants. The information included the goal of the research, the benefits, and what was expected of each participant. The researcher also answered certain demographic questions which the participants asked. Thereafter, information letters (see Annexure B) were handed to the prospective participant explaining everything once again in detail. The participants were asked to sign a consent form (see Annexure C), before the interview commenced.

Each participant was asked if she would mind if an electronic recording device could be used during the interview and permission for its use was obtained. Each participant was informed that the reason for recording the interview was to ensure that no valuable data was lost during the interview process. She was also informed that only the researcher, the transcriber and the supervisors would have access to the recorded interview. The information that was recorded was then transcribed for coding purposes. The participant was also informed that no name would be used on the transcribed data. The only indication of the different interviews was indicated as participant 1, participant 2 and so forth. After the data was analysed, the electronic copies as well as the written coding documents were handed over to the primary supervisor for safe keeping where no persons have access to it, only the supervisor. The data will be stored for a period of five years, as is legally required, after which it will be destroyed.

2.5.3.1 Interviews

A qualitative interview involves the researcher conducting a face-to-face semi-structured interview with the participant (Creswell, 2009:181). As this research was based on the lived experiences of female participants, the researcher applied the strategies of phenomenological research. The researcher conducted semi-structured interviews whereby as much information as possible was obtained. In an semi-structured interview the researcher has a general topic in mind, and specific questions may be formulated once the interview is in progress, based on what the participant may say (Rubin & Rubin, 2012:31).

Babbie and Mouton (2001:289) illustrate the importance of keeping in mind that this is not a normal conversation and it should stay focussed on the purpose of the interview
at all times. The researcher was conscious of how she constructed her questions in order to obtain in-depth answers. The researcher used verbal and non-verbal communication techniques throughout the interview in order to demonstrate that she was interested in what the participant was saying and therefore she gained ample information on the experiences of the participants. The researcher asked two broad, open ended questions: “Tell me how was it for you to be admitted into the hospital?” and “Tell me, how was the rest of your stay in the hospital?”

The interview was conducted where the participant felt the most comfortable. The participant was allowed to choose the venue where the interview would take place, keeping in mind that privacy and confidentiality was of importance at all times. As far as possible the noise levels were kept to a minimum. The researcher attempted to create a therapeutic milieu during all the interviews. Prior to the commencement of the interviews, the seating was arranged in such a manner that the participant felt comfortable.

Two recording devices were used to ensure that if the one recording device failed to record there was a back-up recorder. The interviewer ensured that all equipment was in working order before the interview started. The interview adhered to all communication techniques required for a successful interview. Babbie and Mouton (2001:404) stress the importance of practising interviews before attempting to collect the data. The researcher was able to practice her interview skills during the pilot study.

Brinkmann and Kvale (2015:128) describe seven stages in the interview process. These stages were implemented during the data collection phase.

1. “Thematizing”: Ensures that the purpose of the interview and the concepts are clear. Before the interviewer started with the interviews she was clear on the goal/reason for the interview and stayed focused throughout the interview.
2. “Designing”: Before the interview started the researcher had a clear understanding of how the goal will be achieved, for example, how the interviews would be conducted, where and when, as well as what was needed to ensure that an effective interview would take place.
3. “Interviewing”: The implementation of the design of the interview unfolds at this stage. The researcher implemented the basic framework, which consists of:
introduction, building a relationship, work phase and lastly the termination phase. After the introduction the researcher made small talk and by doing this she assisted the participant to relax and feel comfortable. After this was achieved the researcher asked the two open ended questions to the participant. Prior to ending the interview, the researcher summarized what was discussed to ensure that the participant’s experiences were correctly captured and understood.

4. “Transcribing”: The researcher transcribed the spoken word into written text.
5. “Analysing”: During this step the researcher analysed the data and identified broad topics that were derived from the interviews. Thereafter the topics were divided into three major themes as well as sub-themes that supported the major themes.
6. “Verifying”: Is the process of evaluating the reliability and validity of the data that was collected. An independent coder was involved to ensure that the themes that were generated by the researcher were reliable and valid.
7. “Reporting”: Involves the discussion of the findings. Once the themes were completed, the researcher discussed the end product with the independent coder, supervisor and co-supervisor. The themes were refined and captured.

Creswell (2007:208) state that member checking is a process whereby the researcher goes back to the participants to clarify any doubts regarding the information gained. Polit and Beck (2012:196) mention that member checking takes place throughout the data collection process (interview). It may also take place during a formal process whereby the participants review a summary of the analysis.

In this study, the researcher conducted member checking during and directly after the interviews took place with the each participant. At the conclusion of the interviews the participants were also given the opportunity to add any additional information that they felt was of importance. Using this technique the researcher ensured that the data obtained reflected the true experiences of the participants.

2.5.3.2 Observations and field notes

Polit and Beck (2012:548) state that field notes are categorized according to the purpose that they will serve during the analysis and integration of information. They distinguish between descriptive notes or observational notes and reflective notes
which document the researcher’s personal experiences as well as reflections and the progress that are made in the field. Several additional notes are referred to, namely: 

**Methodological notes:** These are reflections on observational strategies (Polit and Beck, 2012:249); 

**Objective notes:** These concern the conversations that took place, including necessary information like time and place (Polit and Beck, 2012:248); 

**Theoretical notes:** These are the researcher’s thoughts about how to make sense of what is happening (Polit and Beck, 2012:249). 

**Personal notes:** These entail comments on what the researcher is personally feeling (Polit and Beck, 2012:249). The researcher focused on all of the abovementioned notes to ensure that this research study was a true reflection of the information obtained. The different notes are discussed in detail below.

1. **Methodological notes:** During the interviews the researcher attempted to make the environment as therapeutic as possible, within her means. It was noted that not all of the interviews that were conducted took place in a venue that was acceptable to the participant. Certain aspects the researcher did not have control over may have been a barrier, for example, the noise levels in the passages of the clinics where the interviews were held. Despite a sign being placed on the door requesting silence because an interview was in progress, this was not upheld by some staff members walking in the passages passing the office where the interview was being held. In one clinic where three interviews were conducted the telephone was taken off the hook and there was a chronic beeping noise. This caused the researcher to place the phone in the drawer, which assisted in muffling the noise so that it would not distract the participant or the researcher.

2. **Objective notes:** These were made in a specific note book indicating the time and place at which each interview took place.

3. **Theoretical notes:** The researcher also took theoretical notes, indicating that two participants showed signs of fixed delusions at the end of the interview. The researcher believes that the participants felt safe with the researcher and therefore shared their true reality with her. After the transcription of the interviews it was clear that although these patients displayed signs of delusion the information that was given after the questions were asked was congruent and supported what the other participants experienced. Prior to the interview these participants were viewed by the gatekeepers as healthy and it was also clear that they functioned
well in the community in spite of their delusions. Furthermore, delusions were not identified as part of the exclusion criteria. Therefore the researcher utilized their interviews as part of this study. At the end of one of the interviews with a participant it was noted that she had suicidal thoughts. This information was shared with the clinic sister who was designated to her, with the participant’s consent. All the participants received a letter prior to the interview indicating that if they felt emotionally traumatized, counselling would be arranged for further interventions. This was verbally discussed with this specific participant and she preferred to discuss the matter with the clinic sister who was known to her and with whom she felt comfortable. Although this participant did not strictly adhere to the inclusion criteria of not exhibiting symptoms of bipolar disorder it was felt that she functioned well enough and that her contribution enhanced the content of this study.

2.5.3.3 Reflective journals

The researcher left a reflective journal with each of the participants in which they could write their thoughts and feelings during the week following the interview. The participants were encouraged to write about their experiences over the period that they were admitted to a mental health care facility. The reason for the use of reflective journals was to give the participants the opportunity to write down any information that they felt was of importance, but which they forgot to mention during the interview (Badenhorst, 2010:170). The reflective journal was offered to all the participants, but they were reluctant to make use of it. All of them stated that they had said everything and did not feel it was necessary to write anything further after the interview. The researcher respected their viewpoint and did not force the issue upon them. Therefore no reflective journals were used in this study.

2.6 DATA ANALYSIS

To assist with the data analysis, the interviews were recorded with the participant’s permission and transcribed verbatim. Tesch’s method, as adopted by Creswell, was utilized during the data analysis process. Specific themes were identified by following Tesch’s specific steps (Creswell, 2009:186).

- All transcriptions were read with care to obtain the whole picture;
Only one document was analysed at first to get the feel for the whole process, the researcher wrote down thoughts that emerged in the margins;

- A list of topics was made by combining those that were similar;
- Codes were then attached to the topics, the researcher then went back to the data and assigned those codes to the relevant statements;
- Categories were then assigned to the topics to group them to indicate their interrelationship;
- An abbreviation was then used for each category;
- A preliminary analysis was done by grouping together the data for each category;
- A record of existing data was given to the researcher’s supervisor for safe keeping.

The themes generated were used to describe the findings (Tesch, 1990 cited in Creswell, 2009:176). Themes are the recurring ideas or experiences that were mentioned by most of the participants.

The themes were verified by an independent coder. Polit and Beck (2012:593) refer to an independent coder as an intercoder, as someone who is objective to the study and who codes the data, where after the differences between the codes are discussed and resolved. Codes are then refined and defined in order to strengthen the reliability of the study. The intercoder (independent coder) was given a clean data set and a guide of how the analysis was to be undertaken. Thereafter the intercoder was asked to go through the same transcribed data and field notes to independently identify themes. After a discussion between the intercoder and the researcher they reached consensus, and the final themes were identified and described. This was done to strengthen the trustworthiness of the research study.

2.7 LITERATURE CONTROL

Fouché and Delport (2011:134) support using a literature control, because it assists the researcher to have a clearer understanding of the nature and meaning of the interviews that were conducted. According to Burns and Grove (2009:91), the purpose and timing of conducting a literature control may vary from study to study. It seems to be an on-going discussion between phenomenologists when literature should be reviewed and when not.
A literature control is undertaken after the data analysis has been completed. Munhiall (2006) cited in De Vos, Strydom, Fouché and Delport (2011:91) states the importance of explaining and supporting the generated theory by conducting a literature control. After the themes and verbatim quotes that support the themes were identified, the researcher went back to the literature in order find additional data to support the findings.

2.8 PILOT STUDY

A pilot study was conducted prior to the data collection phase. A pilot study is conducted to improve and identify problems with the design (Burns & Grove, 2011: 49). During the pilot study the questions that the participants were asked were evaluated to determine if the necessary information was obtained. The researcher was also given the opportunity to practice her interviewing skills. Opportunities for improving the questions arose after the pilot study was analysed. It was noted that the researcher did not always ask open-ended questions and that some of the questions were leading the participant to say something that she did not experience directly. This could have been a barrier in obtaining the participants’ real lived experience during the admission and stay period in a tertiary psychiatric facility. These faulty communication interview techniques were avoided in subsequent interviews.

The venue where the pilot interview took place was initially prepared by the participant and it proved not to be suitably private enough, whereby confidentiality could be maintained, as the residents of the household were able to hear everything that the participant discussed. This may have led to the participant being less forthcoming regarding her experiences. Therefore, the researcher removed the participant from this venue. In the end the interview took place in the researcher’s car. Fortunately this arrangement worked well. Although the seating arrangement was within close proximity, this did not bother the participant and she shared her experiences in detail. This interview was included in the study as it contained rich data.

Polit and Beck (2012:195) state that the outcomes of the pilot study are lessons to be learned to assist the researcher in gaining important ideas of how to conduct the study in order to avoid unnecessary mistakes. One of the lessons learned in this case was
to arrange future meeting places within a formal setting and ask the psychiatric nurse (gatekeeper) to allocate a room in a clinic where privacy is attainable.

2.9 ENSURING THE QUALITY OF THE STUDY

To ensure quality research, Guba’s model of trustworthiness was followed. Lincoln and Guba (1985), cited in De Vos et al. (2007:346), suggest that the criteria of credibility, transferability, dependability and confirmability will generate information that ensures trustworthiness.

2.9.1 Credibility

Lincoln and Guba (1985) state that credibility means having confidence, not only in the accuracy of data, but also in the analysis of the data. Two aspects are of concern in credibility, namely: the manner in which the study is conducted to increase authenticity and the strategies implemented to prove credibility in the research reports (Polit & Beck, 2012:585). To ensure that the research is credible various criteria were implemented, namely:

- reflexivity
- triangulation
- member checking
- use of peer examiners
- ensuring interviewing technique
- pilot study
- independent coder (intercoder).

*Reflexivity:* Polit and Beck, (2012:589) state that reflexivity encompasses awareness that the researcher has a unique upbringing, individual morals, social and professional characteristics which may influence the research process. Therefore, it is essential that the researcher utilises a reflective journal, to limit subjectivity which may be experienced during the data collection process. It is vital that the researcher writes down her personal thoughts, experiences, previous readings which may have an impact during the data collection and analysis thereof. This should assist the researcher to be more objective and display an understanding of the participants, culture and experiences they share (Polit & Beck, 2012:589). Burns and Grove,
(2011:546) state that reflexivity is the process which the researcher searches for personal feelings and experiences that may have an impact in the study, and it is important that these experiences are included in the study.

The researcher is an Afrikaans speaking white female who has been exposed to many different cultures and situations during her career, as a psychiatric nurse. The researcher also has a qualification as an advanced psychiatric nurse and worked in a variety of settings with bipolar disorder patients. Therefore she felt that she would be able to be as objective as possible, but she also had the insight that she may experience subjective feelings. The researcher prepared herself for any given situation and went with an open mind into the interviews, not knowing what to expect.

In this study the researcher was exposed to participants from different cultures; there were three coloured participants, two of them Afrikaans speaking and one English speaking, one English speaking Indian participant, four Xhosa speaking black participants and one white Afrikaans speaking participant. Three of these interviews were held in Afrikaans as the participants' verbalised that they cannot express themselves effectively in English. In one interview the researcher had to make use of an interpreter as the participant only had full command in Xhosa. The researcher spent time with the participants in their chosen environment where they felt safe to build a trust relationship with the participant.

The researcher reflected on her own subjective experiences and was open to how she felt in certain situations. By using this reflective strategy and field notes, it also ensured that the researcher did not become emotionally involved with the participants and therefore she was still able to interpret the findings.

**Triangulation:** Maxwell (2013:128) states that triangulation is when a variety of methods are used during data collection to explore an occurrence. Triangulation is used to minimize the danger of chance associations and biases due to the use of only one method. Triangulation assists the researcher to make sense and understand various aspects of the research results. It is almost like sucking on a sweet where different layers of colours appear, as the sweet becomes smaller, until you reach the white core. In this study the researcher used a variety of data gathering methods such as interviewing the participants on their experiences during their admission and stay.
in a tertiary level psychiatric facility in the Eastern Cape, South Africa. The interviews assisted the researcher, to understand their personal experiences during their admission and stay. Observations and detailed field notes were captured by the researcher.

**Member checking:** Member checking or participant validation as stated by Maxwell (2013:126), is feedback on the information gained from the participant who gave the information. This is important to ensure that the information gained is a true reflection of what the participant meant to say. Furthermore, it assists with ruling out any biases or misinterpretations from the researcher’s point of understanding (Polit & Beck, 2012:590).

After the researcher gave a summary of the completed interview to the participants, the participants were asked to check their own interview to ensure that what they said was interpreted correctly (member checking). Data analysis triangulation was used, whereby an independent coder, the researcher’s supervisor, co-supervisor and the researcher were responsible for the coding and identification of the themes. They then collaborated and reached consensus to ensure credibility.

**Peer examination:** Peer examination or peer review and debriefing, as discussed by Polit and Beck (2012:594) is another quality enhancement strategy, whereby peers review and study various facets of the study. The researcher consulted her colleagues and discussed the research process and findings with them because of their extensive knowledge of the qualitative research process and knowledge in caring for patients with bipolar disorder.

**Ensuring interview skills:** Before the data collection starts the researcher should ensure that her interviewing skills are refined and that she avoids leading the participant in a specific thought path. Therefore it is important to focus on the manner in which the questions are phrased (Brinkmann & Kvale, 2015:75). In this study, the researcher discussed with her colleagues and read about strategies and processes to obtain clarity on certain issues regarding interview techniques. A pilot study was conducted and analysed, which assisted the researcher to observe effective and ineffective communication techniques utilised. The researcher was guided by her
supervisor to gain insight into the mistakes made during the pilot study. These flaws were corrected during the other interviews.

A pilot study: A pilot study is defined as a minor form of a planned study, used by researchers to improve phases in the research process (Burns & Grove, 2011:49). A pilot study was conducted and various challenges arose, as previously discussed. These were addressed and it was ensured that the researcher would not make the same mistakes when collecting the data from the other participants.

An independent coder (intercoder) was used to ensure that no subjective bias crept in from the researcher’s past experiences. The researcher compared the data that she analysed with the data of the independent coder to compare and identify similarities, differences and any discrepancies. The independent coder and the researcher used Tesch’s steps of data analysis, which was done in a step by step manner (Creswell, 2009:186). An independent coder was utilized to ensure that the information the researcher attained from the data was trustworthy, as was previously discussed in this chapter.

2.9.2 Transferability

Polit and Beck (2012:585) state that transferability or applicability refers to the extent that the findings can be applied to other contexts. It is argued that in a qualitative study each situation is unique and therefore cannot be transferred or compared to another context. On the other hand, Lincoln and Guba (1985), as cited in Polit and Beck (2012:180), state that original research must present sufficiently detailed data to allow comparison and therefore transferability. According to Polit and Beck (2012:585) one of the strategies from Lincolin and Guba’s Framework to assist with transferability is to use a dense description of the method and findings. The researcher gave a dense description of the research methods and findings to provide enough data on the background of the problem and the participants to the reader. Purposive sampling is a technique whereby the researcher chooses specific circumstances and situations to suit the selected study (de Vos et al., 2011:392). Therefore, purposive sampling was implemented as this strategy of selection ensured that the researcher could select participants who were the most informative.
Burns and Grove (2011:291) state that *inclusion sampling criteria* are the characteristics that participants must have to be part of the sample, while *exclusion sampling criteria* indicates that certain characteristics can cause a participant to be excluded from the sample. Inclusion and exclusion criteria were utilized to ensure that the participants suited the stipulated research study. Utilizing this strategy also ensured that a rich description would be provided and would thus make this study more transferable. Participants were chosen who had easy access to the clinic where the interview took place. Participants were selected who had the ability to provide rich data according to the experiences that they had in the tertiary psychiatric facility. De Vos *et al.* (2011:392) state that it is sometimes appropriate to select a sample on the basis of one’s knowledge of a population, its elements and the purpose of the study. This will assist the reader to establish whether the study’s findings are transferable to other settings.

### 2.9.3 Dependability

Dependability means that if a study is repeated with similar participants, the findings should be similar to the findings of the original study (Babbie & Mouton, 2001:278). The following strategies will be implemented to ensure dependability:

- a dense description of the method used
- independent coding
- code - recode
- use of peer reviews (Botma *et al.*, 2010:233).

A dense description, or as Polit and Beck (2012:595) describe, a thick description, refers to a rich, detailed and graphic description of the research setting. As stipulated previously, the participants who were selected were female patients who were between 18-65 years old. These patients had to present with a manic episode prior to admission. The setting where the interviews were conducted was discussed as well as the challenges encountered. The research design and method utilised was also discussed. In chapter three, the experiences that were observed were analysed and coded into three main themes, with additional sub-themes. Verbatim quotes were also included, analysed and discussed in the study. The research processes were followed
and described throughout the study to ensure that the study was accurate and gave a clear picture of understanding to the reader.

Mills and Birks (2014:114) discuss three types of coding, initial coding, intermediate coding and advanced coding. For this study, the researcher focussed on initial coding and intermediate coding. These terms will be referred to as coding and re-coding. Coding is conducted when the text of the transcribed interviews is broken down into manageable pieces where after keywords are attached to these pieces to assist with later recovery during the data analysis phase (Brinkmann & Kvale 2015:363). Re-coding or intermediate coding then follows, this involves further development of categories or themes and sub-themes after the keywords were identified during the coding phase. Re-coding is repeated until saturation of the themes occurs (Mills & Birks, 2014:114). The data that was coded and re-coded was left for a period of two weeks, after which the researcher recoded the data again. The themes which were then generated were compared with the first coding and recoding process and it was observed that the same themes appeared as with the first coding, therefore increasing the dependability of the study. To ensure dependability the researcher asked her peers who specialized in research methodology to scrutinize the themes that were generated and provide critical feedback.

2.9.4 Conformability

Confirmability means that if other researchers should analyse the same data, they should reach the same outcomes or conclusions. Confirmability refers to the objectivity or neutrality of the data. Using a reflective journal during the research study will enhance neutrality. Triangulation, indicating the use of more than one data collection method, will also support neutrality (Botma et al., 2010:292). In this study, the researcher tried to ensure neutrality by using the following two strategies that have already been discussed as well as a conformability audit which will now be discussed:

- triangulation
- reflexivity
- confirmability audit
Triangulation and reflexivity had already been discussed. A confirmability audit is when the researcher can provide all the evidence that substantiates the findings and analyses by means of auditing (de Vos et al, 2011:421). Mills and Birks (2014:227) state the importance of leaving an audit trail, by doing this the researcher will secure credibility in the process whilst conducting the study, in the case that someone wants to confirm the objectivity and neutrality of the study. The researcher has kept the relevant data namely: the field notes, audio data of the interviews, transcriptions of the interviews as well as the coding process. The data will be stored for a five year period as officially required.

2.10 ENSURING ETHICAL STANDARDS

Ethical guidelines assist the researcher to take responsibility to develop their own ethical standards to adhere to when conducting any form of research (Strydom, 2011:114). The following ethical standards were utilised.

2.10.1 Avoidance of harm and beneficence

The most important rule of social research is that no harm should be done to the participants. Although the main focus is emotional harm, physical harm may never be ruled out (Strydom, 2011:115). Burns and Grove (2011:107) state that beneficence inspires to do good and to do no harm. The researcher ensured that the participants were fully aware of what to expect. The possible benefits (beneficence) were discussed with participants prior to commencement of the data collection. Participants were informed that there would be no instant gratification or immediate benefits from the study. However, should they be re-admitted to the facility there may be possible gains in the manner in which patients are nursed. Although this was not evaluated, some of the participants may have benefitted from having someone from outside “listen to their stories”.

Burns and Grove (2011:118) state that participants have the right to protection from distress and harm. Distress and harm in research may be physical, emotional, social, and economic or any combination of these factors. The researcher was aware of the participants’ verbal and non-verbal behaviour throughout each interview. The participants were observed closely to determine if they were experiencing any stress. If any harm was caused, an opportunity would have been given to the participant to
debrief and receive counselling from a therapist. As discussed earlier one participant did share that she experienced suicidal thoughts and this was addressed with the participant’s consent. She also stated that she would prefer going to the known psychiatric nurse, with whom she felt comfortable, instead of a counsellor provided by the researcher.

Harm was also avoided by appointing gatekeepers in the different areas where the interviewing took place to observe the process and to support the participants during the study. The participants were informed that they could have withdrawn from the study at any time that they wished. Some of the participants chose the venue which they felt was the most comfortable to have the interview in together with the assistance of the gatekeeper. The researcher made sure that these venues were private and comfortable.

2.10.2 Voluntary participation

According to Burns and Grove (2011:125), voluntary consent and thus participation must be obtained prior to data collection. Rubin and Rubin (2012:88) state that no one should be forced to participate in a research study. The researcher therefore ensured that all the participants received adequate information regarding all aspects of the study. Hence, the participant was able to make an informed decision whether she would like to take part in the study or not. The gatekeeper made the initial contact and obtained permission from the participant and ensured that each participant did not feel obliged or coerced into taking part in the study. Thereafter, the gatekeeper informed the researcher that she could continue to gain information from the participant.

The selection of participants was conducted in a fair manner. The participants who were chosen suited the inclusion and exclusion criteria thus they were included in the study. No coercion was exerted upon the participants to take part in this research study. Each participant also received an information sheet regarding the study (see Annexure B).

2.10.3 Informed consent

A core requirement of any research study is informed consent. Informed consent ensures the participants understand the nature of the study being conducted, so that
they are aware of the possible risks and that they are not forced to participate. A signed statement by the participant is necessary to indicate that the researcher obtained informed consent (Rubin & Rubin, 2012:91). Brinkmann and Kvale’s (2015:93) definition of informed consent supports the previous statement, they stated that informed consent entails informing the participants about the purpose of the study, the main aspects of the design, as well as any possible risks or benefits from participation in the study. Furthermore, it involves voluntary participation and they can withdraw at any time of the study.

Prior to data collection and after the gatekeeper made the initial contact with the potential participant, the researcher met with the participant and discussed the purpose of the research study. The participant was given an opportunity to ask any questions, which were answered by the researcher. None of the participants requested the presence of the gatekeeper. Each participant signed a consent form (see Annexure C) as an indication that she understood what the research study was about and the role that she played in it. To ensure confidentiality, none of the participants’ names were made known in the research results and findings.

2.10.4 Deception of subjects and/or respondents

Deception is defined as withholding information about the study and providing the participants with false information (Polit & Beck, 2012:154). The participants were fully informed of the expectations and outcomes of the study. The researcher was truthful and did not give false information to the participants.

Permission and consent were obtained from all the role players, prior to data collection. A request to commence with the study was made to the Department of Nursing Science Research Committee as well as the Faculty Research, Technology and Innovation Committee. Ethical permission was also sought from the institutional Research Ethics Committee (Human) of the university (see Annexure D). Therefore, the researcher had an obligation to work within the ethical and legal standards as set out by the abovementioned committees.

The participants were informed that they may decline to take part in the study or withdraw at any stage of the research process. They were not coerced to take part in
the study. Gatekeepers who were known to the participants were available to assist the participants and refer them for emotional support if the participant indicated that she was experiencing difficulty in coping due to what was discussed in the interview. Fortunately, it was not necessary to refer any participant for emotional assistance. All relevant information was given to the participant before the interviews took place giving the participant adequate time to make an informed decision.

2.10.5 Violation of privacy/confidentiality

Every human being has the right to privacy and it is her decision to whom, when and where her attitudes, beliefs and behaviours may be revealed (Strydom, 2011:119). In this research study, data was collected from a vulnerable population. Therefore during all the stages of the study, a sensitive approach regarding the participant’s privacy and confidentiality was maintained. The participants’ interests were protected at all times.

Anonymity indicates that no one, including the researcher should be able to identify any participant after the data has been collected (Strydom, 2011:120). In the case of this study, this was not possible as the researcher herself collected the information by interviewing the participant herself. The participant was thus known only to the researcher and the gatekeeper. Hence, to ensure confidentiality, the gatekeepers were asked to keep in confidence all who participated and the researcher removed all identifiable data from the transcriptions. The participants were informed that no name or other identifiable measures will be used to exploit them in any way when reporting the gathered data (Burns & Grove, 2011:117). Anonymity was maintained while the findings were written up. The researcher made use of numerals to identify the different participants, for example, participant number 1; participant number 2. All transcriptions of interviews and field notes will be stored in a secure storeroom and shredded after a period of five years as requested by the NMMU’s ethics committee.

2.10.6 Denial of treatment

Denying of treatment for the purpose of research is unethical (Strydom, 2011:121). It was envisaged that if a participant had a doctor’s appointment to attend during the planned time that the researcher had made to conduct the interview, other arrangements would be made for the interview. Fortunately, this did not happen during the data collection period. The researcher planned prior to data collection two interview
dates in case a participant could not make the first date due to unforeseen occurrences, such as a doctor’s appointment or transport problems. This was done to ensure that the participant was not prevented from receiving medical treatment.

2.10.7 Compensation

Strydom (2011:121) states that it is reasonable to refund participants for costs spent on the study, such as time away from work or transportation fees. However, it is not seen as a good idea to pay participants for participating in a study. The researcher addressed this matter by reimbursing the participants who had to use their own money to travel to meet with the researcher for the interview. No participant was paid to share any information. It was suggested by the researcher that the participant could have the interview at the clinic on the day she obtains her monthly treatment. This did not inconvenience the participants’ finances, although it may have extended the time spent at the clinic. The other option that some participants chose was that the researcher met with the participant at their own home. The researcher did clarify this matter during the first contact made with each participant. The researcher made sure that the participants were compensated for all expenses.

2.10.8 Debriefing of participants

Debriefing is part of an interview whereby participants can reflect on their emotions after data collection has taken place. Participants may experience a variety of intense emotions and often the interview may have unanswered questions. Research projects are viewed as learning opportunities for the researcher and participants. Hence, debriefing is an ideal opportunity to complete the experience for the participant (Strydom, 2011:121). After data was collected from a participant the researcher assessed the participant’s verbal and non-verbal behaviour. If during the data collection period it appeared that a participant experienced difficulty in coming to terms with issues that were discussed, the researcher would have referred her for a counselling session at the researcher’s expense. Fortunately this did not happen. The researcher did discuss any emotional experiences and questions a participant had at the end of the interview. All participants appeared to leave the interview feeling comfortable.
2.10.9 Actions of competence of researchers

It is the researcher’s obligation to ensure that she is knowledgeable, honest and skilled to conduct a research study (Walliman, 2006 cited in Strydom, 2011:123). Before commencement of this research study, the researcher ensured that she was skilled in conducting interviews and making field notes. The researcher viewed a variety of resources and obtained the necessary knowledge and skills to do so. A pilot study was conducted before commencement of the research to assist the researcher in evaluating any shortcomings and or additions that needed to be made. Peer reviews and gatekeepers were utilized throughout the study and ensured that the study was conducted in a skilled and honest manner.

2.11 CONCLUSION

In this chapter the different processes to gain the necessary information to be able to conduct a research study were indicated, as well as the limitations and recommendations that were experienced. In the following chapter, the reader will be informed about the results, the themes that were obtained and the literature control that was conducted to support the findings of this research study.
CHAPTER THREE

DISCUSSION OF FINDINGS

3.1 INTRODUCTION

In the previous chapter the research design and methodology were discussed. This chapter presents a discussion of the findings of the data which were obtained from the interviews. The research population is presented with a description of the participants. Thereafter, the findings of the study are discussed in the form of three themes, each with a series of sub-themes. The themes and sub-themes are presented in the form of a table in order to have an overall picture of the findings. The findings of the study are supported with literature sources which strengthen the results of the interviews.

3.2 CHARACTERISTICS OF THE PARTICIPANTS

The research sample consisted of nine female participants diagnosed with bipolar disorder. All nine participants ranged between 20 and 55 years of age. Two participants were divorced. One participant was married although her husband had been admitted to a long term mental institution. Six of the participants were never married. All of the participants lived in brick houses with between two to four rooms, with running water and electricity. Three participants stayed with their parents, two had their own homes and four participants stayed with family members. None of the participants had permanent employment. Five of them had never completed schooling, one participant started with higher education but dropped out of the course during her first year of study due to her illness.

All the participants experienced a manic phase prior to admission and were admitted for a period of at least two weeks. Eight of these participants were admitted as involuntary patients under section 32 of the Mental Health Care Act (2002). One participant’s most recent admission was as a voluntary patient, but she had numerous involuntary admissions prior to her last one. Although these participants were stable when the interviews were conducted, two of the participants displayed certain fixed delusions. However, these delusions did not impact on the data that was obtained.
The researcher experienced difficulties finding female participants between the ages of 18 to 65 to partake in the study. The contact details of potential participants that were obtained from the gatekeepers often had changed by the time the study began, which made it impossible to contact these people. Other possible participants were not available to be interviewed due to the deterioration of their mental condition. The pilot study that was conducted was successful and therefore the information obtained was included in the study.

3.3 FINDINGS AND INTERPRETATIONS

Three main themes were identified after the data was collated and extensively analysed. These themes were recurrent topics that the participants shared. These themes and sub-themes are displayed on the following page in table 3.1. Thereafter, the themes will be discussed and analysed.
Table 3.1: Experiences of female bipolar disorder participants during admission and stay in a tertiary level psychiatric facility

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3.3.1 Theme 1: The participants described a variety of negative emotional experiences during their admission and stay in a tertiary psychiatric facility

Bipolar disorder is a condition that affects a person’s mood. A person with bipolar disorder experiences periods of depression and episodes of mania or hypomania. In this study, a participant had to display a manic episode prior and during the initial admission to a psychiatric facility. Manic episodes are displayed as an abnormal, persistent, elevated or irritable mood, for at least one week (Fortinash & Holoday Worret, 2012:230). Therefore, the intensity and fluctuation of a patients’ mood in the manic phase may have an influence on their emotional experiences during their admission and stay at a tertiary psychiatric facility.

One of the challenges of bipolar disorder is the extremes of emotion that the individual undergoes. Indeed people with bipolar disorder struggle to regulate their emotions which may lead to emotional highs and lows (Townsend & Altshuler, 2012:326). In this study, the participants experienced many negative emotions during their admission and stay at a psychiatric facility. The emotions experienced by the participants included frustration, anger, sadness, humiliation, fear and powerlessness. Interestingly, none of the emotions experienced included elation or happiness, which is usually associated with a manic mood. These emotions were placed into sub-themes which will be discussed in the next section.

Kotze (1998:5) states that a person must always be viewed as a whole, consisting of three dimensions, namely; body-psyche and spirit. These dimensions do not exist as single components, but are inter-linked to each other. In this theme the focus will be on the psyche and spirit, although the person must be viewed as body-psyche and spirit throughout this study. The belief is that the psyche is fundamental to man’s thought, intellect, awareness, emotions, perceptions and experiences. The patients’ psyche is a personal experience as she is a unique being, and therefore she may react in a different manner to other patients with the same experience. The spiritual dimension signifies the centre of humanness. The spiritual dimension is the seat of, self-awareness, initiative of relationships and giving of meaning, judgement and the ability of coherent choice and decision making as well as divine existence. A desire for a responsible and a dignified existence is unique to every person, which will
influence a goal directed existence. In essence, the spiritual being of man is continually growing and changing (Kotze, 1998:6). Experiencing emotions both negative and positive are part of the psyche’s functioning.

The patients who are admitted are unique persons, consisting of a matchless body-psyche-spirit. Therefore, psychiatric nurses need to be consistently aware of the patients’ individuality and thus, the care that these patients receive must represent the patient’s uniqueness.

3.3.1.1 Sub-theme 1.1. The participants experienced frustration during their admission and stay in a psychiatric facility

It was found that the participants were frustrated during their admission and stay at a psychiatric facility. Frustration is a feeling of being annoyed and impatient because you cannot do what you want to do (Hornby, 2000:479). The following comment was made by one of the participants, which supports this sub-theme:

“….you never had a choice! You all have to do one thing together.”

During the interview the researcher observed from the participant’s non-verbal communication that on re-counting her experience she felt frustrated that she was locked up and did not have the authority to make her own choices or change her situation. Most of the participants found the experience of being locked up as a negative event.

“Yo!…. I hated that part, I swear (laughs). I hate it.”

The participant above experienced frustration at being unable to come and go as she wanted. When she verbalised her frustration, it was transformed into feelings of anger which brought her to tears. Other statements that were made by the participants focused on the restricted movement that was forced on the patients due to being locked up behind gates. A study was conducted by Hem, Norveldt and Heggen (2008:630) on the consequences that admission to a psychiatric institution can have on patients diagnosed with bipolar disorder. They explain that the participants understood that they were manic when they were admitted, but they also felt that they were not being heard or believed, and often they did not understand the reason for
being admitted, which may have caused them to react with frustration. The following
participant felt frustrated because suddenly she did not have the right to do what she
wanted.

“You are not allowed to be independent and you can’t do what you want.”

Patients who are admitted to a locked ward have limited privileges. They do not have
freedom of movement outside the ward, as they are locked indoors and are not allowed
to go outside or go to the nurses’ office if they may need something. The patients are
cared for behind a big steel gate that is locked with a padlock. They may feel like they
are being incarcerated for a crime. The nursing staff members have absolute control
over the patients’ movements. Few studies have been conducted on what being
locked up in a psychiatric ward means to patients. However, the few studies that
addressed this problem show that it may lead to “feelings of confinement and impaired
autonomy” (Haglund & von Essen, 2005:511). The researcher of this study supports
the abovementioned quote as the participants in the current study felt frustrated that
they could not function independently. Each participant dealt with her own frustrations
in her own manner, some of them reported that they cried and others became verbally
aggressive. Frustration can evolve into aggression, because no matter what the
participant says or does she cannot change the immediate situation. Frustration may
lead to aggression in a patient diagnosed with bipolar disorder, especially if it is not
managed timeously (Bernstein & Saladino, 2007:306).

3.3.1.2 Sub-theme 1.2. The participants’ were not able to move freely and not
understanding the situation caused them to be angry

Some of the participants were angry for being admitted to a psychiatric facility. They
did not feel that they were consulted about their illness and treatment, and this angered
them. According to Hornby (2000:22), aggression is defined as feelings of anger or
hatred that may result in threats or violent behaviour. Fortinash and Holoday Worret
(2012:701) define aggression as acting out behaviours that may cause harm to self or
other people. Bipolar disorder patients may experience irritability which can often lead
to aggression, and indeed most patients experience aggression during the manic
phase. This can present as verbal or physical aggression (Crowe, Inder, Carlyle,
Wilson, Whitehead, Panckhurst, O’Brein & Joyce, 2012:297). The participants who
were interviewed did not display overt aggression. They were all interviewed at least 6 to-12 months after their discharge from a tertiary psychiatric facility. Therefore, the intensity of the anger that they experienced may have diminished due to the time that had lapsed. It was noted that their voices did indicate a level of aggression. However, when recounting their experiences in the hospital, some participants indicated that at the time they experienced feelings of anger. One of the participants explained:

“…. I am not supposed to be here. I’m supposed to be at Dora (a hospital in the Nelson Mandela Bay Municipality) or at home.” (The participant’s voice became loud, and her facial expression showed anger.)

“I hated that part, I swear (laughs) I hate it. I had an imagination that I was in prison…” (This participant sounded angry.)

The participants above expressed a certain amount of anger, because they were subjected to situations that made them feel irritable and aggressive. One of the main sources of their anger appeared to be the behaviour of the nurses. The quote below supports this statement and the participant’s voice became angered when she said the following.

“die sisters was… van die nag sisters het n AAKLIGE ATTITUDE gehad hulle was ONTSETTEND ongeskik” Translation: the sisters were… the night sisters had a TERRIBLE ATTITUDE they were EXTREMELY rude.

This participant said that she asked the night staff why her medication was changed; she verbalised that they could not give an explanation, and were rude to her. She felt angered in the manner in which the nursing staff communicated with her.

Elder, Evans, Nizette and Trenoweth (2014:447) state that people with bipolar disorder may become highly irritable and aggressive when experiencing certain events. The quote below indicates that poor interpersonal communication on the part of the health care practitioner may lead the patient with bipolar disorder to become angry.

“…. Wat vir my baie moeilik was en kwaad gemaak het aan die begin wat ek daar aangekom het ummm was dit baie keer die sisters wat in die aande vir my moes
The participants indicated that they wanted to talk to the nurses, but they were often ignored by them. This was demonstrated by the psychiatric nurse who lifted her hand and said “talk to the hand”. In other words, the patient can say whatever she wants, but the nurse will ignore any comments made by her. According to Duxbury and Whittington (2005:474), poor communication is a forerunner of aggression in people with bipolar disorder. Neurocognitive deficits seen in patients with bipolar disorder are verbal memory, executive functioning and attention (Duxbury & Whittington 2005:474). In addition, the mood component of the bipolar disorder patient may influence her experiences of situations (Depp, Mausbach, Harmell, Savla, Bowie, Harvey & Patterson, 2012:218). The mood component in these bipolar patients clearly influences their experiences. An elated manic phase is associated with pleasure and may lead to behaviours outside the persons control, for example, insomnia, grandiose delusions, life is fantastic (Crowe et al., 2012:297). Yet, patients not experiencing irritable mania may experience life as unpleasant and this feeling may negatively influence their relationships with others and may result in aggressive behaviour (Crowe et al., 2012:297). In this study, it was evident that the participants became irritated and aggressive due to the manner in which they were communicated to by the nurses, due to their frustration at being admitted to a tertiary psychiatric facility and due to the limits placed on their freedom of movement in the ward. In addition to feelings of aggression, sadness was another emotion experienced by the participants.

3.3.1.3 Sub-theme 1.3. The participants experienced sadness at having to stay in the hospital

The participants expressed a sense of sadness regarding their admission and stay at a psychiatric facility. Sadness is the opposite feeling to happiness, and when it occurs a person experiences no joy (Hornby, 2000:1037). Bipolar patients experiencing a
manic phase do not often exhibit sadness, although this has been observed (Oosthuizen, Emsley, Niehaus & Koen, 2008:260).

From a psychiatric viewpoint, sadness is associated with loss, pessimism, despondence, hopelessness and emptiness (Reighly, 1988:57). All the participants expressed this feeling during the interviews. Patients diagnosed with bipolar disorder may experience rapid mood swings, which means that one moment they are on top of the world, feeling elated and euphoric and the next they are feeling sad and depressed (Mehta & Calabrese, 2005:10). Depressive symptoms are part of the clinical picture of a person with bipolar disorder. During this stage patients may experience more emotional pain due to the fact that their thoughts are negative and they may feel that they are caught in a hopeless situation (Kniesl & Trigoboff, 2013:368). All the participants mentioned that they were saddened by their admission and stay in the tertiary psychiatric facility. They felt hopeless, caught in a situation where they did not have the control or power to change it. If patients do not feel in control they may experience sadness indicated by tears, which may lead to suicidal thoughts as demonstrated by the quote below.

“Ek wil nooit weer soon toe gaan nie want wat sê hul as ek soon toe gaan?. As dit weer kom sal ek myself regtig self dood maak. Ek sal nie cope nie…. (starts to cry)”

Translation: I never want to go back, because what will they say if I go back? If I have to go back again I will kill myself, I cannot cope… (Starts to cry).

A high incidence of attempted and completed suicides is linked with bipolar disorder. According to Breznosckakova (2012:121), 25% to 60% of bipolar patients have attempted suicide at least once in their lives. Risk factors that may contribute to this high incidence are psychosocial stressors, for example, being admitted to a tertiary psychiatric facility, family history, hypomania or mania and clinical features such as hopelessness, agitation, dysphoric mania, depressive mixed states and comorbid disorders (Breznosckakova, 2012:121).

Some of the participants felt lonely and sad after being admitted into a psychiatric facility because they were removed from what they considered to be a safe environment, an environment where they were able to move around freely and do as
they wished. Sadness may also occur when patients are removed from loved ones and their support systems. The loneliness and accompanying sadness were expressed by the participant below.

“The rest of the day you just sit alone on your bed or with other patients and thinking of everything, feeling sad and lonely maybe.”

Although the participants were surrounded by other patients they may still have felt lonely, because they did not know the people who were incarcerated with them. A variety of factors may influence the patient to feel lonely, for example, the patient's admission may lead to confusion, fear and a sense of losing control as well as the stigma related to her admission to a psychiatric facility. The patient may also isolate herself, which leads to the feeling of loneliness (Reed, 2008:86). Furthermore, the other patients were all mentally ill and may not have been able to communicate, reach out or build a relationship with the participants, due to their inability to socialise. Skorpen, Thorsen, Forsberg and Rehnsfeldt (2014:160) discuss the importance of patients needing a relationship with the staff, which is built on confidence and trust, ensuring that the patient does not experience loneliness and rejection. In a study conducted by Clarke and Winsor (2010:244), it was noted that all participants felt lonely during a stage of their hospitalisation. Once admitted into a psychiatric facility, some of the participants felt that they had lost their autonomy regarding their daily living activities. Such thoughts of disenfranchisement may sometimes trigger feelings of sadness (Crowe et al., 2012:299).

Sadness may be experienced due to being taken out of their familiar environment where they have relationships with family, friends and or neighbours who support and understand them. Suddenly they find themselves in an environment where they may seem to have no common ground or relationships, therefore an increased feeling of loneliness may occur.

The patients have lost independence as they are bound to follow a ward programme and do not have the independence they had before their admission. Furthermore, being admitted against their free will, may make them feel humiliated in the situation that they find themselves in and intensify the feeling of loneliness, which may reflect in them feeling sad. For a number of the participants, a contributing factor to their
feelings of sadness may have been the experience of feeling humiliated, as will be discussed in the next sub-theme.

3.3.1.4 Sub-theme 1.4. The participants felt humiliated and exposed

The participants stated that they felt humiliated during their admission and stay at a psychiatric facility. Humiliation is defined as the feeling of being reduced to a lower point in one’s eyes or others’ eyes (Svindseth et al., 2007:47). A few feelings associated with being humiliated are feelings of being disrespected, powerlessness, loss of dignity and shame. In the context of this study, it was an emotion that the participants experienced when they were exposed to verbal or physical abuse. A participant stated that male security guards forcefully removed her clothing so that the psychiatric nurse could inject her in her buttocks. They may have felt inferior and ashamed of themselves due to the disrespectful manner in which they were verbally and physically treated. To be forcefully stripped naked in front of anyone, therefore without consent from the patient, may make them feel extremely humiliated. A patient’s body is concealed under clothing and viewed as private by the patients; for anyone to view their anatomical structure may make them feel a total loss of dignity.

Svindseth et al. (2007:47) state that one of the main causes of humiliation during the admission process was that the patients did not understand why they were removed from society. The participants in this study also felt humiliated by the admission process which of itself was often degrading to the participant. Most of the participants were admitted against their will, and were kept in a 72 hour observation unit before being transferred to the tertiary psychiatric facility. In the 72 hour unit they had to sleep in a dormitory with unknown female patients, of whom they may even have been afraid. Suddenly they were no longer in their own environment where they felt safe. They were now subjected to the care of strangers and they could do nothing to change the circumstances. Simply being admitted indicates to the patients that they do not have the ability to cope with life stressors. Therefore they may feel stigmatised, which aggravates the feeling of humiliation.

One aspect that the participants experienced was their loss of dignity and privacy. The participants had to shower with fellow patients; up to three patients were placed in the shower at a time, where they were watched by staff and fellow patients, while they
washed themselves. The staff’s presence during bathing time is viewed as a precaution to ensure patients’ safety, as some patients may be unpredictable and may practice harmful behaviour to themselves or others. Even though this may be explained to them, the participants felt a loss of privacy that led to feelings of humiliation due to exposing their bodies to complete strangers.

“…we are three in the shower, we are naked. All of the ladies are naked. We are pressurized: “Come on. Come on!” everything like that…”

“we always have a bath before five in the morning because that’s how the nurses bath all patients, before five you see…. And she stands and she cleans four of us at a time……it’s the nurse that’s doing it now, so we can’t say we don’t like it or whatever but she is in charge of us and I feel it’s bad…."

When a person is naked she may feel exposed to the world and there are no barriers, she is vulnerable, emotionally as well as physically. To be stripped of all your clothing is a humiliating experience, especially if you know that you are being watched by strangers who in some cases were apparently male nurses. The participants did not know the routine of the hospital when they were first admitted. Hence, they were confused and frustrated at being expected to get up so early to take showers. Baumeister (1997) as cited in Svindseth et al. (2007:47) indicates that humiliation can lead to self-destructive behaviour such as attempted suicide. Wood, Giordano-Beech, Taylor, Michela and Gaus (1994) as cited by Svindseth et al. (2007:47) state that humiliation is also linked to social isolation, which may develop into an anxiety disorder. The following statement demonstrated the undignified treatment experienced by one participant possibly leading to the feelings of humiliation.

“All I want to say is that they must not call men if we are going to be injected, they must call woman…yes, they call men and say the men they must grab us, strip us to our underwear and they see us naked.”

Based on the above quotation, it seems that the hospital staff members did not act in a respectful manner towards the patients. Allowing male nurses to become involved in the bathing procedures of female patients or in the management of aggression in the ward is not acceptable. Such behaviour may make the patients feel that they are
not worthy of respect, thus strengthening the feelings of humiliation. These patients had already experienced being admitted against their will to a hospital with an unfamiliar environment causing them to feel that their lives were out of control. Svindseth et al. (2007:53) discuss this aspect in a study concerning patients’ experiences of humiliation in the admission process to acute psychiatric wards. The patients in the study reported that they felt they were treated as inferior persons. They state that when the multi-professional team listened and reacted in a coherent, helpful manner they experienced less humiliation.

In a study by Johansson, Skärsäter and Danielson (2009:248), it was found that control overshadowed the health care environment of a locked ward. The staff members felt it was their duty to be in control and master the situation. The patients had no control emotionally or physically in this environment and were totally left in the hands of the staff. They were dependant on staff for their care and freedom. The patients experienced feelings of captivity, impaired self-government and lower satisfaction of care which led to aggressive incidents (Johansson et al., 2006:248). Once humiliation has been experienced the patient may fear what will happen next. The problem of fear will be discussed in the following sub-theme.

3.3.1.5 Sub-theme 1.5. The participants experienced being residents in a locked up unit as frightening and provoking fear

The participants shared their feelings of fear during their admission and stay in a psychiatric facility. They did not have a clear understanding of what it means to have bipolar disorder and were afraid of where the symptoms and their illness could lead. Fear is defined as a bad feeling when you feel you are in danger, when something frightens you (Hornby, 2000:427). According to Elder et al. (2014:525), fear is defined as a response to a known threat and is expressed in the same manner as anxiety. Fear may be caused when a person does not understand an event and does not know what will happen to them next. Not knowing what to expect causes anxiety that is experienced as fear, the fear of the unknown. Two participants expressed their fear as follows:

“… they inject me say for for….. two times a day. They don’t explaining what was the injection for. It was so painful it was as if uh,....”
“I am really afraid and really afraid the way that is keeping on coming this sickness.”

The first participant expressed fear at having to be injected twice a day. Fear of injections is not uncommon among patients, the needle may resemble pain that will be felt and the manner in which it is administrated may be fear provoking. The second participant above expressed that the mental illness she was suffering from caused her life to be out of control and she feared the future. She was fearful of the symptoms and did not understand the disease process, symptoms and the role of the treatment. She was only aware that the behaviour she displayed when she became ill caused her to be admitted to a hospital. Other participants expressed their fear as follows:

“I was very scared of being traumatized”

“I was scared. I was a bit scared because I thought that, I mean I haven’t been to hospital…”

“ek was bang vir die mense om my. Van hulle hulle was, hulle was……een het met my baklei…” Translation: I was scared of the people around me, some of them… one had a fight with me;

The fear of the unknown may have had an influence on the intensity that the participants experienced fear. A study by Jeffs, Rose, Macrae, Maione and Macmillan (2012:433) supports the finding that patients fear that they may be harmed by staff or by other patients. In the previous quotes two stressors are mentioned. First, is the fear of the unknown (quote one and two), as they do not know what to expect of the unit, the staff in the unit, the routine as well as expectations – what is allowed and what is not allowed. Stuart (2013:218) states that fear has a specific foundation or matter that the person can recognise and define.

Fear is caused by a physical or psychological experience to a threatening situation and therefore, produces anxiety. A physical response to anxiety is the fight or flight response described by Cannon (1932) as cited by Fortinash and Holoday Worret (2012:88), whereby the body alters internally without a cognisant effort. Two types of autonomic responses may occur, namely, parasympathetic (preserving body responses) or sympathetic (trigger body processes) response (Stuart, 2013:219).
Therefore the patient’s behaviour is unpredictable, she may become physically aggressive, for example, breaking windows, throwing chairs or even assaulting fellow patients and or staff. The other side is that she may withdraw and totally isolate herself. The third quote indicates the fear that the participant experienced from the people who could harm her; a patient fought with her and therefore, may have influenced the level of anxiety she experienced. This participant’s reaction in this incident may have been influenced by certain factors as indicated by Kniesl and Trigoboff (2014:127), namely, the participant’s previous coping styles, her personal characteristics, intellectual ability, physical functioning, environmental and cultural aspects. The last sub-theme of this theme will focus on the participants’ experiences of powerlessness.

3.3.1.6 Sub-theme 1.6. The participants felt powerless during their stay in the unit

The participants felt powerless as they were not heard or listened to by the hospital staff members. According to Hornby (2000:911), the term powerless is defined as not having any control in or over a situation. Powerlessness can be characterised by depression and anxiety which may result in passivity and despondency (Reighly, 1988:194). The participants felt disempowered when they were not included in the discussions and decisions regarding their treatment regime. They did not understand why they had to take medication and felt powerless to stop taking the medication. When they addressed the matter with the staff they did not receive a satisfactory answer. For example, one participant felt that her medication did not have the desired effect, but indicated that there was no other option for her than to take the treatment.

“…maar die amount pille wat hulle jou gee is sterk en laat jou in die aand snaaks voel. Ek was op twee verskillende pille gewees. Ek kan nie die naam onthou nie maar ek weet Lithium is die een waar op ek nou is. Hy werk nie vir my nie en ek het vir hulle gese hy werk nie vir my nie.Maar hulle se, nee dit werk vir my, ek het nie dit gevoel vir my, ek het die nie ‘n keuse nie. As ek die pille los word ek weggestuur; as ek die pille vat dit maak my vet ook.”

Translation: The amount of tablets that you receive is strong and makes you feel funny at night. I was on two different tablets. I cannot recall the name, but I know Lithium is the one that I am receiving currently. It is not working for me, I told them that it is not
working for me, but they say it does work for me. It feels as if I do not have a choice. If I do not take the treatment, I will be sent away. The medication also makes me fat.

The participants felt that they had to do what they were told to do. They felt that their thoughts and feelings were not taken into account and that they were no longer autonomous. Health care practitioners had discussions on the treatment they were to receive and did not give attention to the patient’s opinion. They were also threatened about being sent away, presumably far from where they come if they did not adhere to the treatment. This threat may have contribution to feelings of powerlessness.

Duxbury, Wright, Hart, Bradley, Roach, Harris and Carter (2010:2481) conducted a study regarding the interaction between nurses and patients during the administration of medication. Three broad aspects arose, namely: the procedure of administering medication, interpersonal skills and relationships between staff and patients, and medication management. Even though medication was not a focus point in this study, limitations regarding the procedure of medication distribution were noted, after the data analysis. The participants experienced the administration of medication, negatively. The interpersonal skills between the staff and patients regarding their medication were inadequate. Therefore, medication management from the participants’ point of view, was poor. Medication administration was experienced in a negative manner. A participant stated in theme 1.4 that she was stripped naked by male security guards in order to receive an injection in her buttocks. The lack of interpersonal skills during administration is evident in sub-theme 1.5, where a participant stated that she received injections without any explanation. Furthermore, another participant verbalised that the nursing staff on night duty did not inform her of any medication changes prior to administration. The participant queried the adjustment of her medication but the nursing staff could not give her an answer. They also did not try to find out why it was changed, but instead they reacted in a rude manner. It seems that the nurses did not have the knowledge or interpersonal skills to administer and manage medication effectively.

The psychiatric nurses were focussed and task orientated while administering the treatment, but there was no explanation regarding the effect of the medication or why it would be beneficial to the patient. Duxbury et al. (2010:2488) state that a ‘business-like’ style was adopted which had a negative effect on the patient-psychiatric nurse
relationship. Strauss, Zervakis, Stechuchak, Olsen, Swanson, Swartz, Weinberger, Marx, Calhoun, Bradford, Butterfield and Oddone (2013:463) state that patients who participated in their own treatment plan during hospitalization validated more satisfaction with the care received. In addition, findings in a literature review by Adams et al. (2007) as well as Noble and Douglas (2004) as cited in Straus et al. (2013:463) state that patients expressed a need to participate in their treatment plans and decision making in their mental health care. The participants expressed their views as follows:

“We can’t say we don’t like it or whatever. The nurse is in charge of us and I feel it is bad.”

“They inject me so for two times a day. They don't explain what was the injection for. It was so painful....”

These patients felt they did not have any say in how their treatment was implemented. Zolnierek (2011:70) argues that patients want to be involved in their own care and treatment. In the current study, the participants felt helpless due to the fact that they were not consulted, informed or listened to when they asked questions regarding their own pharmacological treatment. As a result, the patient may become less compliant and may only take medication under duress. Some patients may experience side-effects from the treatment that they are placed on, for example, weight gain. If this is not discussed with the patient and alternative options not investigated, the patient will eventually become non-compliant. During hospitalization the patient may feel that she does not have a choice but on release she may assert her newly acquired power by not sticking to her treatment regime.

In this theme, the participants described a variety of negative emotional experiences during their admission and stay in a tertiary psychiatric facility. They experienced frustration and anger due to not understanding the reason for their admission. A feeling of sadness and humiliation was experienced during their admission. They expressed fear regarding their admission. Lastly, the participants felt powerless during their stay in the unit.
3.3.2 **Theme 2: The participants’ cognitive functioning was compromised leading to misunderstandings, negative emotions and behavioural problems**

Patients diagnosed with bipolar disorder experience a decline in their cognitive functioning. Cognitive impairment may contribute to job-related and interpersonal difficulties in the individual's life and continue through the life of the person diagnosed with bipolar disorder (American Psychiatric Association, 2013:138). The participants did not have a clear picture why they were diagnosed and medicated. Although patients diagnosed with bipolar disorder may be in contact with reality, their cognitive processes are not functioning in a normal way. Levy (2013:71) observed in a study on cognitive functioning in patients with bipolar disorder that chronic physiological stress accompanied by mood symptoms may lead to cognitive decline over the course of the illness. Hence, the patient may think her thought content is normal, but this may not be the case. They may experience an inability to make good judgements. They do not always have the ability to identify danger and they may be easily distracted and therefore have a low concentration span. They may also experience a flight of ideas and they may have delusions. Sometimes they present with delusions of grandeur or persecution and have loose associations (Stuart, 2013:295). Delusions of persecution, is a belief that other people are trying to hurt the individual (Kniesl & Trigoboff, 2014:307). This belief causes fear in the patient and therefore, the patient’s behaviour maybe unpredictable and aggressive. Hence, patients may lack insight into their condition owing to poor cognitive functioning, which may in turn result in feelings of fearfulness, because they do not know what causes the symptoms such as acoustic hallucinations and persecutory delusions. Fontaine (2009:706) defines a hallucination as a manifestation of a vision, sound, touch, aroma or taste without any exterior incitement to the equivalent physical body part, but this experience is a reality to the person. Due to the reality of the hallucination that the person is experiencing this may trigger fear. Hence, behaviour will be displayed associated with this emotion, as the brain cannot distinguish between reality and the hallucination (Fontaine, 2009:351). These behaviours are all related to a decline in cognitive functioning that is a consequence of bipolar disorder, as will now be discussed.

As mentioned, Kotze (1998:5) discusses the person as a three dimensional unit in her conceptual model, namely, the body-psyche and spirit. This theme focusses on the
psyche of the human/man. The notion is that the psyche is the core of man’s thoughts and understanding, awareness, feelings, view and experiences. All humans are unique and react differently to different aspects of life, even though the environment may be the same. Therefore, patients who are admitted experience their admission physiologically in a unique manner that cannot be compared to other patients.

3.3.2.1 Sub-theme 2.1. The participants’ lack of contact with reality (thought content) may have led to misunderstandings which activated behavioural problems

During the manic phase of bipolar disorder, a patient’s cognitive functioning may be compromised and this may lead to behavioural changes, such as temper outbursts, isolation, flirting or overt sexual expression. During the manic phase patients may experience flight of ideas, pressured speech, and loose associations. Therefore, they may come across as confused and lack contact with reality. Such behaviour may lead to misunderstandings and influence the manner in which they are managed in the facility. This may aggravate their behavioural problems.

Poor cognitive functioning may result in lack of reality orientation. Patients may experience hallucinations, such as visual and auditory hallucinations. These sensations may cause confusion which may activate abnormal behaviour. The quotes below illustrate the poor cognitive functioning that some patients experience.

“Daar was mense wat stemme gehoor het en gelag het vir hulle self en somtyds violent was.” Translation: There were people that heard voices and laughed about themselves and became violent.

“Most patients are confused. Most of them do funny stuff and do something that’s abnormal like pooh uh next to your bed and stuff like that…”

Many patients who are admitted to psychiatric facilities experience psychotic symptoms. During this period the patient is unable to distinguish between reality and the hallucinations or delusions. Grandiose delusion is often associated with patients diagnosed with bipolar disorder (Kniesl & Trigoboff, 2014:341), whereby they consider themselves to be of great importance. If they perceive themselves as very important they may not understand why they are treated in such a poor manner. They have
difficulty interpreting the environment correctly and therefore may act strangely, for example, defecating on the floor, laughing and talking to themselves, and becoming aggressive for no apparent reason. Reed (2008:89) notes in a literature overview of first episode psychosis that patients may have difficulty in understanding these sensations and this may lead to confusion. Hence, patients may isolate themselves and become socially dysfunctional. Therefore, patients are at great risk of harm, as indicated by the first quote below:

“I was scaring the people I thought they were animals. I was so rough. I did not want people to tell me the right thing”

“I was not eating good food from the hospital. I was hearing voices and was sleeping most of the time in the hospital.”

“I was hearing many voices and I couldn’t see properly, I felt as if I was going to die.”

These quotes indicate the manner in which the participants experienced delusions and hallucinations. The first quote was the result of a delusion that the participant experienced, she believed that other people were animals and therefore did not listen to anyone who wanted to correct her. The last two quotes above, demonstrate the effect that auditory hallucinations had on them. One participant mostly slept during her stay and the other participant believed that she was going to die. Another participant related a delusion as follows:

“I had an imagination that I was in prison because I use to watch TV and used to see people in prison. Like they were locked up in these big gates. So sometimes I would like cry and say jo, my mom took me to prison, my mom is not fair.”

In this quote the participant explained her confusion and distress caused by the delusion. These patients had difficulty interpreting reality. A participant in a study conducted by Inder, Crowe, Moor, Luty, Carter and Joyce (2008:128) stated “I actually mentally change and think differently and act differently”. During the manic phase of bipolar disorder the patient does not have the ability to make sense of the experience and this may lead to a sense of disbelief as to what is happening to her. In the following
sub-theme the focus will be on the participants’ disbelief at being admitted to a psychiatric hospital.

3.3.2.2 Sub-theme 2.2. The participants experienced disbelief about being admitted to a psychiatric facility

The participants did not specifically use the term “disbelief”, however it was apparent through the interviews that they could not believe that they had been admitted to a tertiary psychiatric facility and could not believe that the admission really happened. According to Hornby (2000:329), the term “disbelief” means not being able to believe something. “Belief”, on the other hand, means to feel certain that something is true (Hornby, 2000:329). Disbelief is viewed as something that cannot be true: “It cannot happen to me”. One of the participants described her experience of disbelief regarding her situation as follows:

“Dit was horrible gewees, ek het dit nie gelaai nie. Ek het gevoel ek behoort nie daar nie.” Translation: it was a terrible experience, I did not like it. It felt as if I do not belong there.

This participant experienced disbelief concerning her admission to a tertiary level psychiatric facility. According to the participant nothing was wrong with her and she felt that she did not belong there. Patients diagnosed with bipolar disorder lack insight into their illness, due to their cognitive decline. Therefore lack of insight may be a contributing factor to the feeling of disbelief, as they do not view themselves as mentally ill, especially when they are experiencing a psychotic episode during a manic phase. Reed (2008:86) mentions that during the psychotic episode of a mental illness, the patient has difficulty in making sense of their experience. Sadock and Sadock (2003:552) explain that patients diagnosed with mood disorders are often unwilling to be admitted into a psychiatric facility due to their decreased thinking ability and complete lack of insight into their condition. Therefore, decline in cognitive ability to understand the process, may contribute to the participant experiencing a sense of disbelief. Caring for her could become more challenging and difficult for the staff at a psychiatric facility due to her denying that she is mentally ill. One of the characteristics of a person with bipolar disorder is that she feels on top of the world and that nothing is wrong with her, therefore she may become irritable and even aggressive during the
admission and stay period. Proudfoot, Parker, Benoit, Manicavasagar, Smith and Gayed (2009:121) state that many patients have a fear that their situation is uncommon, and they often deny their illness. It was noted that patients understood more readily that they were ill during the depressive phase of bipolar disorder, but during the manic phase the patients could not comprehend that they were ill (Proudfoot et al., 2009:121). Furthermore, Proudfoot et al. (2009:124) state that patients experienced a feeling of disbelief, shock and anger, after they were informed of their diagnosis.

The participants in this study were experiencing a manic phase when they were admitted. Therefore, their insight into their illness may have been compromised and strengthened the feeling of disbelief. The behaviour of a patient who is in a state of disbelief may be disruptive and may end up in aggressive behaviour. Staff may view this behaviour as a threat to their control and may abuse their power by secluding the patient (Hellzen, Lind, Dahl & Hellzen, 2005:12). It has been reported that patients may feel offended because of this abuse as the patients do not receive support and may be isolated (Gutafsson, Wigerblad & Lindwall, 2014:177). The next sub-theme focuses on the confusion that some patients experience, which stems from this sense of disbelief.

3.3.2.3 **Sub-theme 2.3. The participants’ difficulty in cognitive functioning may have led to confusion influencing their behaviour.**

The term “confusion” can be described as disturbances of the consciousness displayed as disorientation in time, place and person (Sadock & Sadock, 2004:275). Confusion can result in disorientation, uncertainty and behaviour changes. The following quote shows one participant’s confusion during her admission and stay in a psychiatric facility.

“…. I am not supposed to be here. I’m supposed to be at Dora (a hospital in the Nelson Mandela Bay Municipality) or at home.”

This participant could not understand the reason for being in a psychiatric facility as she experienced low abdominal pain and did not feel that she was mentally ill. She did not understand why she had been admitted and treated in the ward; she was confused and lacked cognitive insight into her illness. Another participant stated:
“There is a stigma because they always think that everything you talk is shit and is not true”

This participant felt that everyone had a negative attitude towards her; this may be due to delusions or impaired thought processes that led to a confused state of mind. Proudfoot et al. (2009:125) report in a study conducted on the experiences of patients with newly-diagnosed bipolar disorder that the patients did not know when to trust themselves as they were confused regarding what was reality and what was not. It was mentioned that it is important for the health professional team to be aware of the feelings of confusion that patients may experience when diagnosed with bipolar disorder. A participant explains her confusion as follows:

“Dit was vir my moeilik gewees om weer daar terug te gaan, daarna toe. Um…. In die eerste plek het ek dit nie verstaan nie, wat soek ek daa vir?" Translation: It was difficult to go back, in the first place I did not understand why I was there?

Although this participant had previously been admitted to the tertiary level psychiatric facility, she did not understand the reason for her readmission. During the participant’s third admission, she was hospitalised for two months. The participant stated that she suffers from bipolar disorder, but at times her illness is not a reality for her. Therefore, the decline in her cognitive functioning may influence the manner in which she comprehends her illness. Torrent, Martinez-Aran, Daban, Sanchez-Moreno, Comes, Goikolea, Salamero and Vieta (2006:254) argue that a decline in cognitive ability is caused by certain factors such as, the number of hospitalisations, the incidence of psychotic symptoms and the period of illness. Levy (2013:71) supports this statement and elaborates further that enduring psychological stress that goes with severe mood symptoms is theoretically neurotoxic and may cause cognitive decline due to the chronicity of the illness. Furthermore, the duration and amount of hospitalisations the participant had previously experienced, may also influence her cognitive functioning.

The participant above was confused regarding her admission. She mentioned that she isolated herself in the beginning of her stay. Later on she became more aggressive and was involved in physical fights with other patients. She stated that some of the patients experienced hallucinations and delusions and she experienced their behaviour as strange and could not associate with these patients. She verbalised that
these behaviours made her more confused and ill and contributed to her aggressive behaviour and prolonged stay in the tertiary psychiatric facility. The following sub-theme focusses on the participants’ level of knowledge and lack of insight regarding their illness.

3.3.2.4 Sub-theme 2.4. The participants’ level of knowledge and lack of insight regarding their symptoms and treatment lead to behavioural problems

If the level of knowledge of a patient is sufficient, regarding their illness and treatment it will assist a patient to gain more insight and therefore, lead to less behavioural problems. During the manic phase of a patient diagnosed with bipolar disorder the patient’s cognitive abilities are affected. It might be that on previous admissions the disease process and action of the medication had been explained, but during a manic phase the patient may ignore this information. On numerous occasions the participants indicated that they did not understand what was happening to them due to their own ignorance of what constitutes the condition as well as the treatment of bipolar disorder.

“hulle prop jou net vol pille” Translation: They just stuff you with tablets

“The medication, it is so many”

“en dan is hulle op pille gesit en dan het die patiente nie geweet hoekom nie…” Translation: And then they are given pills and the patients do not know why

The above quotes indicate that the participants did not understand the importance that the medication administrated to them had for their illness; they did not understand the workings of the treatment. Clearly this shows poor knowledge of the medication with which they were treated and may have contributed to their lack of insight, which may also lead to non-compliance once discharged from the facility. Zolnierek (2011:70) states that hospitalised patients with severe mental illness feel that they do not have control over their own treatment. In a study by Silva, Santana, do Couto, Maroco, Guerreiro and de Mendonca (2009:629), patients with bipolar disorder were more impaired than patients with mild cognitive impairment in the following areas: attention, initiative, calculation and verbal abstraction abilities. Bearing this in mind, it is reasonable to believe that patients with bipolar disorder may experience difficulties in
understanding their illness and treatment, which may lead the patient to become non-compliant. Non-compliance may lead to irritability, resulting in aggressive behaviour. Russell and Browne (2005:187) state that it is critical that patients with bipolar disorder learn about their illness in order to manage their treatment effectively. Medication plays an important role in the treatment of a patient admitted to a psychiatric facility.

Fortinash and Holoday Worret (2012:705) state that insight is the capability of observing oneself realistically and understanding one’s own behaviour. Some of the participants lacked knowledge and therefore did not have an understanding of how their behaviour contributed to their admission. They could not understand why they needed to be taking medication as they felt so good about themselves. One participant exhibited her lack of knowledge as follows:

“The problem I have is low abdominal pain…. I’m not supposed to be here. I don’t know why, why the doctors keep on,… keep me to come here because I have this distended abdomen.”

It was evident that this participant experienced somatic symptoms and lacked knowledge regarding her illness. This was established after the necessary physical assessment was conducted and no abdominal abnormality was diagnosed. Somatising is not uncommon in people with chronic mental diseases (Kniesl & Trigoboff, 2013:151). This participant focussed on physical symptoms such as her distended abdomen and saw that as the cause of her admission. It was observed that some participants lacked knowledge about their illness and treatment. After pharmacological treatment was initiated the participants received education on their condition and perceived themselves more realistically. This was noticed in the manner they viewed their admission as necessary during the data collection phase. In general, patients who are admitted involuntarily usually do not have the necessary knowledge and insight into their condition therefore, they object to the admission; they seek ways to be discharged as soon as possible (Moosa & Jeenah, 2008:111).

The fact that the participants did not have knowledge and understanding into the reason for their admission may have had an influence on their experience and perception of the environment into which they were admitted. Consequences that may occur due to lack of knowledge regarding their admission include non-compliance,
poorer prognosis and deficits in social and occupational functioning (Hopko, Averill, Cowan & Shah, 2011: 91).

In this theme the focus was on the participants’ compromised cognitive functioning that led to misunderstandings, negative emotions and behavioural problems. Disturbed thought content such as, hallucinations and delusions influenced their contact with reality, which once again, led to misunderstandings regarding their admission. Due to their cognitive decline they could not believe that they were admitted and did not view themselves as ill. They felt confused and did not understand that they were mentally ill. Lastly, it is evident that they had poor knowledge and understanding regarding their illness and the management thereof. The participants’ experiences of the environment or therapeutic milieu will be discussed in the last theme.

3.3.3 Theme 3: The participants experienced the environment as unfriendly and unpleasant

This theme looks at the participants’ experiences of the physical and social environment in which they found themselves during their time at a tertiary psychiatric facility. The focus of this theme is on the participants’ experiences and perceptions of the environment and the effect it may have had on the process of their healing.

Psychiatric nurses are responsible for creating a therapeutic milieu for patients. Stuart (2013:643) discusses the five aspects of a therapeutic milieu, namely: containment, support, structure, involvement and validation. Containment refers to providing support for the physical well-being of patients and the reduction of the various means of seclusion and restraint. Some of the participants mentioned that they did not feel that they were heard by the staff, and if they complained of a physical issue, they were ignored. It was also noted that some of the participants were placed in the seclusion room for unnecessary incidents. Support indicates the staff members’ specific efforts to assist patients to feel better and improve their self-esteem. Only one patient verbalised that the nursing staff supported her and tried to assist her when she felt sad. Structure entails all aspects of the milieu by creating a ward program that suits the individual needs of each patient. Some of the participants felt that the ward program did not address their specific needs; they felt that they had lost their
autonomy. Involvement regards placing an emphasis on creating opportunities where the patient can become actively involved in their treatment plan and to gain life skills to build their confidence. The participants indicated that they did not understand the process, and they were not informed or consulted regarding their illness and the management thereof. Lastly, validation concerns the staff and the manner in which they display respect and acknowledge the value of each patient. The participants felt humiliated, disrespected and not listened to during their stay in the psychiatric facility.

The nursing accompaniment theory was created by Kotzé (1998:4) to assist nurses to deliberate a problem philosophically and empower them to cultivate sensitivity, verdict and cognitive ability in order to agree to disagree only after giving the problem comprehensive thought before accepting a point of view. In nursing there are primary principles which affect and guide situational decision making as well as verdicts on life, the world, man, science and nursing (Kotzé, 1998:3). This theme focusses on the experience that the participants had in the environment that they were in during their admission to a tertiary psychiatric facility. Therefore, the researcher will focus on how Kotzé viewed the world. The world is where the man lives, objectively and subjectively. The objective or external world involves the following: the world of science and technology, nature, ecology, astronomy and micro-organisms. The subjective world or life world includes the personal world, the intrapersonal world, the world of co-existence and the dimensions of time in which man exists (Kotzé, 1998:3). The correlation in this study regarding the world is not only the external environment that the participants were exposed to, but also their personal world where they found themselves. It must be kept in mind that the personal world gives a person a sense of security and safety. However, suddenly the participant is removed from the world as she knows (objective and subjective) and is placed in a foreign world. This experience may be confusing and may threaten her feeling of safety and security. This state of mind may negatively contribute to her already compromised cognitive ability, due to her mental illness and may influence the manner in which she responds within this changed world.

The following sub-themes indicate the specific aspects that the participants experienced, regarding the environment or milieu, during their stay at a tertiary psychiatric facility. These sub-themes will look into how the participants adjusted to
being in the locked up unit as well as their experiences regarding isolation and how this may have contributed to their experience of the “coldness” in the unit. Furthermore, the participants shared their experiences regarding the staff who often avoided them and demonstrated a lack of compassion. Although some participants focussed on the negative aspects of their experiences some did experience their admission as a positive intervention and were grateful to the staff for their care and management.

3.3.3.1 Sub-theme 3.1. The participants had difficulty adjusting to a locked unit after their admission

This sub-theme deals with the struggle that the participants had to adapt to the physical structure of the locked unit and the inability to move around freely. The participants were admitted as involuntary users and were incarcerated in the unit against their will. They experienced this as distressing, difficult and embarrassing. The loss of autonomy and forcible detention influenced the participants’ perceptions of the environment (Moosa & Jeenah, 2008:111). The participants felt cut off from the outside world. They were locked behind steel gates and experienced limits on their freedom of movement. A patient who is admitted to a locked unit may experience feelings of confinement which may lead to a loss of control and may even cause a change in behaviour (Johansson et al., 2009:501). One of the participants compared her admission to being imprisoned, quoted below.

“… is soos ’n tronk, dit maak jou meer siek om daar te wees.” Translation: It is like a prison, it makes you more ill to be there.

Two of the participants felt caged in and unable to move freely, quoted below.

“jy is ingehok binnekant en daar is regtig nie iets om te doen nie” Translation: You are caged inside; there is absolutely nothing to do.

“ daai bars afhaal daar sodat mense in die tuine kan loop en so, en vry voel. Hulle gaan mos nie weghardloop nie, daar is mos security. Hulle treat mens soos n moordenaar”. Translation: They should remove those bars so that a person can walk in the gardens and feel free, they won’t run away, there are security guards. They treat you like a murderer.
These quotes indicate that the participants had difficulty adjusting to the experience of being physically locked up. They felt restricted in their movements due to the prison-like environment of the locked unit. Being admitted to a psychiatric facility may cause the patients to feel punished and stigmatized (Chow & Priebe, 2013:10). Johansson et al. (2009:501) explain how a locked unit influences a patient’s experience, where they feel a loss of individualism and unsafe, which leads to more frequent aggressive incidents. As the above quotes indicate, the participants felt trapped. Therefore they felt more dependent on the staff in the locked unit. Participants also indicated primarily being subjected to the loss of independence and secondarily degraded when they were incarcerated. View the following quotes.

“very um much a structured kind of thing. You are not allowed your independence and you can’t do what you want"

“you have to stay there and there is no bells. You have to stand at the gate and then open up your big mouth, NURSE! It is not nice because you don’t feel like shouting and then you feel like your throat gets dry.”

“When you want toilet paper and like maybe you have stomach pains and you want some medication, you must shout at the nurse please come and then they would”

These participants were not used to losing their independence as they were adult females who were able to function independently and therefore prior to admission had the ability to make their own decisions and do as they please. Suddenly they were locked in a ward, which not only limited their movements, but even basic private bodily functions cannot be done independently as they are monitored. They found it embarrassing as they had to shout for toilet paper. These restrictions may aggravate negative behaviour.

In a literature study conducted by Chow and Priebe (2013:3), restriction of freedom was found to be associated with psychiatric facilities, not only due to the structural layout, but also due to policy and legal frameworks regulating patient care. Patients may lose the independence and freedom they once had due to the staff enforcing changes in their behaviour. Some of the participants’ negative perceptions of the physical environment may have been influenced by their limited insight into their
condition. Van der Werf-Eldering, van der Meer, Burger, Holthausen, Nolen and Aleman (2011:351) note that patients who present with lifetime psychotic features experience more intense impairments that indicate poor insight into their illness.

As mentioned earlier, patients diagnosed with bipolar disorder experience cognitive impairments such as impaired perception or interpretation of sensory observations. They do not have the ability to analyse and process the environment in which they find themselves.

In this sub-theme it was observed that the therapeutic milieu was absent. This leaves the patient in need of validation. The patients may feel disrespected, not valued as human and humiliated due to these restrictions. Lacking the required validation as well as positive stimuli, the locked up unit may be a contributing factor to their experience of isolation. This will be discussed in the next sub-theme.

3.3.3.2 Sub-theme 3.2. The participants felt isolated during their admission and stay in a psychiatric facility

This sub-theme focused on the participants feeling that they were isolated and how it impacted on them. Fortinash and Holoday Worret (2012:705) define isolation as a feeling of being alone that may be perceived as social rejection and or an absence of care from other people. Patients who are experiencing a manic phase have poorer levels of social functioning (Hanwella & de Silva, 2011:137). Therefore, these patients' ability to build and maintain relationships may be limited. Bipolar disorder negatively affects patients' relationships with their families, peers and intimate partners. The cause for this is the influence of mood changes and the adverse reactions of other people (Inder et al., 2008:126). Mental illness interferes with building and maintaining relationships, therefore patients with bipolar disorder choose not to begin relationships (Inder et al., 2008:127). Thus, they withdraw and isolate themselves from other people. When a person is isolated, that person receives little or no interaction from people or things. This may occur on an emotional and or physical level. In the past they may have had physical contact with family or friends in the form of, for example, a hug. After being admitted they may not experience these hugs or a caring word, which may lead to feelings of loneliness. Although they were surrounded by other patients they
felt all alone with no emotional contact with either staff or loved ones. The participants explained this isolation as follows:

“um jy is baie afgesny…” *Translation: Um, you are cut off from others.*

“Jy voel uitgesluit van die lewe af.” *Translation: You feel shut off from everyday life.*

The participants reported that they did not experience a lot of interaction with the staff members. Although the participants received physical care to provide for their basic needs from the staff, not much attention was given to their social or emotional needs. Reed (2008:86) states that patients may isolate themselves during the acute stage of their illness, which may lead to a feeling of loneliness.

According to a study conducted by Thomas, Shattell and Martin (2002:105), it was found that patients admitted to an acute psychiatric ward expressed their wish to understand themselves and their problems. However, some patients would rather forget their admission process, as the feeling of isolation was unbearable and the necessary support from the staff and involvement of their family was not experienced. Therefore, they may feel alienated from the world. It was found that patients who are acutely ill want a deeper connection with the staff. It was stated that patients appreciate nurses who show respect, empathy and tolerance, who are available to them and who spend time with them.

A patient who was admitted as involuntary may experience her admission as coerced and therefore experience their admission as less acceptable than patients who voluntarily admitted themselves (Strauss *et al*., 2013:458). The participants reported that they had little to no contact with their loved ones; they felt isolated and rejected by both their relatives and the staff who did not make themselves available for communication. They did not have the capability to make in-depth contact with the other mentally ill patients who had been incarcerated with them, meaning that patients felt isolated from each other. The participants tended to keep to themselves, and did not socialize and this caused the participants to be trapped in their own thoughts, doubting themselves. Mentally ill individuals often have difficulty communicating and building relationships (Inder *et al*., 2008:126).
In this sub-theme it was observed that there was a lack of communication and relationships in the therapeutic milieu. Therefore, the support that the patients received from the psychiatric nurses was ineffective and did not satisfy their needs. Various factors impact on the patient’s feelings of isolation as will be indicated in the following sub-themes. The following sub-theme will discuss the feeling of physical coldness that the participants experienced in the locked unit, which may be a contributing factor to the experience of isolation.

3.3.3.3 Sub-theme 3.3. The participants reported extreme physical discomfort in the unit such as being very cold

This sub-theme focuses on the experience of physical coldness that the participants reported. The term coldness is described by Hornby (2000:214) as the non-existence of warmth, and that may indicate a state of being physically cold. The type of coldness which was noted in this study is a physical cold. Patients who are admitted to a tertiary psychiatric facility may experience a physical coldness as the buildings are often old and not maintained adequately. The participants described conditions in the ward as follows:

“I was sleeping in a very cold room with uh it was very very bad…..just the place it was not very nice.”

“…… and it was not nice because it’s very cold.”

“…but all I am complaining is that there was a cold inside. I wake up in the morning and then I’m feeling I’m feeling like there’s someone who beats me like there is a coldness…..”

“….the thing that hurts most was the coldness and what else, the lying in hospital especially when you not are used to lie in the hospital you see. Those two things were not nice.”

These participants clearly experienced the physical discomfort of coldness as they were admitted during the winter, when the nights are extremely cold. They did not receive enough blankets from the staff to keep them warm during the night. Furthermore, the tertiary psychiatric facility in this study had no indoor heating systems
to maintain a warm temperature in the ward. The therapeutic milieu did not cater for their physical requirements, thus the participants did not experience contentment. One of the roles of a psychiatric nurse is to ensure that the patients are comfortable, which was not experienced by the participants. They experienced a cold environment and to worsen matters not only did they experience this coldness physically but they felt that the staff avoided making contact with them, as will be discussed in the following sub-theme.

3.3.3.4. Sub-theme 3.4. According to the participants, the staff avoided making contact with them

The following sub-theme focuses on the interaction between the staff and the participants. The participants indicated that the staff did not interact with them. They stated that the staff only came behind the gates to do a specific task, for example, helping during meal times and ensuring the patients were bathed. They did not spend time communicating with the patients or enquiring about their well-being. No relationships were built between staff members and participants.

It may be that the staff members did not have the necessary knowledge and skill to interact with female patients diagnosed with bipolar disorder. Hyde and Davis (2004:1413) state that some psychiatric staff may feel afraid that they may become mentally ill, or lose self-control if they interact with mentally ill patients. On the other hand, it may be that the staff members do not feel safe in dealing with certain situations such as aggression and are concerned about their own personal safety (Thomas, Beaven, Blacksmith, Ekland, Hein, Osborne & Reno, 1999:53). One of the participants explained the attitude she observed from the staff in the quote below:

“…no no they see you, they don’t see you cry…. They come in the wards when they serve the food only, when they serve the food and when they dish out medication, and um that’s about it. Maybe they are scared also, that they are going to get killed or something (laughs).”

The staff members seem to be reluctant to spend time with patients who are deemed to be psychotic or have unmanageable behaviour. This may be due to the staff's inability to create an atmosphere of compassion or due to previous experiences where the staff member had not been able to console a patient. Maatta (2009:180) states
that it is important for the nurses to develop certain strategies to care and manage patients who are admitted to a psychiatric hospital.

Sharing information, being warm and listening to the patients’ needs is seen as an essential part of the therapeutic process (Duxberry et al., 2010:2487). Interacting actively with the patient and creating opportunities for discussion by the nurse may diminish the feeling of loneliness. Proudfoot et al. (2009:121) explain how patients valued the assistance of competent and empathetic health care professionals. These attributes will contribute to the patients’ well-being.

As discussed in chapter 1, the psychiatric nurse has an obligation to work within the framework of the Scope of Practice of Registered Nurses (professional psychiatric nurses) (South African Nursing Council, The Nursing Act 33 of 2005:25). The psychiatric nurse must be the patients’ advocate to ensure that the patient receives effective care and treatment during her stay. The psychiatric nurse is the contact person between the family and the patient as well as with the rest of the multi-professional team. The psychiatric nurse must ensure a therapeutic milieu whereby the patients’ well-being is enhanced. Effective therapeutic relationships are essential and must be built to gain the patient’s trust, thereby assisting the patient to a speedy recovery in a holistic manner. The following sub-theme will explore the participants’ experiences of receiving compassion from the staff members.

3.3.3.5  Sub-theme 3.5. The participants had both positive and negative experiences regarding the compassion of the staff

The last sub-theme focuses on the compassion shown by the psychiatric staff. It looks at the experiences of the participants regarding the staff members displaying or not displaying compassion towards them. Hornby (2000:227) describes compassion as a feeling of caring and empathy for people who are in distress and in need of help. Compassion is generally defined in the health care setting as being thoughtful to the distress of others and with an obligation to relieve it (Crawford, Gilbert, Gilbert, Gale & Harvey, 2013:719). The most common characteristics of people with compassion are, the ability to care, to be helpful, to be generous, to be supportive and to have a sense of understanding (Crawford et al., 2013:721).
Some of the psychiatric nurses did not show compassion towards their patients. A participant mentioned (see quote below) that one evening it was very cold, and she and a fellow patient decided to lie in one bed to build up heat. The staff observed this during their rounds and immediately removed her and placed her in the seclusion room. This was done without enquiring from the patient what the reason was for sharing a bed. The participant did not understand the nurses behaviour as she felt that she did not do anything wrong. The staff did not take time to ask the participant the reason for them sleeping together. The uncaring manner of how the staff addressed the situation was noted. The participant was not given an opportunity to explain the situation. It appears that the staff assumed that this was indecent behaviour and therefore removed the participant and placed her in isolation, as a form of punishment.

“Yes if you sleep, if you sleep. A lady and a lady both of them, both of you in the bed they will keep you in the single room. In the…… plank, in the…. single room. It was so painful because it was not for the first time…so many times… They said, they said I am rude.”

An article written by Spandler and Stickley (2011:555) discusses the importance of developing compassion as this will assist patients with mental illnesses to develop their own coping style in order for them to accept and live with their mental illness. Below are two more quotes of participants who did not experience compassion from the nurses. They felt rejected and not respected as human beings.

“The cruelty of nurses…. when you trying to talk to her (nurse) it’s just going away just and talk and talk ….. anyhow.”

“Yes they (nurses) ignore us, they talk anyhow and showing that it’s so that they don’t like you….. They even scold me too” (This participant’s tone of voice became raised and her facial expression displayed anger.)

These two quotes indicate that the staff did not display a caring attitude towards the patients. It seems that there is a lack of empathy towards the patients and that the staff members do not have time to care for the patients in a therapeutic manner. Conversely, another participant experienced the care in a more positive way; she mentioned that the staff members were caring.
“But I could say something that made me like comfortable, when I feel like crying, was the nurses. They were okay. They would come to you and ask why are you sitting alone? Why are you not sitting with the others? Why are you not watching TV? And I would say I feel like going home and they would say no chill, relax a bit, time is going to come. You’re not okay, yet that’s what kept me, gave me faith that yes I’m going home.”

The participant explained that she did experience compassion. She received comfort through the presence of a nurse. She felt that someone listened to her and cared. Although the discussion that took place was not on a therapeutic level with effective communication techniques, what is of importance is that the participant felt comforted and cared for when in need. She also expressed that it gave her hope for a more positive future. Indeed, Spandler and Stickley (2011:556) describe compassion as a communicated sense of empathy which supports the experience of the participant mentioned above.

In this theme the participants shared their experiences regarding the environment. Most participants experienced the environment as negative. However, the experiences of the participants demonstrate that the support that was received was not consistent. According to the interviews, the therapeutic milieu in the unit in this study was insufficient as the participants did not take part in activities that were based on the individuals’ needs. The participants were not actively involved in their own treatment plan. Lastly, not all the participants felt valued or respected by the staff.

3.4 CONCLUSION

This chapter presented the experiences of female bipolar disorder patients during their admission and stay in a tertiary level psychiatric facility. Three themes were identified namely: the participants experienced a variety of negative emotions during their stay in a tertiary psychiatric facility, their cognitive functioning was compromised leading to misunderstandings, negative emotions and behavioural problems and lastly, they experienced the environment as unfriendly and unpleasant. It was clear that most of the participants experienced a variety of negative emotions namely: frustration, anger, sadness, humiliation and powerlessness. The participants experienced a sense of disbelief, and displayed a poor knowledge and insight into their admission. A
contributing factor to this may have been their compromised cognitive functioning. In the last theme it was also evident that they had difficulty adjusting to the environment to which they were admitted. They experienced isolation and felt that the staff avoided them. It was also noted that not all the staff were as compassionate as they should have been. The participants also felt powerless not having any input in their treatment. Although this seems to paint a bleak picture of the experiences of females with bipolar disorder admitted to a tertiary level psychiatric facility a patient did experience her admission and stay as beneficial and a positive experience.

In chapter 4, the focus will be on the development of broad guidelines for psychiatric nurses to assist in the care of female patients with bipolar disorder during their admission and stay in a tertiary level psychiatric facility. The focus will be on the therapeutic milieu (environment) which encapsulates all the aspects that have been discussed in this chapter.
CHAPTER FOUR

GUIDELINES, LIMITATIONS AND CONCLUSIONS

4.1 INTRODUCTION

In the previous chapter the experiences of female patients with bipolar disorder during their admission and stay in a tertiary level psychiatric facility was discussed. Three major themes were identified namely: that they experienced a variety of negative emotions; that they experienced compromised cognitive functioning which may have led to behaviour problems and lastly, that they experienced the environment to be unfriendly and unpleasant during their admission and stay in a tertiary level psychiatric facility.

In this chapter, broad guidelines will be presented to assist the professional psychiatric nurse in managing the female patient diagnosed with bipolar disorder during her admission at a tertiary level psychiatric facility. The chapter will start with the objectives as stated in chapter one. The guidelines developed from the themes will then be discussed followed by recommendations for professional psychiatric nurses to care for women with bipolar disorder. Thereafter, the limitations of the study and conclusion will be presented.

A study by Johansson et al. (2009:505) found that patients need to experience a ward as a place of shelter, a place for privacy that offers security, peace and a homely atmosphere. These qualities may be essential for a patient to seek help and the need to be acknowledged as an individual human being to assist in relieving the patients of their ‘suffering’. Therefore, each psychiatric ward should apply therapeutic milieu (environment) principles, to ensure safety, structure, support, socialization skills as well as self-understanding to achieve mental health (Kneisl & Trigoboff, 2013:253).

4.2 OBJECTIVES OF THE STUDY

The first objective of this study was to:

- Explore and describe how female patients diagnosed with bipolar disorder experience their admission and stay in a tertiary level psychiatric facility during a manic phase.
The second objective of this study was to:

- Develop broad guidelines to assist the psychiatric nurse to optimally manage female patients diagnosed with bipolar disorder during their admission and stay in a tertiary level psychiatric facility, when admitted during a manic phase.

The first objective was achieved by discussing the experiences of female patients diagnosed with bipolar disorder regarding their admission and stay in a tertiary level psychiatric facility. These experiences were gathered using semi-structured interviews and transcribed. Thereafter the content was coded and analysed. Three main themes were identified.

The second objective was achieved with the development of the guidelines. The themes and sub-themes that were derived from the data and discussed in chapter 3 were utilized to develop the guidelines to assist psychiatric nurses in the care of female patients diagnosed with bipolar disorder. The guidelines were developed from the analysed data, the literature and the feedback of experienced professional psychiatric health team workers.

4.3 CONCLUSIONS OF STUDY

After the analysis of the data the following main aspects became evident. Three main themes emerged from the data. The participants experienced a variety of emotions during their admission and stay in a tertiary psychiatric facility. Multiple reasons can be given for these specific emotional experiences as will now be discussed.

4.3.1 Theme 1

In the first theme the focus is on the emotional aspects that female patients with bipolar disorder experienced during their admission and stay in a tertiary level psychiatric facility. These emotions were experienced negatively. The participants experienced frustration due to being locked up in a ward which caused a restriction on their freedom of movement in the ward. Their autonomy and independence was taken away. They felt angered because they were in a situation over which they had no control. They also experienced poor interpersonal communication from the psychiatric nurses. At times they felt ignored by the staff and felt that they were not involved in their own treatment plan. This contributed to the participants experiencing feelings of sadness.
In addition, losing autonomy and being isolated in a locked unit, away from family and friends made them feel hopeless and lonely. Furthermore, the participants also experienced various humiliating situations. They experienced being watched by the nurses while showering often three together in a shower. There was no privacy. The negative attitude and inconsiderate behaviour of the staff was highlighted by the participants. They were undressed by male staff members, which intensified the feelings of powerlessness, loss of dignity, disrespect and an overall feeling of shame. These experiences contributed to the emotion of fear. They felt scared as they did not understand their illness, the process or treatment thereof and the impact that their illness may have on them in the future. In addition, the participants did not only have to deal with their own internal fears, but the fear of sharing the same sleeping and living quarters with other patients who experienced severe psychoses, displaying unpredictable and often aggressive behaviour. They felt scared for their own safety being locked up with these patients. The participants felt powerless emotionally and physically. They were not listened to and had no control over their situation and this made them despondent.

It is apparent to the researcher that attention must be given to these matters that were voiced by the participants. It is obvious that they were not cared for in a holistic manner. Basic principles of nursing care were not implemented, which is unacceptable, as the professional nurses had been trained as psychiatric nurses, which entails nursing a patient using a patient-centred approach. Basic communication skills and holistic nursing is in the curriculum not only of professional nurses, but also of enrolled nurses and assistant nurses. Drastic interventions should be implemented to address this matter. Each patient needed to be included in her own treatment plan from the first day that they were admitted. Ward programmmes should be adjusted or created to include these treatment plans. This will guide the psychiatric nurse how to care effectively for a female patient diagnosed with bipolar disorder. The following aspects are of importance: The patients need to have an opportunity to move more freely especially outside of the building. Individual attention should be given to each patient so that they feel valued and respected as human beings. Privacy should be upheld especially during bathing times and psycho-education should be given on an individual basis as well as in a groups.
4.3.2 Theme 2

In theme two the focus was on the compromised cognitive functioning which bipolar disorder patients may experience. Their limited cognitive ability may have influenced their behaviour during their admission and stay in the psychiatric facility. The participants thought content was disrupted during their admission and stay in the tertiary level psychiatric facility. They lacked insight into their condition, they did not understand the reason for their admission, and they experienced auditory hallucinations and delusions. Hence, the behaviour of the patients may have been interpreted as aggressive. Staff members need to understand that acting out behaviour is a symptom of the patient’s illness and therefore the psychiatric nurse needs to have the skills to handle such behaviour, with caution and effectively. The participants’ thought processes were disturbed and they were confused and wary of any interaction with people. The behaviour that may be displayed could be defensive which may rapidly change into aggression, especially if their needs are not met when they feel disrespected. The participants displayed a lack of insight into their symptoms and treatment due to their decline in cognitive functioning.

The results of this study recognised that the patients were not cared for according to a patient-centred model. Specific attention must be given to educating the individual patient and their families on their illness and its treatment. Individualised education programmes should be developed for each patient, keeping in mind that the cognitive ability of a patient with bipolar disorder is compromised. Furthermore, the staff can benefit from attending in-service training sessions or short learning programmes on how to interact with patients whose cognitive functioning is compromised as well as de-escalating techniques during aggressive outbursts.

4.3.3 Theme 3

Theme three concentrated on the participants’ experiences of the environment, namely, the tertiary level psychiatric facility in which they stayed. After the data analysis was conducted it came to light that the participants experienced the environment as unfriendly and unpleasant. They did not only feel cut off from the outside world, but it felt as if they were in prison, being punished for something over which they had no control. Their freedom of movement was limited, minimal activities
other than the basic, bathing, sleeping and eating activities were allowed. Before admission they could do any activity that they might like to do, such as walking, writing and visiting family and friends. However, now they were not permitted to do any individual activities such as, drawing, writing and needlework. Suddenly they were confined to an area where they slept in a dormitory with other people not known to them, sharing the same unfriendly environment. There living situation was now totally different to what they were used to before admission. They therefore found it difficult to adjust to their new situation. Some participants became angered and others isolated themselves. Due to their admission they did not have everyday contact with family members and known friends, which reinforced their feeling of loneliness. The old buildings as well as an environment which was not conducive to an ideal living space, coldness was experienced. In addition, an insufficient supply of warm bedding and clothing contributed to the coldness. This coldness was vividly recalled during the data gathering phase. Furthermore, some participants experienced the staff as distant and uncaring towards them.

The researcher observed that there is a great need for the participants to receive positive interaction from the psychiatric nurses. Strategies should be implemented so that the patients can feel part of the community and not cut off from the outside world. Currently, the therapeutic milieu (the physical layout and daily programme) does not seem to have a positive effect on the patients admitted to the acute female ward in the tertiary psychiatric facility where the study took place. The participants did not feel acknowledged as people.

4.4 RECOMMENDATIONS

Based on the findings, the researcher makes the following recommendations for the nursing practice of psychiatric nurses to assist them in caring for female patients diagnosed with bipolar disorder in a tertiary psychiatric facility.

- Broad guidelines need to be made available to the tertiary psychiatric facility acute female ward.
- The psychiatric nurses working with female patients diagnosed with bipolar disorder should be made aware of the patients' specific needs.
• The psychiatric nurses should be informed about the challenges female patients diagnosed with bipolar disorder experience once they are admitted to a tertiary psychiatric facility.

• A detailed programme is needed to assist the psychiatric nurse in optimally caring for female patients diagnosed with bipolar disorder during their admission and stay in a tertiary psychiatric facility

4.4.1 Recommendations for education

Gaining knowledge and using this newly gained knowledge is a never ending process in nursing science, therefore the following suggestions are made regarding nursing education.

• During the four year nursing programme the students should be exposed to a practical skill whereby student nurses implement a situational analysis of an acute psychiatric ward, and address the aspects that need to be changed to ensure an effective therapeutic milieu programme.

• In-service training sessions should be conducted regarding individualised nursing care plans, diagnoses, intervention strategies and the evaluation thereof. Examples of such sessions are:
  o Assessment strategies of a patient diagnosed with bipolar disorder
  o Recognising specific nursing diagnoses (problem areas) to address the patient’s needs
  o Planning specific interventions that are attainable in order to address these nursing diagnoses
  o Implementing these specific, appropriate interventions to improve the patient's mental well-being with bipolar disorder
  o Lastly, evaluating the interventions that were implemented and how to move forward if not resolved.

• In-service training sessions should be held on all aspects concerning bipolar disorder:
  o Types of bipolar disorders
  o Onset and course of bipolar disorder
  o Etiologies
  o Psychopharmacological interventions
Multidisciplinary interventions
Alternative therapies

- Practical in-service training sessions should also be conducted:
  - Building a trusting therapeutic professional relationship
  - Managing a manic patient
  - Managing an aggressive patient

4.4.2 Recommendations for clinical practice

In order to assist psychiatric nurses in the care of female patients diagnosed with bipolar disorder the following aspects should be taken into consideration.

- Delegate a psychiatric nurse as a “primary therapist” to a certain number of patients
- Allocate other psychiatric nurses, assistant nurses and enrolled nurses to work with her in a team
- Design evidence-based, individualised nursing care plans to attend to the needs of the specific patient and implement this plan accordingly
- Include the patient in her own treatment programme and give her more autonomy
- Create a therapeutic programme that can be implemented according to the needs of the patients
- Explain to the patient the reason for her admission to the locked unit in the psychiatric facility
- Ensure that the patient has more freedom of movement on a daily basis within and outside the ward
- Create opportunities for patients to engage with the world outside the facility
- Discuss issues that are currently going on in the news and hold debating sessions
- Invite patients who were treated for bipolar disorder and who are stable to share their stories with the patients
- Allow visitors, even if it is not within regular visiting hours, but only if there is no therapeutic intervention in progress
- Design a bathing schedule to ensure privacy during what should be regarded as a self-care activity
- Allocate staff to assist with group sessions and also individually in leisure activities
• Educate the patient, family members and caregivers regarding bipolar disorder and the management thereof
• Ensure that adequate resources are available such as blankets and warm clothing, especially in winter

4.4.3 Recommendations for research

Further research that is needed on specific themes that were identified owing to the limited literature available was:

• Patients’ disbelief about being admitted to a psychiatric facility
• Patients ability or lack of ability to adjust to a locked unit after admission to a psychiatric facility
• An intervention study based on the guidelines developed by this study after their implementation

4.5 LIMITATIONS OF THE STUDY

The study contained a number of limitations as the following demonstrates:

• Not all the participants strictly met the inclusion criteria as some participants exhibited symptoms of delusion. One participant displayed overt delusions, experiencing an erotomonic delusion, whereby she believed her pastor was in love with her. Although this participant has had this belief for many years, she is in contact with reality and functions well in the community. She also displayed a certain understanding of her illness. This participant added rich data which was congruent with the other participants’ experiences and therefore the information was used in this study. Another participant presented with pressured speech and at times she diverged from the topic. She was gently guided back and gave relevant information of her experiences during her admission and stay in the tertiary level psychiatric facility. Therefore her contribution was included in the study.
• Initially difficulty was experienced in making contact with the proposed participants as they lived far away and did not always have contact numbers and did not attend the clinic during the data sampling period. Therefore, only a limited number of participants were available.
A language barrier occurred with one of the participants. The researcher could not converse in Xhosa and made use of a Xhosa speaking psychiatric nurse to interpret for the interview. This may have influenced the data obtained as the participant did not provide as much rich information of her experiences during her admission and stay in the psychiatric facility compared with the other participants.

4.6 GUIDELINES

The overall purpose of these broad guidelines is to improve the quality of care of female patients diagnosed with bipolar disorder and admitted to a tertiary psychiatric facility. The guidelines were developed to guide and improve the care offered by psychiatric nurses to patients with bipolar disorder (National Institute for Health and Clinical Excellence, 2012:7).

The guidelines were developed after the data was gathered and analysed. A literature review was conducted and incorporated in the developing of the draft guideline. Discussions were held with mental health care practitioners regarding the best way forward. Once again, the broad guideline was refined after consultation with a social worker, psychologist and a professional nurse, who specialize in mental health care and have knowledge and experience in this field. The guideline was revised and finalised to ensure that female patients diagnosed with bipolar disorder would receive optimum care according to their specific needs as indicated in chapter 3.

The following table will discuss the guidelines. Two principle guidelines were developed with a number of sub-guidelines. The two main guidelines are:

- A therapy programme should have a patient-centred approach
- A therapeutic milieu should facilitate the development and implementation of an individualized treatment plan

Sub-guidelines are divided under these two main guidelines which will be discussed in the following pages.
Table 4.1: Broad guidelines for professional psychiatric nurses to improve the care of female patients diagnosed with bipolar disorder in a tertiary psychiatric facility

<table>
<thead>
<tr>
<th><strong>THE STRUCTURE OF THE THERAPY PROGRAMME BASED ON A PATIENT-CENTRED APPROACH</strong></th>
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<tbody>
<tr>
<td><strong>Description of the problem</strong></td>
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<tr>
<td><strong>Rationale</strong></td>
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This therapeutic relationship should last until the problems have been resolved and the patient frees herself from the relationship with the psychiatric nurse; this will occur, once the patient has been discharged (Kniesl & Trigoboff, 2014:49; Pryimacchuk, 2011:35).

<table>
<thead>
<tr>
<th>Actions</th>
<th>The psychiatric nurse should actively listen to the patient's emotional, physical, social and spiritual needs</th>
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<tbody>
<tr>
<td>The psychiatric nurse should:</td>
<td>The psychiatric nurse should:</td>
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<tr>
<td>• display a non-judgemental attitude towards the patient</td>
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<td>• give the patient an opportunity to express her personal needs during regular intervals address these needs step by step by being supportive and actively listening to her</td>
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<td>• collaborate with the other multi-professional team members to ensure that all the patient’s needs are addressed and managed effectively</td>
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<tr>
<td>• offer emotional and physical support to the patients from the first day in the psychiatric tertiary facility until her discharge</td>
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<td>Actions</td>
<td>The psychiatric nurse should include the patient in her treatment programme</td>
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<td></td>
<td>The psychiatric nurse should:</td>
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<td>• inform the patient of the process that may be followed to assist her to recover as soon as possible. The patient should also be informed when conditions change such as being nursed in a less stern environment.</td>
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<td>• give the patient an opportunity to ask questions and these should be answered honestly ask the patient what she expects of her treatment and how this should be achieved</td>
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<td></td>
<td>• follow the nursing process, assessment, planning, interventions and the evaluation of this intervention, and this should be shared with the patient</td>
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<td>• include the patients family members, educate and guide those who are involved with the patient after discharge</td>
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<td></td>
<td>• ensure that the patient’s treatment should be goal orientated (Fortinash &amp; Holoday Worret, 2012:4)</td>
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<tr>
<td>Actions</td>
<td>The psychiatric nurse should develop a personalized nursing care plan for each patient (will be elaborated in the second guideline)</td>
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<tr>
<td>• after the first assessment and in collaboration with the patient develop a personalized care plan, addressing each problem that is observed, prioritizing the most important problems first</td>
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<tr>
<td>• develop a care plan that consists of specific nursing diagnoses, interventions for these specific nursing diagnoses (problems), outcomes that are envisaged for each problem and a resolution date for when these problems should be resolved; this should be made with the patient herself and other multi-professional team members</td>
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<tr>
<td>• compile an evaluation report which must be written to indicate if the outcomes (goals) have been achieved on the envisaged resolution dates</td>
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<td>• develop new interventions, and if the outcomes have not been achieved, these new interventions should be planned, implemented and re-evaluated until all the outcomes developed have been achieved (Fontaine, 2009:22)</td>
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<tr>
<td>Actions</td>
<td>The psychiatric nurse must reassure the patient of her abilities</td>
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<td></td>
<td>The psychiatric nurse should:</td>
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<td>• assist the patient to identify her own strengths</td>
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<td></td>
<td>• give positive feedback when due</td>
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<td></td>
<td>• structure activities to assist the patient to accomplish them</td>
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<td></td>
<td>• begin with simple activities and/or decisions that the patient must make reinforce positive efforts</td>
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<td>• communicate in a positive manner towards the patient</td>
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<td>• be consistent and attentive towards the patient and her needs/discussions</td>
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<td></td>
<td>• encourage the patient to develop her own abilities (Reighley, 1988:56)</td>
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<table>
<thead>
<tr>
<th>Actions</th>
<th>The psychiatric nurse should implement strategies to ensure the milieu contributes to the patient’s emotional and physical well-being by:</th>
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<tbody>
<tr>
<td></td>
<td>The psychiatric nurse should:</td>
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<tr>
<td></td>
<td>• develop a structured day programme to ensure that the patient activities of daily living (ADL’s) is clear to the patient and she knows what to expect and when and where</td>
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<tr>
<td></td>
<td>• develop a personalized day programme for the patient to address her specific needs</td>
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<tr>
<td></td>
<td>• provide specific time slots for group activities, individual sessions, meals and administration of medication</td>
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<td>• encourage the patient to participate in programme activities</td>
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- provide a variety of activities in which all patients will be interested in participating (Fontaine, 2009:168)

<p>| 4.5.2. THE DEVELOPMENT AND IMPLEMENTATION OF AN INDIVIDUALIZED TREATMENT PLAN |
| Description of the problem | The participants verbalised that their physical well-being was often overlooked. They received limited support from the staff members to help them to feel better and improve their self-esteem. The milieu is not always conducive to enhance emotional and physical healing. Patients are not actively involved in their own treatment plan and do not feel valued as individuals. In the acute care ward, use is made of standard care plans according to the diagnosis of bipolar disorder and not the individual needs that are displayed by each patient. |
| Rationale | Patients need to be nursed in a holistic manner to ensure that they are nursed according to the nursing process in a scientific method namely: assessment, nursing diagnosis, outcome identification, planning, implementing and evaluation (Fortinash and Holoday Worret, 2012:39). This process should include physical safety and support to reassure that the patient feels safe and that the plan will contribute to the healing process. Consistency and structure make the patient feel safe and contributes to the healing process. The patient’s input will be valued and therefore her self-esteem and self-dependence will increase (Stuart, 2013:643). |</p>
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<tr>
<th>Actions</th>
<th>The psychiatric nurse should ensure that the physical well-being of the patient is catered for using the following aspects:</th>
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<tr>
<td></td>
<td><strong>Admission phase</strong></td>
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<td></td>
<td>• Assessment phase to be undertaken by the psychiatric nurse.</td>
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<td></td>
<td>• Build a trusting therapeutic relationship with the patient</td>
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<td>• Listen actively when the patient is expressing a need for physical or emotional care and attend to this matter</td>
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<td>• Conduct an extensive history taking of the patient (this may not necessarily be completed on the first day, but depends on the severity of the patient’s mental status; it should be completed as soon as possible)</td>
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<td>• History taking includes the patient’s mental status, psychosocial state, physical health, pain level, and non-verbal behaviour</td>
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<td>• A physical examination should be done and appropriately recorded in the patient’s file</td>
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<td>• Orientate the patient towards the hospital policies, physical layout, the unit routine, and environment</td>
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<td>• Include the patient from day one in her treatment plan; ask the patient to contribute to her own treatment plan and value the patient’s contributions</td>
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<td>Actions</td>
<td>Nursing diagnosis</td>
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<td>• Depending on the patients' needs, identify the problems the patient is exhibiting (risk, actual and potential problems)</td>
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<td></td>
<td>• Formulate nursing diagnoses</td>
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<td>• Prioritize the nursing diagnoses</td>
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<td>• Discuss these identified needs with the patient.</td>
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**Outcomes**

• Specific, measurable, appropriate, realistic, time bound outcomes must be derived to address the specific nursing diagnosis that was developed for the individual patient

**Plan interventions**

• Determine the interventions and prioritise them
• Select evidenced-based interventions to achieve the outcomes for the individual
• Emphasise the patient’s special needs (e.g., culture, spirituality, values/beliefs)

**Implement the interventions**

Interventions should entail the following aspects:
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<th>Actions</th>
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<tr>
<td>• Promoting health and safety</td>
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<td>• Monitoring of medication and side effects</td>
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<td>• Building on coping skills</td>
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<td>• Preventing relapse</td>
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**Evaluation**

- Determine if the outcomes have been achieved on the proposed date the resolution date
- Continue implementing the interventions of the unmet outcomes
- Reassess and change the interventions as needed

**Documentation**

- Patient safety, responses to treatment plan
- Interventions implemented and outcomes (Fortnash & Holoday Worret, 2012:40)

Throughout the admission and stay period the psychiatric nurse must:

- Ensure that furniture and medical equipment are available to maintain the activities of daily living; for example, that there are enough beds, enough blankets; and that the ablution facilities are in working
<table>
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<tr>
<th><strong>Actions</strong></th>
<th>order, chairs; and additional resources to complement the day programme for example magazines, radio and a television. If these are not available ensure that facilities are upgraded or stock is ordered.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Reduce the use of seclusion and chemical restraints by:</td>
</tr>
<tr>
<td></td>
<td>✓ Observing early agitated verbal and non-verbal behavioural signs; therefore a staff member needs to be with the patients at all times</td>
</tr>
<tr>
<td></td>
<td>✓ Speaking in a clear calm voice and diverting the patient’s thoughts onto another activity, for example, walking, reading to, listening to music, spending time with the patient to reflect on her emotions.</td>
</tr>
<tr>
<td></td>
<td>✓ Acknowledge the patients feelings and be there for the patient</td>
</tr>
<tr>
<td></td>
<td>✓ Communicate expected behaviour to encourage the patient to control aggressive outbursts (Stuart, 2013:581)</td>
</tr>
<tr>
<td><strong>The psychiatric nurse should improve the physical and emotional support that is rendered to the patient by:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Accepting the patient unconditionally</td>
</tr>
<tr>
<td></td>
<td>• Engaging in therapeutic activities with the patient</td>
</tr>
<tr>
<td></td>
<td>• Offering the patient time to spend outside during the day</td>
</tr>
<tr>
<td></td>
<td>• Involving the family members and encouraging other support structures</td>
</tr>
</tbody>
</table>
Actions

- Establishing regular meetings between the primary nurse, where the patient can vent her emotions on a regular basis
- Referring to other members of the multi-professional team as the need arises
- Making contact with the patient’s family and include them in the patient’s treatment programme (Stuart, 2013:643)

The psychiatric nurse should include the patient in her own treatment plan by:

- Delegating a psychiatric nurse to a few patients (not more than ten) to act as a primary “therapist” in order to offer continuum of care throughout the patient’s admission and stay in a tertiary psychiatric facility
- Ensuring each psychiatric nurse develops an individualized care plan for the patients allocated to her/him
- Following-up on the patient and viewing their progress, addressing challenges and referring to the appropriate members in the multi-professional team
- Ensuring the advanced psychiatric nurse does assessments and interventions as indicated by the patient’s specific needs
- Assisting with the rehabilitation of the patient to enable her to reintegrate into the community to which she will return after being discharged
| Actions | • Including the family members and providing them with information and assisting the family with coping strategies to care for the patient once she is discharged (Susman, 2010:34; Registered Nurses Association of Ontario [RNAO], 2010:2). |
4.7 SUMMARY OF GUIDELINES

Two main guidelines, with sub-themes were developed to assist the psychiatric nurse to optimally manage female patients diagnosed with bipolar disorder during their admission and stay in a tertiary level psychiatric facility, when admitted during a manic phase. The first guideline focused on the structure of the therapy programme based on a patient-centred approach. The psychiatric nurse should place emphasis on the following aspects: the building a trusting relationship with the patient, including the implementation of active listen skills to understand the patient’s needs. The patient should be included in her treatment programme therefore, a personalized nursing care plan for each individual should be developed and implemented. Furthermore, the psychiatric nurse should reassure the patient of her abilities and implement strategies to ensure the milieu contributes to the patient’s emotional and physical well-being.

The second guideline focused on the development and implementation of an individualized treatment plan, the following strategies was developed to assist the psychiatric nurse in achieving this. The psychiatric nurse should ensure that the physical well-being of the patient is accommodated during her admission and stay. Therefore, it is important that the psychiatric nurse should improve the physical and emotional support provided to the patient and include her in her own treatment plan. These guidelines should assist the psychiatric nurse to optimally manage female patients diagnosed with bipolar disorder during their admission and stay in a tertiary level psychiatric facility.

4.8 CONCLUSION TO THE STUDY

It can be determined that there is a great need to invest time in adjusting the therapeutic milieu of an acute female psychiatric unit of a tertiary level psychiatric facility, where female patients are admitted and stays during their hospitalization period. Emphasis should be placed on using a client centred approach, where the patient is nursed in a holistic manner. The client centred approach, should assist the psychiatric nurse to optimally manage female patients diagnosed with bipolar disorder during their admission and stay in a tertiary level psychiatric facility.


Clarke, D. & Winsor, J.2010. Perceptions and needs of patients during a young adult’s first psychiatric hospitalization: “we’re all on this little island and we’re going to drown real soon”. Mental Health Nursing, 31: 242-247.


ANNEXURE A: REQUEST FOR PERMISSION TO GAIN CONTACT DETAILS

March 2013

Ms M Barnard
Nursing Manager
Psychiatric Clinics

REQUEST FOR PERMISSION TO GAIN CONTACT DETAILS

Dear Ms Barnard

My name is Anneki du Plessis, and I am a MCur psychiatric nursing science student at the Nelson Mandela Metropolitan University in Port Elizabeth. The title Master’s dissertation is “Guidelines for psychiatric nurses to assist in the care of female patients with Bipolar Disorder during their admission and stay at a tertiary level psychiatric facility in the Eastern Cape, South Africa” This project will be conducted under the supervision of Prof J Strumpher (NMMU, South Africa) and co-supervisor Dr D Morton.

The objectives of this study will be:

- To explore and describe how female patients diagnosed with Bipolar Disorder experience the admission and stay in a tertiary psychiatric facility.
- To create clinical guidelines to assist the psychiatric nurse to manage female patients diagnosed with Bipolar Disorder during their admission and stay in a tertiary level psychiatric facility to help them experience their stay in a most favorable manner.

I am hereby seeking your permission to ask assistance of the professional nurses at the Psychiatric clinics to provide contact details of willing and appropriate patients that fits the inclusion criteria.

- Patients should be diagnosed with Bipolar Disorder according to the DSM- IV-TR
- Patients who have experienced a manic phase before admission
- Patients who are at least 18 years of age but not older than 65
- Patients who spent at least one week in a tertiary level state psychiatric facility
- Patients must have been admitted as an involuntary patient

Furthermore I would appreciate it if these professional nurses can initiate the first contact with the selected patient and obtain oral consent for me to make personal contact with them. Once this is done and the patient has no reservation of being in the research project I will make contact and obtain written consent after a full explanation has been given on what the objectives of the project is.
I have provided you with a copy of my dissertation proposal which includes copies of the measure and consent and assent forms to be used in the research process, as well as a copy of the approval letter which I received from the NMMU Research Ethics Committee (Human).

Upon completion of the study, I undertake to provide the Department of Health with a bound copy of the full research report. If you require any further information, please do not hesitate to contact me on 041 504 2965/2122 or Anneki.duplessis@nmmu.ac.za. Thank you for your time and consideration in this matter.

Yours sincerely,

Anneki du Plessis
Researcher

Prof J Strumpher
Supervisor
Dear Participant

You are requested to participate in a research study. In this letter an explanation will be given regarding the proposed research.

The title of this research study is: “Guidelines for psychiatric nurses to assist in the care of female patients with bipolar disorder during their admission and stay in a tertiary level psychiatric facility in the Eastern Cape, South Africa

The goals of this research project are to:

- To explore and describe how female patients diagnosed with Bipolar Disorder experience their admission process and stay in a tertiary level psychiatric facility.
- To create guidelines to assist the psychiatric nurse to manage female patients diagnosed with Bipolar Disorder, during the admission process and stay in a tertiary psychiatric facility.

With your consent I would appreciate it if I can have an interview with you. In the interview I will ask you three broad questions namely:

- How did you experience your admission and stay in a tertiary level psychiatric facility?
- How was the rest of your stay in the hospital?
- If you look back what is your overall experience?

Thereafter I will leave a journal for one week with you to jot down any aspects that you might remember and would like to share of your experiences during your admission and stay in the psychiatric facility. During my first contact I will explain the reason for the research and what your role will be. Any questions or concerns you might have will be discussed.
The interview will be recorded using an electronic voice recorder as to give a true reflection on what was discussed. Confidentiality is of high importance and your name will not be used or referred to during the research process.

Furthermore, it is important that you are aware of the fact that the proposed study had to be approved by the Nelson Mandela Metropolitan University before conducting it. This is to ensure that your welfare is protected and that the study is conducted in an ethical manner. Any queries that you may have regarding your rights can be directed to the chairperson of the Departmental Research Committee, Prof J Strumpher at (041) 504 2122, or the chairperson the Ethical committee who can be reached by 041 504 research office.

Your participation in this research is completely voluntary. You are not obliged to take part. If you do participate, you have the right to withdraw at any stage during the study.

Yours sincerely

Anneki du Plessis
(Researcher)

Prof J Strumpher
(Supervisor)
ANNEXURE C: CONSENT FORM

I ______________________________ give voluntary consent to take part in the research study of Anneki du Plessis. The title of the research study being Guidelines for psychiatric nurses to assist in the care of female patients with Bipolar Disorder during their admission and stay at a tertiary level psychiatric facility in the Eastern Cape, South Africa

I understand I will be interviewed and that the interview will be recorded electronically. I will also be given a journal (notebook) in this book I may reflect more on the experiences I had during the period I was admitted. I may withdraw from this study anytime during the study and that no personal information will be given in this study so that I would be identified as a participant. No pressure was exerted on me to take part in this research study.

I hereby acknowledge that I received all relevant information regarding this study and all my questions was clearly answered.

Signature: ______________________________

Date: ______________________________

Witness: ______________________________

Date: ______________________________

Witness: ______________________________

Date: ______________________________
ANNEXURE D: RESEARCH ETHICS COMMITTEE (HUMAN) APPROVAL LETTER

Chairperson: Research Ethics Committee (Human)
Tel: +27 (0)41 504-2235

Ref: [H12-HEA-NUR-012/Approval]

RECH Secretariat: Mrs U Spies

2 April 2013

Prof J Strümpher
NMMU
Nursing Science
J Block – 102A
Summerstrand North Campus

Dear Prof Strümpher

GUIDELINES FOR PSYCHIATRIC NURSES TO ASSIST IN THE CARE OF FEMALE PATIENTS WITH BIPOLAR DISORDER DURING THEIR ADMISSION AND STAY AT A TERTIARY LEVEL PSYCHIATRIC FACILITY IN THE EASTERN CAPE, SOUTH AFRICA

PRP: Prof J Strümpher
Pt: Ms A du Plessis

Your above-entitled application for ethics approval served at the Research Ethics Committee (Human).

We take pleasure in informing you that the application was approved by the Committee.

The ethics clearance reference number is H12-HEA-NUR-012, and is valid for three years. Please inform the REC-H, via your faculty representative, if any changes (particularly in the methodology) occur during this time. An annual affirmation to the effect that the protocols in use are still those for which approval was granted, will be required from you. You will be reminded timeously of this responsibility, and will receive the necessary documentation well in advance of any deadline.

We wish you well with the project. Please inform your co-investigators of the outcome, and convey our best wishes.

Yours sincerely

[Signature]

Prof CB Cilliers
Chairperson: Research Ethics Committee (Human)

cc: Department of Research Capacity Development
Faculty Officer: Health Sciences