UNIVERSITY OF KWAZULU-NATAL

EXPLORING STUDENT NURSES' NARRATIVES ON NURSING MENTALLY ILL PEOPLE IN A MEDICAL WARD IN THE UMGUNGUNDLOVU DISTRICT

NOLUNDI RADANA

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2011

DECLARATION

I, Nolundi Radana, declare that "Exploring Student Nurses' Narratives on Nursing Mentally Ill People in a Medical Ward in the Umgungundlovu District" is my own work except for the referenced citations. This work has not been submitted for any examination purposes before.

SIGNATURE: …………………………… DATE:……………
Nolundi Radana

SUPERVISOR'S SIGNATURE:……………………… DATE:…………….
Charlotte Engelbrecht

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No undertaking of a project as intense as this study is possible without the support and contribution of many people. It is not possible to single out all those who offered support and encouragement during what at times seemed to be a 'long and winding road with no end in sight.' However, there are people without whom this project would not have been completed, and to them go my sincere gratitude and acknowledgement of their contributions.

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May God richly bless you!

Dedication

I dedicate this thesis to my children, Zimvo, Nonikwa, Lizalise and Akahlulwa,

And

My brother, Ntlokoma Jevu.

Thank you for believing in me, you are the wind beneath my wings

ABSTRACT

The promulgation of the Mental Health Care Act of 2002 in South Africa came with challenges or changes in the nursing of mentally ill people. One of the changes required that mental patients need to be observed and assessed for a period of 72 hours in a general or medical ward before being transferred to a specialist hospital. Sometimes the person remains in the ward for more than the 72 hours. This means that nursing students doing their comprehensive four year diploma (R425) are exposed to nursing people with mental illness in their first, second and third year of training, which is prior to the mental health nursing/psychiatric nursing module undertaken in the last semester of the fourth year. The purpose of this study was to explore student nurses' narratives on nursing mentally ill people in a medical ward. Narrative inquiry was used as the research methodology.

Purposive sampling was used to select 5 participants for this study. The inclusion criteria specified that participants had to be second year students participating in the four year Comprehensive Nursing Diploma Programme (R425) who have nursed, or been in contact with a mentally ill person, for a period of eight weeks. The study was conducted before the participants were exposed to the psychiatric module, which is undertaken in fourth year of the diploma course. Data collection took place through a total of 5 sessions of focus groups which took place in a boardroom. While personal names were excluded, participants were required to fill in certain demographic details.

Data analysis was undertaken using narrative data analysis, which looked at narrative strings, which are presenting commonalities and narrative threads which are major emerging themes.

The narrative strings or commonalities that were identified were in the area of beliefs, with the dominant beliefs regarding the causes of mental illness being culturally or socially based. Emotions such as fear, sadness and frustration were identified, as well as ignorance which

leads to stigmatising attitudes. The narrative threads or emerging themes that were identified were: making sense of experiences; moments of awakenings; breaking free moments; and acceptance of a known person with mental illness. The following themes were identified: moments of awakenings or realisation, where the participants started seeing the mentally ill person in another light; and moments of strengths/unique outcomes, where participants recognised their own strengths in dealing with a mentally ill person.

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CHAPTER 1

INTRODUCTION AND BACKGROUND TO THE STUDY

"Stories help to make sense of, evaluate, and integrate the tensions inherent to experiences: the past, with the present; the fictional with the real, the official with the unofficial; personal with the professional,....Stories help us transform the present and shape the future of our students and ourselves so that it will be richer or better than the past"

(Dyson & Gernishi, 1994)

1.1 Introduction

This chapter describes the background to this study. It also includes the problem statement, the purpose and objectives of the study, the research questions and the significance of this study.

1.2 Background and rationale of the study

In line with the WHO declaration and the international trends, the Mental Health Care Act South Africa was promulgated in 2002 and came into effect in 2005. The objectives of the Act were to provide mental health care in the primary, secondary and tertiary levels of care (Act no.17 of 2002), as well as to maintain the dignity, rights and privacy of those being cared for (Act no.17 of 2002; Act no.108 of 1996).

According to Burns (2008), this was a welcomed move, particularly as it was a move away from the1973 Act, with all its shortcomings, intentional or otherwise. The Mental Health Care Act of 1973 (Act no. 18 of 1973) did not provide for the welfare of patients in terms of their dignity, and human needs were neither valued nor

prioritized. People suffering from mental illness were certified in mental institutions which had political ideologies that allowed practices fraught with abuse and prejudice, thus depriving patients of their basic human rights (Burns, 2008). The new act prescribes that mental health services should be provided in primary, secondary and tertiary levels of care and, being in line with the Constitution of the Republic of South Africa (Act No.108 of 1996), it guards against unfair discrimination of people with mental or other disabilities. Thus, contrary to the old act (Act 18 of 1973) which put emphasis on treatment and control, the new Mental Health Care Act puts emphasis on care, treatment, rehabilitation and the acknowledgement of the rights of people who are mentally ill.

However, the integration of mental health care into the general stream as per the Act's objectives has not been without challenges, among which Szabo (2006) and Burns (2008) have identified the following:

- Lack of adequate facility resources (material, human and financial)
- Staff limitations in terms of necessary skills to manage people living with mental illness
- Not enough knowledge of the act itself.

One of the biggest challenges, however, has been the implementation of the 72 hour observation period. This is the period of assessment in district hospitals, whereby a person believed to be mentally ill is assessed both physically and mentally every 24 hours for a period of 72 hours before being transferred to a specialist hospital. This is aimed at excluding general medical conditions such as delirium, epilepsy, head injuries, meningitis, to mention but a few. The rationale of the 72 hour observation period is as follows:

- Avoidance of stigma which may be caused by unnecessary admission to a psychiatric hospital
- The person may recover quickly as, for example, in cases of substance abuse.
- It will improve decentralisation and integration of mental health services in the general stream.
- The person will be treated nearer home which will help family members to be actively involved (Act no 17 of 2002: 34; Burns, 2008).

Thus, during this period, investigations are done, diagnosis made, and treatment prescribed and commenced at the district hospitals, and only after 72 hours a patient is referred to a psychiatric hospital, if deemed necessary.

However, the implementation of the 72 hour observation period has not been without problems which have resulted in suboptimal and improper care such as the heavy sedation of mental patients making assessment almost impossible, resistance to change, the unavailability of drugs used in psychiatry and the unavailability of trained and experienced staff (Burns, 2008). Another factor is the difficulty in managing the sometimes aggressive, violent and agitated behaviour of the mentally ill, which turns a general ward setting into an unsafe environment (Burns, 2008; Mavundla, 2000).

There is literature, both international and local, with regard to mental health care from the perspective of the mental health care user. Amongst the studies reviewed is a study which addresses violence and abuse directed at mental patients in an inpatient institution as well documenting some of their experiences in an acute mental heath ward (Lucas & Stevenson, 2006; Wood & Pistrang, 2004). What I found very

interesting is that the researchers cited above are in accordance with other researchers in suggesting that factors such as inadequate staffing, an unsafe environment and work overload can also be the causes of negative perceptions, experiences and attitudes and, thus, contributory factors in abusive and violent behaviour towards mental health care users (WHO, 2007; Mavundla, 2000). This has made me realize that it is important to make a comprehensive review and not to isolate the components as they are all interrelated.

Nursing is considered to be a stressful occupation that can lead to moral distress (Corley, Minick, Elswick & Jacobs, 2005). In addition to negative attitudes, various sources have identified lack of autonomy, physical and psychological demands, hierarchical structure, being answerable to other professions, as well as rigid hospital or organisational rules as factors contributing to moral distress (McCarthy & Deady, 2008; Zuzelo, 2007). As nursing students are further down the hierarchical structure of the profession, they may experience the lack of autonomy more than the other categories (Tully, 2004), and the resulting feelings of disempowerment and vulnerability contribute to their anxieties and stress (Melo, Williams & Ross, 2010; Edwards, Burnard, Bennett & Hebden, 2010).

There is quite a large body of literature relating to mental health or psychiatric nursing. Most literature I have reviewed (Sharrock & Happell, 2006; Reed & Fitzgerald, 2005; Nijman, Bowers, Oud & Jansen, 2005; Berg & Hallberg, 2000; Mavundla, 2000) has been on nurses' attitudes towards mentally ill people, nurses' experiences in dealing with aggression, as well as nurses' perceptions on nursing mentally ill patients. Regarding the attitudes, experiences and perceptions of registered nurses, there is enough evidence in the literature to support the studies that

have already been done (Sharrock & Happell, 2006; Reed & Fitzgerald, 2005; Nijman, Bowers, Oud & Jansen, 2005; Berg & Hallberg, 2000; Mavundla, 2000). In three of the studies mentioned above, the general feeling was that the participants felt they lacked expertise, that their skills and knowledge regarding mental health care were inadequate and that they would benefit from training and education (Sharrock & Happell, 2006; Reed & Fitzgerald, 2005; Mavundla, 2000; Burns, 2008). It is interesting to note that the last two studies in the citations above were conducted in South Africa. I would also like to add that these are people who are and have to be role models for the students and are therefore expected to teach by precept and /or example (Mellish, 1987; Hlongwa, 2005).

Several studies have identified the stigma and structural discrimination attached to mental health nursing which have been manifested through lack of policies, policies that don't favour mental health, mental health care workers not being involved in policy and decision making, lack of resources, lack of training and inadequate staffing needs (Liggin & Hatcher, 2005; Global Mental Health series 2007; Walker & Gilson, 2004). These findings support the thinly described, problem saturated stories about mental illness in general, and mental health nursing in particular. Because little research has been aimed at hearing the stories of people living with mental illness, not many conclusions have been reached in this respect.

The media has also played a role in perpetuating sensational stories that give the public a distorted perception of those who are mentally ill. In 2009, there was a spate of these descriptions in the district where the study was being conducted, seen through headlines like *"Madman Bludgeons Woman"* and *"Psychiatric Patient Runs Amok"* (The Witness, August 18, 2009; News 24 com). These articles gave descriptions of a

mentally ill person as some crazy person who was running around wielding a weapon, a murderer who was out to get the blood of innocent people by killing them mercilessly. Whilst I do not in any way condone the killing or injuring of people, I feel it would have helped if the articles had rather highlighted the reasons behind the attack and the type of mental illness affecting the perpetrators involved. I believe this in turn would encourage the government or the various stakeholders involved in the mental health/mental illness fraternity to plan strategically for displaced mental health care users and what can be done to help them. These thin descriptions of people suffering from mental illness, as highlighted by the media, and the negative attitudes and perceptions of health care workers and others in the communities can lead to false conclusions being reached about people living with mental illness. This is further compounded by dominant problem saturated discourses that can lead to feelings of disempowerment, not only for those living with mental illness, but also for the students who come in for training (Morgan, 2000).

Against this background, we have students coming from their homes in their respective communities to start training in the institutions. According to the learning theory of Vygotsky (1978); Moen (2006); Daniels (2009)and; Parke (2009), learning has already taken place through culture, therefore the students come with culturally and socially constructed discourses, attitudes, perceptions and, perhaps, even experiences of interacting with people living with mental illness (Weedon, 1987; Foucault, 2003; Walker, 2006). These students have also been exposed to stories in the media of mentally ill individuals, which have often been peppered with negative undertones, further perpetuating the predominantly negative stories and stereotypes.

When the students are placed in clinical areas to gain learning experience, their first areas of placement are in medical and surgical wards and in the medical and surgical outpatient departments, thus bringing them into contact with mentally ill individuals. These situations form the cradle of the development of new behaviour based on environmental conditions as it is known in the behavioural learning theories (Slavin, 2006; Moen, 2006; Daniels, 2009; Parke, 2009). While the focusing on objectively observable behaviours in the learning environment (in this study, the clinical placement areas) is essential for the acquisition of new skills, the student also learn the attitudes and perceptions of their role models.

Amongst other anecdotal reports, the following scenario illustrates the above. At the selected institution, it was reported at the nurse manager's report meeting that one of the mentally ill patients had apparently violated a corpse in a medical ward whilst the staff and students were waiting for the mortuary attendants to come and take the body (Mngadi, 2010). This was a shocking experience for both the staff and the students, highlighting their already developed perceptions of the mentally ill. Although this incident prompted the Chief Executive Officer of the institution to provide a seclusion room for the acutely psychotic individuals, it would appear that no debriefing or discussion of the situation was offered to any of the staff or students.

Bearing in mind that most of those participating in this research are African, for those brought up in the African culture, the significance of this incident is two-fold: Firstly, it may be believed that the perpetrator is a witch (*uyathakatha*), a demon possessed who is cursed (*uloyiwe)*, probably because of rituals that were not done for him. It could also be seen as a manifestation of a crime or evil deed (like killing someone or raping someone) that he probably committed secretly which is coming out in the open

(uyatyhilwa), (Amaze, 2002; Phiri, 2009; Ngobese, 2003; Radzilani, 2010; Moyo, 2004). Secondly, in the African cultural context, a deceased person or corpse is viewed as sacred, to be treated with awe and respect. This is because of the belief that the person is now an ancestral spirit which has the power to bring about curses or calamity when angered (Amaze, 2002; Phiri, 2009; Ngobese, 2003; Radzilani, 2010; Moyo, 2004). This may fuel feelings of anger towards the perpetrator and feelings of fear that his actions may bring curses not only to him, but also to his family and those who witnessed the incident.

The cumulative effects of reports or stories such as this can put students in a position of vulnerability and disempowerment simply because they have their own culturally and socially constructed beliefs which are being challenged, while at the same time, being mere students, they are unable to challenge the hierarchical structure of the nursing profession.

1.3 Problem statement

It is my observation that much of the literature confirms that dominant cultural and socially constructed discourse in the nursing profession in general, and mental health nursing in particular, have contributed to negative attitudes, perceptions and experiences of those who are mentally ill as well as to the stigma attached to being mentally ill.

Gergen (2000: 126) describes dominant culture as the "*very shape of our lives, the rough and the perpetually changing draft of the autobiography we carry in our minds, which is understandable to us and to others only by virtue of cultural systems of interpretation.*" In other words, dominant culture could be described as views passed

from generation to generation, transcending time and socially maintained, that are prevalent in our thinking, being and reality such that the meanings of our experiences, and the world around us is shaped by these views (Engelbrecht, 2005). This view or description seems to confirm Michael White's suggestion that our life narratives are determined by our culture and that as human beings we make sense of our lives through stories. These include both cultural narratives we are born into and the personal narratives we construct in relation to those that are dominant in our culture (Epston & White, 1990).

Dominant cultures in their small forms give rise to discourses. Whenever two people are communicating, a discourse is created (Engelbrecht, 2005; Foucault, 2003). These discourses manifest themselves in different levels: familial, societal and institutional or organisational. They can also be internal or intrapersonal, taking place inside; and external or extrapersonal, taking place outside (White, 1995; Foucault, 2003).

When students come in from their communities to study nursing for the first time, they come into contact with people who are mentally ill and are subjected to the prevalent problem saturated discourses regarding mental illness. It is inevitable that they will inherit the culture of negativity, thus creating a never ending cycle of negative attitudes, perceptions and stigma attached to mental illness or people living with mental illness. In this way, dominant discourses lead to marginalisation of other forms of meaning and understandings, keeping these out of the mainstream so that alternative stories or outcomes cannot be generated (White, 1995; Engelbrecht, 2005). Student nurses, who have not been exposed to the psychiatric nursing component of the four year course, are placed in medical wards in which MHCU are cared for. The

lack of academic exposure and formal supportive network is suggested to impact the student nurses and therefore patient care

1.4 Purpose of the study

Therefore the **purpose** of this research was to co-author the stories told by student nurses who have been placed for clinical learning at a particular institution in the Umgungundlovu district by documenting their stories of working with patients who are suffering from mental illness. It was hoped that this would help them to view mental illness from a new perspective as they generated new understandings and attitudes toward an illness that has previously been thinly described and stigmatised, leading to unique outcomes. The knowledge and understanding of unique outcomes gained through this study could be used to inform curriculum development.

1.5 Objectives

To achieve the purpose, the following **objectives** were set:

- To deconstruct the thinly described narratives of the individual, community and professional lives of student nurses interacting with mentally ill individuals.
- To develop alternative narratives and unique outcomes on mental illness/health in the professional and personal lives of student nurses.

1.6 Research questions

1.6.1 The broad question

What are the dominant and alternative stories of mental illness told by students placed in a medical ward exposed to 72 hour observation procedures (Act no: 17 of 2002) for clinical learning purposes?

1.6.2 Specific research questions

- What are the thinly described narratives of the individual, community and professional lives of student nurses interacting with mentally ill individuals?
- What are the alternative narratives and unique outcomes in the professional and personal lives of student nurses?

1.7 Significance of the study

1.7.1 Nursing Practice

This study might contribute to the body of knowledge in the nursing praxis by identifying challenges or pitfalls and areas that need improvement in mental health nursing which, in turn, will lead to the modification of behaviours and perceptions of nursing professionals in dealing with mentally ill people in medical wards. This study may help to reduce the stigma and structural discrimination associated with mental illness.

The study might assist those involved with nursing education to deal with some of the challenges which face student nurses in their training, such as dealing with stigma associated with mental illness. It may lead to student nurses receiving more support in dealing with stressors inherent in the clinical environmental, particularly when faced with mental illness. This study may also lead to a curriculum review of the mental health-nursing programme through the knowledge and understanding of the students' unique outcomes, this in turn will empower the students with necessary skills on interacting with the person with mental illness.

1.7.3 Nursing management

This study might serve to influence policies and decision making in the field of mental health.

It may also lead to the implementation of a support system for both staff and students through debriefing and construction of nursing praxis. In this way students, as future nurses, will have opportunities of life-long learning.

1.8 Operational definitions

Narrative inquiry: Narrative inquiry is a *"way of understanding experience. It is collaboration between researcher and participants, over time, in a place or series of places and in social interaction within a milieu…simply stated narrative inquiry is stories lived and told"* (Clandinin & Connelly, 2000: 20)

Experiences: Experiences are actual observations of, or practical acquaintance with, facts or events which could be regarded as eroding or gaining knowledge and skill resulting from this (The Readers digest Oxford Dictionary, 1993: 59).

Student nurses: Student nurses are persons undergoing education or training in basic nursing (Nursing Strategy, 2008). For the purposes of this study, a student nurse is a nurse in the KwaZulu-Natal College of Nursing who is in the process of undergoing a four year diploma course leading to registration as a nurse (general, community, psychiatry) and midwife, according to regulation R425 of 22 (SANC: 1985), as amended.

Nursing: According to the South African Nursing Act of 2005, nursing is an art of caring practised by a person registered with the South African Nursing Council, which supports, cares for and treats a health care user to achieve or maintain health and, where this is not possible, to care for a health care user so that he or she lives in comfort and with dignity until death

Narratives/Stories: Narratives or stories are units of meaning that provide a frame for lived experiences (White, in Epston and White, 1992: 80). The terms, narratives and stories, will be used interchangeably in this study.

Deconstruction: Deconstruction is a process of acknowledging and taking apart beliefs, ideas, practises of the broader cultures in which a person lives that are serving to assist the problem and problem story (Morgan, 2000).

Alternative stories: Alternative stories are stories that have the ability to reduce the influence of problems and create new possibilities of living (Morgan, 2000).

Unique outcomes: Unique outcomes are moments of strength, autonomy and emotional vitality hidden in life stories that are otherwise saturated with problems or sufferings (White, 1995:26).

Problem saturated stories: Problem saturated stories are stories that imprison people and limit people's visions of themselves, their relationships and views of the world as well as leaving little room for alternative or counter-stories or for contradicting evidence (White, 1995).

Dominant stories: Dominant stories are stories formed from the memories and experiences of individuals through views of family members and significant others and these tend to prevent infiltration of alternative experiences that bring hope and capabilities, thus leading to self fulfilling assumptions (Van Wyk, 2008).

Social constructionism: Social constructionism is the proposition that all knowledge, including so called 'scientific knowledge' is not a neutral body of data independent of cultural norms and values, but is actually socially constructed in support of particular values and understandings (Maree, 2007).

Thin descriptions: Thin descriptions refer to the meanings attached to or reached about the problems and challenges in the face of adversity. Thin descriptions allow little space for the complexities or contradictions of life, little space for people to articulate their own particular meanings of their actions and contexts within which these occur (White,2002 ; Morgan,2002).

Thin conclusions: Thin conclusions result from the thin descriptions about people's identities often expressed as truths about the person who is struggling with the problem and their identity (White, 2002; Morgan, 2002).

Thick/Rich description: Thick or rich descriptions involve articulation in fine detail of the story lines of a person's life (White, 2002; Morgan, 2002).

Medical ward: A medical ward is a ward in a hospital that admits patients diagnosed with medical conditions. In this study, a medical ward is a ward that admits people with mental illness for the 72-hour observation period.

72 hour observation: 72 hour observation period is the period prescribed by the Mental Health Care Act of 2002, which prescribes observation of a person to rule out medical cause for altered mental status.

Co-authoring: Co-authoring involves the documentation of people's thinly described and problem saturated narratives concerning certain experiences in their lives, and ways of addressing them, so that these experiences and knowledge can be distributed to others through the written word.

Discourse: Discourses are ways of constituting knowledge, together with social practises, forms of subjectivity and power relations between them. Discourses are more than the ways of thinking and producing meaning (Foucault, 2003).

1.9 Summary of the chapter

In this chapter, the background of this study was explained. It also included the problem statement, purpose, objectives, research questions and the significance of the study. Chapter Two will explore the literature reviewed in this study, which is with respect to the student nurses nursing mentally ill persons.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature in the area of student nurses nursing mentally ill persons. The following areas and keywords were investigated: student nurses and mental illness; students' perceptions of a mentally ill person; nursing students' experiences and attitudes on nursing mentally ill people in the ward and; students' perceptions after classroom exposure. The following databases were used: CINAHL, EbscoHost, ScienceDirect, Biomed Central, Pubmed, Cohrane Library, Academic search complete, Healthsource Nursing/Academic Ed,Proquest, SA-e Publications and Springerlink.

Holloway and Freshwater (2007a) caution against having a too detailed literature review in narrative inquiry as this may lead the researcher into a particular direction instead of listening to the participants' stories (Holloway & Freshwater, 2007 a). Dhunpath (2010), however, is reluctant to adopt this view and makes a valid point that literature reviews are crucial to ensure that the rigour of the scientific inquiry is beyond reproach. I personally found it useful to consult the following literature to ensure that this research will make a meaningful contribution to knowledge production (Dhunpath, 2010) and will give a picture of the context of the study.

While looking at what was available on students' experiences and perceptions, I noticed that there is plenty of literature on students' experiences regarding patient aggression and mental health clinical nursing (Nau, Dassen, Halfens & Needham 2007; Suikkala & Leino-Kilpi, 2005; Melrose & Shapiro, 1999).

2.2 Negative perceptions

In looking at the literature regarding students' experiences and attitudes, it became clear to me that the dominant stories were indeed influenced by stereotypes, culturally constructed beliefs about mental illness and personal experiences (Cleary & Happell, 2005; Hayman-White & Happell, 2005). It also became clear that the dominant stories consisted mainly of negative perceptions. Many studies made reference to the emotion, fear. It appeared, however, that it was not the behaviour of mental patients that was feared, but rather not knowing how to deal with it and feeling excluded (Midgley, 2006; Orland-Barack & Wilhelem, 2005). Feelings of fear were also accompanied by anxiety about expectations and increased stress levels (Cleary & Happell, 2005; Hayman-White & Happell, 2005; Hoekstra, Van Meijel & Hooft-Leemans, 2010; Penn, 2008). Various studies reviewed agreed that students need more competencies in dealing with violent behaviour, which can be achieved by empowering them with knowledge about aggression, communication skills, such as assertiveness, as well as interpersonal skills and relations (Hoekstra, van Meijel & Hooft-Leemans, 2010; Penn, 2008) .

In a roundabout way, I learnt that some positive experiences have been reported by students and that confidence, empowerment through knowledge and orientation to clinical areas increased positive attitudes towards nursing or interacting with mentally ill people (Chan & Cheng, 2001; Cleary & Happell, 2005; Hayman-White & Happell,

2005; Hoekstra, van Meijel & Hooft-Leemans, 2010; Penn, 2008). Positive experiences could, and do, contribute to general positive attitudes according to these aforementioned authors.

2.3 Student nurses attitudes after classroom exposure

Studies have also been reviewed of attitudes of student nurses who come into contact with mentally ill people after classroom exposure (McLaughlin, 1997; Muir-Cochraine, Bowers & Jeffery, 2008; Stacey, Felton & Joynson, 2009), as well as their perceptions regarding their experiences of clinical nursing, including communication with mental health care users (Middleton & Uys, 2009). McLaughlin's findings suggest that being exposed to classroom theory can change a student's attitude towards mentally ill patients, usually in a positive direction. The above mentioned researcher did feel, however, that this study needs validation as it is in direct contrast with the findings of Procter & Hafner (1991), as cited in the article by McLaughlin (1997). Various other studies have been conducted regarding the attitudes, perceptions and experiences of first year or novice students and findings revealed mainly negative attitudes in the form of fear and anxiety, even when not directly involved with people with mental illness (Midgley, 2006; Orland-Barack & Wilhelem, 2005).

In most of the literature reviewed, there is a general consensus about negative portrayals and perceptions of people with mental illness. The question that comes into the minds of many is what can mental health nurses do to improve these negative portrayals (stories) which are stigmatising and discriminating (Happell, 2005) ?

Reflecting on this, Happell, as cited above, suggests moving beyond our individual reactions so that mental health nurses can recognise their roles as advocates. She refers to these negative attitudes as an iceberg and that by chipping away at it, meaningful contributions can made in improving the attitudes towards the consumers of mental health services and the quality of services that are provided to them.

Internationally, more interest has been focused on nurses' attitudes, perceptions and experiences during the last decade, and changes in the Mental Health Care Act have stimulated research in South Africa in the past few years (Lowane,1990 ;Mavundla & Uys, 1997). Hlongwa (2005) studied the perceptions of nurses who completed the R425 diploma regarding their psychiatric nursing competencies. She found that poor orientation to the psychiatric units as well as lack of flexibility due to bureaucratic order and stereotypes were perceived as contributing factors towards incompetency. These findings seem to support Khoza (1996), as cited in the same study, who found that negative attitudes of senior professional nurses could be a factor contributing towards incompetency. Khoza's view supports a study conducted in the Limpopo province by Lowane (1990), who also found that the negative attitudes of ward sisters influenced negatively on student nurses' learning in clinical situations. Such attitudes may in turn influence the students' own attitudes towards nursing and learning. It was interesting to note that comparative studies have shown that nurses with higher levels of education and specialised psychiatric training had more positive attitudes than those without psychiatric training (Mavundla & Uys, 1997; Tay, Pariyasani, Ravindrani, Ayyo & Rowsudeen, 2004; Björkman, Angelman & Jönsson, 2008; Ross&Goldner, 2009; Chambers, Guise, Välimäki, Botelho, Scott, Staniuliene & Zanotti, 2010). Whilst these studies were not specifically aimed at mental health care, it makes one question what impact the same negative attitudes have on student nurses

nursing a mentally ill person in a medical ward. While the study by Ross and Gardner (2009) supports the view that negative attitudes do have a negative contribution, they believe that being familiar with people who are mentally ill leads to a change of attitude that is more positive towards people with mental illness. However, there is no evidence of studies specifically aimed at student nurses' experiences of nursing people living with mental illness before they have been exposed to the psychiatry module of their nursing diploma, which is undertaken during the second semester of the fourth year of study in the four year programme in South Africa (KwaZulu-Natal College of Nursing rule book). This study, therefore, might fill the gap and contribute to the body of knowledge in this field.

2.4 Summary of the chapter

This chapter consisted of a literature review in relation to nurses' experiences and perceptions while nursing mentally ill people in psychiatric wards, with particular reference to the perceptions of student nurses regarding nursing mentally ill people and their perceptions post classroom exposure.

Chapter 3 will be looking at the methodology used.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the research approach, as well as the setting and design of this study. It also includes the sampling procedures, how data was collected, managed and analysed, and the ethical issues and how these were managed.

3.2 Philosophical assumptions

In undertaking this research, I have chosen to use the post-modernism/social constructivism paradigm as it puts more emphasis on human-centred approaches and values the subjectivity of experiences and the multiple voices of individuals (Gergen, 2001; Muller, 2003; Maree, 2007). Post-modernism does not only look at the subjectivity of the experience, but also at deconstructing and uncovering new meanings and interpretations of experiences (Maree, 2007). Post-modernism encourages a comprehensive and holistic approach in dealing with a phenomenon, while also acknowledging the complexity of life (Shaw, 2001; Maree, 2007). It also facilitates thick descriptions of experiences, by adding to or changing the previously thinly described descriptions which have been dictated by discourses from the society in which the person lives (White, 1995; Foucault, 2003; Morgan, 2000; Engelbrecht, 2005).

3.2.1 Narrative inquiry

I have chosen narrative inquiry as the research design as it not only looks at the experiences of the participants, but also seeks to explore the social, cultural as well as organisational or institutional narratives within which the individual's experiences were constituted, shaped, expressed and enacted (White 1995; Clandinin & Connelly, 2000; Foucault, 2003). Narrative inquiry, through the study of experiences, also seeks to enrich and transform these experiences, not only for the participants, but also for myself as the researcher (Clandinin & Rosiek, 2007; White, 1995). This transformation results in the reconstruction of an individual's preferred stories and experiences in his or her relationships and social milieu (Morgan, 2000; White, 1995; Clandinin & Connelly, 2000). Narrative inquiry is viewed as a relational form of inquiry as it looks at contextual influences that are always present and which a researcher cannot control. Clandinin & Connelly (2000), as cited by Clandinin & Rosiek (2007), describe these multiple contexts as spatial, cultural, social, institutional, place and people. This study will use these contexts to describe the way participants go about making sense of their experiences in an ongoing manner. Another reason for using this approach is to search for the meanings rather than the truths, as these are obsolete and research of experiences cannot be quantified (Saunders, 2007; Grigoratos, 2006; Holloway & Freshwater, 2000 b). Narrative inquiry makes it possible for people to make sense of their experiences, because bringing in the multiple truths and the power of these experiences leads to negotiated meaning (Kerr, 2005; Kelly & Howie, 2007). Narrative inquiry is described by Moen

(2006), as telling a story in a sequence of events that have significance for the narrator.

This phenomenon is described as being the narration of lived experiences that creates an identity for the narrator (Frid, Ohlen & Bergbom, 2000). I chose to use this approach in this study as it will give the participants a chance to tell individual stories about experiences from their lives and also give them permission to have their voices heard (Sandelowiski, 1991, as cited in McGillis & Kiesners, 2005; Allen, 2006; Maree, 2007). Holloway & Freshwater (2007b:705 asserted that by giving the participants a chance to tell their stories, they can understand their experiences better and be able to share their emotional experiences with others. According to these authors, "*Stories are devices for individuals to come to terms with their vulnerability and it is through stories individuals may take control and subsequently feel empowered. People also wish to attribute responsibility, blame or praise to specific individuals. Stories help individuals create meaning and master experiences*."

As narrative researchers, we position ourselves within the post-modernism or some would say social constructionism paradigm. This does not only have implications for the way we think about truth, but also for the way we try to be truthful in doing research (Muller, 2003).

In this study, the narratives are described in such a way that the participants, the researcher and the reader will form a deeper understanding of these socially constructed narratives students are living by.

3.3. Research setting

The research setting is one of the campuses of the University of KwaZulu-Natal, College of Nursing. It is situated in the Umgungundlovu district (DC22),

Pietermaritzburg, and falls under the umbrella of a nearby, rural hospital where the students are sent to do their clinical training. This hospital catered mainly for the previously disadvantage group, but is now, however, a district and tertiary level facility. The campus consists of approximately 450 students and offers the following programmes: a four year Comprehensive Diploma in Nursing (general, community, psychiatry) and midwifery (R425); a two year bridging course (R2172); and a one year midwifery course (R254). A second floor boardroom on campus was used for the interviews as it afforded privacy and was free from distraction. A round table was available to seat participants during the group sessions.

3.4. Selecting of participants

The study was conducted using student nurses in their second year of training who had not yet been exposed to the Psychiatry/Mental Health Module, which is undertaken in the last semester of the fourth year of the Comprehensive Nursing Diploma. This was to investigate the narratives and pre-judgements of student nurses before they had had the benefit of the mental health teaching module.

Purposive sampling was used in this study and participants were invited to participate. I chose a sample of 5 participants from those who fitted the inclusion criteria and who were interested in sharing their stories. Selection also depended on the uniqueness of the stories and experiences. Only 5 participants were needed because in narrative research the depth, not breadth, of the experience is sought. The selection of research participants depended, therefore, on the response of the participants.

3.5 Inclusion criteria

To be eligible for inclusion, participants had to meet the following criteria:

- to be a second year student in the four year Comprehensive Nursing Diploma course (R425);
- to have been allocated to a medical unit where 72 hour assessment is practised according to the Act for at least a period of 8 weeks or more, and to have been in contact with a mentally ill person during that period; and
- to be able to converse in English.

3.6 Demographic description of participants

Pseudo names have been used in order to maintain confidentiality and protect the privacy of participants.

Themba is a 35-year-old male with no history of mental illness in the family. He grew up in a rural area in a traditional Xhosa household and went to school at one of the Black or Bantu Education Schools, as they were known in those days. Prior to nurse training, he was a security officer and had worked with people who are mentally ill He has worked in a medical ward nursing a person with mental illness

Nobuhle is a 26-year-old female. She grew up in a traditional Zulu household and she went to a Black school. Although she has an uncle who is mentally ill, she had never worked with a mentally ill person before training. She has since worked in a medical ward with mentally ill people.

Joy is a 25 year old female. She was born in a rural area, but later, at a young age, relocated to an urban area where she attended an Indian school. She had a cousin who had mental illness, but who died in a car accident. She had never worked with a mentally ill person before training. She has since worked in a medical ward with mentally ill people.

Promise is a 22-year-old female with no history of mental illness in her family. She was born in a rural area, but moved to an urban area after her mother died and she was fostered by the white family who had employed her mother. She attended a previously white, model 'C' school. She had never worked with a mentally ill person, but had encountered them during social outreach programmes at her school. She has since worked in a medical ward with mentally ill people.

3.7 Procedure for data collection

Data collection commenced after permission was received from relevant stakeholders according to protocol. The venue was a boardroom on the nursing campus, which afforded privacy. After participants had responded positively to their letters of invitation, they were contacted telephonically to make the appointments for their first session. The data collection process consisted of five group sessions, with the first session being more of an ice-breaker, and the last, a debriefing and celebratory session. At the first session, information sheets were given, read and explained to the participants. These explained the purpose of the study, their rights, who to contact should they need clarity about issues and how confidentiality would be maintained. Biographical and demographical data were also collected during this session in order to describe the characteristics of the sample. The sessions lasted between 45 minutes

and 1 hour 30 minutes. Although it was not one of the conditions for participating in the study, refreshments were served during the sessions.

3.8 Data analysis

3.8.1 Narrative Analysis

Data analysis in narrative inquiry has no clear cut methodology. It is broad based as the procedures and processes used in narrative analysis have been drawn from different scholars in various disciplines (Riessman, 1993; Lieblich,Tuval-Mashiach & Zilber,1998; Emden, 1998, as cited in Kelly and Howie 2007; Grigoratos, 2007; Priest, Roberts & Woods, 2002; Mcleod & Balamountsou, 2001). Huttunen, Heikkinen & Syrjala, (2002), as cited in Bleakley (2005), refer to narrative analysis as a *"loose frame of reference ... amoeba-like"* (Bleakley, 2005: 535), alluding to the fact that it does not have a well defined or set structure to follow. Narrative analysis is fluid, like waters in a lake that move in ripples towards the same direction, as in this case analysis. According to Grigoratos (2007), the field of narrative analysis within the qualitative research has no set methodology and is extensive such that it may explore linguistic, biographical and psychological aspects.

Therefore, there are different methods to analyse narratives. Lieblich et al, for example, as cited in Bleakley (2005), while suggesting that narrative analysis can hardly be taught, go on to describe a framework for narrative analysis. These authors describe two dimensions; Holistic vs Categorical and Content vs Form. They further suggest that these dimensions intersect to form a matrix of four cells which are not always clear in the reality of analysis and interpretation.

In the Holistic vs Categorical dimension, the holistic aspect approaches the story as a whole in the context of culture and history, while the categorical approach looks only at particular episodes. In the Content vs Form dimension the content approach looks at the 'What', while form looks at the 'Why'. When intersecting these dimensions, holistic content looks at what happens in the story, the overall pattern and the content of the complete story; holistic form looks at how the pattern of a story unfolds, is taken into context and how it develops; categorical content, commonly known as content analysis, is a classical way of doing research using narrative material as it looks at what happens in a particular episode of a story as it is analysed for structure, it is a content analysis of the topics and utterances which have been extracted; and categorical form, which focuses on the discrete stylistic or linguistic characteristics of aspects of the story, looks at how a particular episode of a story occurs (Lieblich et al (1998). In some cases, content and form cannot be separated and too much attention given to the content at the expense of form, or vice versa, which may lead to the loss of important information. It follows then, that one shouldn't be too rigid in one's approach.

Riessman (1993:54), shares her thoughts on the issue of narrative analysis, which she perceives "*not as a set of prescriptions, but as guidelines for getting started*". This author goes on to say that compared to some forms of qualitative analysis, narrative analysis has no standard set of procedures or steps, and this has led to several approaches and uses of narrative in qualitative research. This has been supported by Priest et al (2002). Riessman describes representation in research as being multilayered involving five processes; attending, telling, transcribing, analysing and reading. She explains further that these processes are permeable and not absolute.

Attending: This process focuses on remembering, reflecting, recollecting and observing. Attending, therefore, puts meaning to certain events (Riessman, 1993; Grigoratos, 2007; Hodgskiss, 2009).

Telling: Awareness is expressed through words in the form of a narrative. This level depends on context and the way of communicating, which means that the story may be told in a different manner to different people (Riessman, 1993; Kerr, 2005; Grigoratos, 2007).

Transcribing: Transcribing an experience is interpretive in nature, depending on the person transcribing, hence the same story/narrative may be subjected to different meanings from different people in the way it is constructed (Riessman, 1993). Taping and transcribing with close attention to the truest representation is essential in narrative research (Van Wyk, 2008; Hodgskiss, 2009). Riessman, (1993) advises that one should get the entire interview on paper in a first draft and that it should include selected features like long pauses or crying. Thereafter, portions can be selected for transcription.

Analysing: At this level, the researcher takes the context into account and decides on the style and form of presentation (Riessman, 1993).

Reading: This is the last level in which the reader encounters the story. As mentioned earlier, it is unavoidable that different readers will attach different meanings to the content as their own experiences will influence their interpretations, thus bringing a multiplicity of voices to each story (Riessman, 1993; Grigoratos, 2007).

Labov's Framework

Labov has developed a framework that focuses on core narratives. Riessman (1993) refers to this framework as Labov's functional elements. These include:

- Orientation, which describes the time, place, situation and participants.
- Abstract, which summarises the substance of the narratives.
- Complicating Action, which takes into account the sequence of events, themes and conflicts.
- Resolutions, which reveal what finally occurred out of the narratives.
- Evaluation, which makes the point of the story clear.
- Coda, which is the end of the story when the listener is brought back to where the story started (Riessman, 1993).

I have used Labov's framework to construct a story from the primary experiences of the students and have interpreted the significance of events in clauses which have been presented in the form of a metaphor.

Maree (2007:6) describes narrative analysis as analysing data by searching for narrative strings (present commonalities), narrative threads (major emerging themes) and temporal/spatial themes (past, present and future contexts). He further acknowledges that narrative analysis encompasses various processes that are aimed at making meaning of narratives generated in research.

Although Mcleod & Balamoutsou (2001), as cited by Kelly and Howie (2007), are of the view that researchers should create their own methods of data analysis, Priest et al (2002), also cited in the above study, advises novice researchers like myself to follow a set procedure. In view of this conflicting advice, I have chosen to mix the methods

described above, in the hope that this will contribute richness or thickening of the plot. The processes chosen are interpretive acts, informed by my lens, that is, my values and belief system. Narrative inquiry is a process of inquiry designed to allow for narrative exploration and one of the objectives of this study was the possibility for the participants to re-author their stories. It was clear to me that different aims require different levels of interpretations (Van Wyk, 2008; Hodgskiss, 2009).

3.8.2 Listening

Each session was audio taped and each tape was labelled with the appropriate date and session covered. After each session, I commenced with what I call first analysis, which was listening to the tapes without transcribing the contents. I did this to familiarise myself with the participants' voices and to reconnect with them (Riessman, 1993). I found that listening to the tapes took me back, transported me back to the scene of the interviews, which helped in remembering nuances or small details such as non-verbal communication, tone of voice, posture, eye contact or contextual features like culture and familiarity that may have seemed or looked unimportant, but which may impact on the overall interpretation. Thus, listening helped to re-orientate myself (Riessman, 1993).

3.8.3 Transcription

After listening to the audiotapes, I then started what I call the first round of transcription, or rough transcription, whereby the audio-tapes were transcribed manually verbatim as rough data to facilitate the concept of data immersion (Terre Blanche, Durrheim & Painter, 2006). This proved to be time consuming and laborious and could not be done in one sitting. The fact that I wanted to be part of the process

coupled with periods of reflection/reflective thinking contributed to the process being laborious and time consuming.

The process of rough transcription was followed by listening to the tapes again and comparing them with the rough transcriptions. After making certain that the transcribed rough data corresponded to the audio-data, it was then re-written and re-typed as formal data. At this stage, questions and personal comments that I had written down were deleted. The transcripts were then re-read to absorb and appreciate the content and to check for sense (Kelly & Howie, 2007). Even although focused group interviews were used during data collection, I felt that the transcripts must be separated according to participant so as not to drown the individual stories and, therefore, lose the participants' individual voices (Emden, 1998). This resulted in five individual stories. To further justify separating the narratives during transcription, I wanted firstly, to give attention to each story and secondly, to show how each story contributed to the overall plot (Emden, 1998; Polkinghorne, 1995; Kelly & Howie, 2007; Hemsley, Baladin & Togher, 2007). Identifying of the plot of each participant's story informed the development of a written summary of an overall story of narratives about nursing a mentally ill person.

3.9. Data management

Data was transcribed using my personal computer, which could only be accessed by means of a code. Identifiable features such as names and places were removed from all transcripts. The hard copies of biographical data and transcribed interviews are stored in a locked cupboard at the school of nursing, where they will remain for a period of five years. The audio-cassettes are also stored in a locked cupboard and will

be destroyed after a period of two years if the results of this study are published, or five years if no publication results from this study.

3.10 Data dissemination

The examined and corrected report will be bound and submitted to the library of the University of KwaZulu-Natal. The completed study will be prepared, with the supervisor, for publication in an accredited nursing journal.

3.11. Ethical considerations

3.11.1 Power relations

Narrative inquiry is also concerned with power relations that might go unnoticed and encourages people to become aware of how power operates in their lives (Manda, 2009). According to Epston & White (1992:20), participants should be given opportunities *'to negotiate passage from novice to veteran, from client to consultant'* during the interviews and I encouraged them to move beyond dependency on expert knowledge by constantly asking them what meaning they, themselves placed on the stories. As a lecturer at the College of Nursing, I was aware that certain power relations may come into play as a result of the dual role I was adopting by conducting this study (Josselson,2007). Although I hold a professionally responsible role in the scholarly community, it was important for me, as a researcher, to build a relationship with the participants. This was not always easy for me, and at times as an analyst I had to suspend my own values and beliefs as well as practice constant self reflection in order to respect and honour the participants. I recognised, however, that I was entering into a relationship with them and that all of us would learn and change in this encounter (Pinnegar & Daynes, 2007). Muller, 2004; Holloway & Freshwater, 2007b

suggest that researchers should build a relationship with participants that is based on trust and which fosters sensitivity towards each other, thus promoting humanity. I believe that this was achieved by inviting the participants to take part in the study and also during the first ice-breaking session. It soon became evident that building a trusting relationship and rapport definitely facilitates power sharing. Also, in accordance with the advice of the abovementioned authors, I attempted to ensure responsible and accountable research that would be non-exploitative by referring to the participants as 'research participants' instead of 'subjects' which also contributed to decentralisation of power or power sharing.

3.11.2 Permission (ethical clearance)

Permission to conduct the study was sought from the Research and Ethics Committee of the University of KwaZulu-Natal, the Principal of the KwaZulu-Natal College of Nursing, the Campus Principal and the Department of Health. Approval was granted by all relevant stakeholders. Permission was also sought from the participants after the purpose and process of the study had been explained to them.

3.11.3 Informed consent

I provided the participants with clear detailed information of what the research entailed, what methods would be used, and the benefits and risks involved. This was done verbally during the first session when the participants were being oriented to the process. After all the explanations, participants were given the information sheet which they could keep. They were asked, however, to sign and return the informed consent (Terreblanche, Durrheim & Painter, 2006). These consent forms are kept in a

secure place, separate from the data, and will be destroyed after the period stipulated by the University of KwaZulu-Natal has lapsed.

3.11.4 Anonymity and Confidentiality

Confidentiality means that no information provided by the participant will be divulged, or made available to any person (Uys & Basson, 1991; Polit & Beck, 2004). In this study, I was the only person who had access to the documents during data collection. The data was stored on my personal computer and could only be accessed by using a code. Anonymity was ensured in the sense that no names or personal details were written anywhere during the study.

3.11.5 Privacy

To ensure privacy, a boardroom was used during the sessions of focus groups. The participants were reminded that they had the right to refuse to answer specific questions and to decide whether they wanted to reveal any information deemed to be confidential. Uys & Basson (1991: 98-99) describe privacy as meaning that a person can behave and think as she/he pleases without interruption of thoughts with the possibility of these being used to humiliate the person. The self-respect and dignity of the participants were maintained throughout the study.

Fundamental ethical principles were also used to guide me in this study.

3.12. Debriefing

Because the research was in connection with mental illness, there was the possibility that recounting their experiences may trigger emotional trauma for the participants. To cater for this, debriefing was done during the last session by me in my capacity of

psychiatric nurse. An independent counsellor was also available if the participants felt they needed help. The contact details of the counsellor were provided in the information sheet received by the participants.

3.13 Trustworthiness

To guide me in the question of trustworthiness, I have used Lincoln & Guba's (1985) work, as cited in Holloway & Freshwater (2007a).These authors describe four elements that are focused on ensuring trustworthiness. These are: credibility, transferability, confirmability and dependability. These are discussed below.

3.13.1 Credibility:

This looks at whether re-presentation of reality as described by participants is undertaken. In order to ensure credibility in this study, I have collaborated and undertaken prolonged engagement with participants, as well as requesting them to review the typed transcripts on data analysis. No changes were made by participants.

3.13.2 Transferability:

Transferability refers to whether the research can be transferred to a similar situation, with similar types of participants and similar context. Sufficient information about the study was provided to enable the reader to transfer the findings to a similar situation.

3.13.3 Confirmability

Confirmability looks at whether the background and feelings of the researcher (myself) are transparent enough and are open to public scrutiny. In order to ensure the

confirmability of this study, I have placed myself within the study as a co-participant and have sought to make my position and subjectivity known using bracketing.

3.13.4 Dependability

Dependability refers to consistency and accuracy. I have sought to be transparent to ensure dependability by detailing clear steps (audit trail) for the whole research process in terms of design, data collection and data analysis.

3.14 My position as a researcher

In narrating my own story, I am positioning myself (Dhunpath & Samuel, 2009). I am laying my background and beliefs open and am being transparent about my subjectivity pertaining to the topic of study. I would like to start by first saying experience is an integral part of people's everyday lives (Kerr, 2005). I believe that experience shapes what we are and precedes all aspects of beliefs and understanding. This is echoed by Burns (2001), as cited in Kerr (2005), who further asserts that learning is achieved through experience and leads to understanding and knowledge. I believe that for learning to be effective, teaching or facilitation has to take into account the emotions, fears and vulnerabilities of learners.

I am a female mental health nursing/psychiatric nursing lecturer, who has worked with fourth year student nurses (the level in which mental health nursing module is offered) for a period of 5 years. I have observed how the socially/culturally constructed discourses have sometimes influenced students' learning. I have also seen them showing fear as an emotion; fear of interacting with a mentally ill person, fear of the relatively unknown (to them) module of psychiatric nursing, and fear and uncertainty as to what is expected of them in the clinical setting. I hope to contribute

to the self empowerment of students such that when they start the psychiatric module, they will be open to gaining new knowledge.

I think it is important to situate myself in the study because of my background and personal interest in my desire to listen to the stories of student nurses nursing mentally ill people in a medical/surgical ward. I am aware that I come with my own belief system which will have a role to play in guiding my research and, therefore, recognise the implausibility of being able to truly distance myself from what I already know, and what I will come to know and understand. I find myself identifying with the constructionist paradigm reference. In line with the post-modernism/social constructionist view, experiences can be understood by interacting with participants and listening to them (White, 1999; Dhunpath & Samuel, 2009). In view of this, I endeavour to practise reflexivity and act with *"integrity, demonstrate trustworthiness, being virtuous and applying rigor"* (Bullough & Pinnegar, 2001:20).

The narrative approach of this research is based on the stories of the participants and their own personal interpretations, therefore my role as a researcher is firstly to listen to the stories carefully and write them down without manipulating the meanings implied by the storyteller (Renjan, 2007), to identify the unique outcomes in the stories as well as helping the story teller to move from thin descriptions to thick descriptions, and to report the data drawn from the research material.

3.15 Summary

In this chapter I have looked at the research methodology, the setting, the selection of participants, data analysis, ethical considerations and how the issues of

trustworthiness were ensured Chapter 4 will be looking at the presentation and discussion of findings.

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CHAPTER 4

PRESENTATION AND DISCUSSION OF FINDINGS

4.1 Introduction

In this chapter, I will present the findings of the study and the discussion thereof. I will first explain the use of the metaphor and thereafter go onto the presentation that will consist of two levels. The first level of presentation will be in the form of a metaphor. The second level will be in the form of vignettes, starting with supporting text, which will be followed by discussion on each area or theme.

4.1.1 The Travellers Journey

I am adopting the metaphor of a traveller in the presentation of the findings of this research project. The metaphors of a miner and traveller were suggested by Kvale (1996) as a way of describing various theoretical understandings of knowledge generation. The traveller journeys along with the participants or natives, uses her curiosity by asking questions that lead to the participants telling their stories of their lived world and the meanings thereof. On the other hand the miner metaphor is of the modernistic view that knowledge is a *"given, buried metal to be excavated and the researcher is seeking objective facts"* (1996:3).

I identify with the metaphor of the traveller as it fits with the social constructionism/post modernistic approach of this study as a social research. In presenting the findings, I seek to describe the journey in which I, as a researcher, encountered the participants and conversed with them to co-construct their stories of nursing a person with mental illness (Eskell-Blokland, 2005; Van Wyk, 2008).

4.1.2 On the use of a metaphor

As I have explained previously, the first level of presentation of data analysis will constitute a metaphor. The search for narrative strings (present commonalities), narrative threads (major emerging themes) and a discussion of each section will follow this.

The Pocket Oxford Dictionary of current English defines a metaphor as *"an application of a name or descriptive term or phrase to an object or action to which it is imaginatively, but not literally applicable"* (Allen, 1984:461). Kerr (2005) identified several authors who view metaphors as being part of people's thought processes and everyday lives and, in that way constitutes more than language strategies. She goes on to explain that metaphors create new aspects and allow for different understandings of the world. Metaphors can be used to understand the experiences of people and allow for understanding of what is being communicated (Burns, 2001; Kerr, 2005). Therefore, metaphors precede any understanding the person may have, because without live or told experiences, understanding cannot be developed (Kerr, 2005:41). I have sought to describe the feelings of the participants and to hear them metaphorically through representation of the findings. I recognise that entering into this relationship, or this journey, with the participants has the potential of changing me as a researcher as, when you are preparing a journey you own the journey, however, once you have started, the journey owns you (Clandinin & Connelly, 2000; Shope, 2006:165). Due to the personal nature of metaphor usage, I do not pride myself in managing to 'interpret' the participants' narratives; therefore, I would like to remind the reader of the post-modernistic stance of this research endeavour. I believe in the subjectivity of the experiences, values and views, the

multiplicity of individual's voices, understandings and meanings attached to experiences as well as the fact that human beings exist in relation to others (Shaw, 2001; Speedy, 2000; Maree, 2007). I acknowledge that there will be different meanings and understandings from different readers, and there will be different understandings from the same reader (Shaw, 2001; Kerr, 2005).

The metaphor of my journey in this study

As a traveller, you observe, you encounter, you converse, and you become curious about the people you meet, wanting to know more about them, about their lived world and how they make sense of their world and experiences. Therefore their stories become alive, you get into their shoes so to speak, you interpret it for yourself, it becomes your story. This is what I have come to understand the participants' stories; this is how the story of the duckling and the lake came about.

In this story the lake represents the nursing profession in general, or the ward, Little Jimmy and his brothers and sisters represents the student nurses. The swans represent the registered nurses trained in psychiatric or mental health nursing. The small boys represent all the other people working and helping in the wards including the health care workers not trained in psychiatry/mental health nursing who don't have full understanding about mental illness. The dragon flies represent senior student nurses. The 'monster' represents the person with mental illness.

4.2 The duckling and the lake

The lake was a vast amount of uncharted water, which seemed unlimited, untamed and rather sinister. It was silent and held the splendour of Mother Nature's presence, unmistakable beauty and daunting eloquence. It was calm and a step in the water

started a set of purring ripples. It was so calm that it veiled the menacing danger of the deep, desolate dam.

The swans, dogs and small boys amusing themselves by hurling stones at unsuspecting victims graced the lake. It was such a beautiful day, clear blue skies and warm breezes. Joy in the heart of all, the warm sun-baked lake almost a haven of happiness, except for little Jimmy and his siblings, five of them in all. Feeling cold, wet and miserable, the all around smiles proved to be confusing to the newborn ducklings. Instinctively, little Jimmy knew everything about the lake and, from his understanding, there was nothing to smile about. He was scared of the monsters everyone was talking about. Water splashed the air and came down with a hammer-like thud on the small duckling. He was dipped under water, but slid under a nearby rock for safety. He thought he saw the monsters or were they dragons now? He couldn’t remember.

They paddled forward momentarily, speeding across the buzz of dragon flies that swarmed the reeds. Jimmy felt sorry for the dragonflies as he stopped and watched on to see a mishap that he knew well, almost too well, the cursed monster in waiting. Wanting to be safe they swarm closer to the dragon-flies in case something might happen. They reckoned the dragon-flies were safer as they could fly away from the monsters and possibly take the small ducklings with them.

The big buzz of the dragon flies came to a small hum as a family of bullfrogs slowly divided them, curious to see what they were looking at. There, in the middle, they could see something, could it be the monsters everyone had talked about? They stood still waiting, not sure of what to do. They fled, they were now close to the other side

of the lake. Jimmy’s worries being the leader in the group were mounting on the scare of not finding their mother as the monster was swimming alongside them.

He raced across the remainder of the darkened, polluted water and about to reach the other side as wet and confused as they were on the other side. Alone and lost, their mother was nowhere to be found. Little Jimmy looked around and failed again to understand the happiness and joy that seemed to envelope the family of swans. His understanding of the lake was insufficient in this case, more so about the monster. Once more, they looked around, and this time Jimmy saw the familiar flip of the wings and the quack almost the same as theirs, what of the feathers. He could have sworn the monster was reaching out to them. He looked around at his brothers and sisters once more and saw the mask of confusion on their faces, for they had also noticed something about the monster. Being the leader of the flock he came closer to the monster.

Well clear of the confusion that the lake had piled on them, he began to see the beauty of it all. He recognised the small insignificant traits that have been overlooked and underappreciated. Realisation dawned on him and in a loud quack (voice) he yelled, ‘No, don’t touch him, don’t harm him, He’s not a monster, he is one of ours’.

A thousand times the ducklings had been warned about the monsters in the lake, even before leaving their nest and a thousand times he had slipped around the almost imaginary monsters fearfully, almost skidding and breezing as he swarmed through. Now they caressed the experience of being able to defy all odds, they finally understood the happiness and joy that seemed to radiate from the family of swans back there. They chatted and embraced. Moreover, although caution still pressed on

their young hearts, they swam freely through the mass waters, with the monster that turned out to be a duck after all.

Together with his brothers and sisters he swam across the mighty lake's shallow end. They got out of the water and shook themselves dry, and each drop felt like the shedding of oppression and fear.

He looked back at the imaginary monsters in the big lake and smiled. "Mother Nature made you, Mother Nature made me, we are the same," he thought as he walked into the sunshine.

4.3 Second level of presentation

The second part of this analysis following the metaphor presentation will be in a form of vignettes. This will start with a presentation of data or supporting text, followed by a discussion of the findings. The quotes of the participants are in italics and, where a vernacular language has been used, the actual words of the participants will be in italics followed by the, interpretation in brackets.

4.3.1 Seeking clarity through the dark, murky waters (Beliefs)

As illustrated in the following quotes, one of the common beliefs shared by the participants, stemming from their cultural upbringing, was the belief that somehow a higher power, a supernatural being, was responsible for causing mental illness.

"umama wakhe unezilwane,ngoku yena ziyamgulisa ngoba akazamkeli amthwese" (his mother has animals, now they make him mentally ill because he is refusing to take over from her) (**Themba**).

"Kukhona indlu engavulwayo ivulwa ngutata wakhona kuphela ,inamagundane amakhulu aletha imali,ukhe wavula uzokwelama uhlanye" (there is a hut that is kept closed always, only the father of the house opens it and its got white mice that brings money, if you see these or you open up you will get mad) (**Zuko**).

It's a culture thing where it involves ancestors…it's 'amasiko' (traditional rituals)*…ulaka* lwabaphantsi (ancestral wrath)*…it's beyond our powers* **(Zuko).**

*It's almost an example of a lightning …it's like supernatural***… (Joy)**

…the uncle because they didn't like him so they did this…they bewitched him **(Promise)**

Their relatives, they believe that it's the father who did that…yebo uloyiwe izihlobo zakhe (yes, he was bewitched by his relatives)*…I think its man-made* **(Nobuhle).**

The person has killed someone…the family of the victim they go to the grave or witchdoctor so the person will be mentally disturbed **(Joy).**

People take it it's a man-made thing…hayi ngunina owayenezilwane (the mother had creatures-believed to be used in witchcraft)…*because of the family…he was bewitched* **(Themba).**

Ingxaki kuthiwa akayanga entabeni… (The problem is they say he did not undergo circumcision ritual), **(Themba).**

The participants, through their dialogue, seemed to be wading through the dark and murky waters of the lake, as they reflected within themselves, searching for the causes of mental illness. These examples show that most of their beliefs are based on stories,

hearsay, folklore, rumours or the grapevine and are unfounded, having no scientific base.

Their cultural beliefs regarding the cause of mental illness led to commonalities amongst the shared narratives and various beliefs were identified: witchcraft, ancestral wrath in the form of punishment for rituals not performed, curses and demonic spirits. Of the five participants, three really believed in supernatural powers whereas the other two knew about them, but did not actually believe in them. The three that shared these beliefs were not able to elaborate further on the powers they attributed to the supernatural. One participant attempted to explain it by giving an example of lighting. According to this participant, lightning just happens, sometimes it strikes people and no one can explain that. This is in line with the concept of 'spiritualism', which is described as the recognition that there is a Higher Power which plays a significant role in a person's life (Hill, 2003; Abdullah & Brown, 2011). The findings are also consistent with various studies conducted on African beliefs which have found that those brought up in an African culture believe that ancestral spirits not only protect their people from dangers, but can actually punish people when they break traditional moral norms (Amaze, 2002; Ngobese, 2003; Moyo, 2004; Phiri, 2009; Radzilani, 2010). This has implications on the causative factors of mental illness, the treatment strategy to be used and the way the westernised treatment is viewed. Culture and religion inform not only the social constructions, but also the behaviour expected and accepted in different situations (Radzilani, 2010). An example of this would be the response of one participant on being asked to take a walk in the shoes of a person with mental illness. He responded, "…*I would go down (kneel), burn incense and ask my ancestors what is the problem"…*

Interestingly, two of the participants did not entirely share the beliefs although they came from the same cultural background. They believed that it was more likely that stress or drugs were the causes of mental illness. While the other three lived in rural areas, these two had grown up in urban areas. One participant grew up in a white household and the other in a traditional Indian community. This seems to agree with a study conducted in Ghana by Quinn (2007), as cited in Schafer (2010), of attitudes and beliefs about mental health. He found that people in rural areas were more likely to believe a curse or a bad spirit is responsible for mental illness than people in urban areas who showed diversity of beliefs.

4.3.2 Losing the lights….(dealing with negative emotions)

Another narrative string identified as being common amongst the participants were negative emotions of fear and anxiety, and sadness and frustration.

All the police especially the women, they started to back off. This person was not aggressive at the time… they all just went back.
When I came in…I would just first run away, cos even in town, people will tell you, hey you know don't ever walk where a mentally ill person is walking because of the stories…then my friend ran away as in running. Some told different stories, some scary you know…every time I was sent something I used to look over my shoulder all the time, even if something falls **(Joy).**

If he came we used to walk to the other side cos we felt …they are going to attack you, they gonna hurt you.
Cos in the beginning we were scared, were frightened of them…like in the village, in the beginning they were like you make sure if you are walking, you walk opposite or

you run away.

I did not want to associate myself with them…I have a fear about them…like even some registered nurses, you know they are like no, don't go near that one…maybe she'll attack you, you know she'll hurt you. We were scared, we were frightened of them **(Promise).**

…then I ran away…maybe the way I talked I showed that I am afraid of him…hayi mina (no, I) *I'm afraid of them...I don't want to associate myself with them…hayi I'm afraid of them but the one that I (m) used to, my relative I know him. He is not* aggressive *…kodwa I'm afraid of them* **(Nobuhle)**.

…really I was scared of eh, these mentally ill patients…I was even afraid and I was in the station (nurses station) myself as a man **(Zuko).**

Negative emotions of fear and anxiety, and sadness and frustration became evident in the above excerpts, as the students told their stories, recounting how they felt when interacting with people with mental illness in the wards. It also became obvious that some of their emotions were based on hearsay from some of the other nursing staff in the wards as well as others in their communities. The one male participant, (Zuko) acknowledged that as a man, he found it very uncomfortable having to confront his fear and anxieties. When questioned on this issue, he answered that as an African man he was not supposed to show fear and anxiety, especially in front of females. This view supports the cultural, racial and gender stereotypical dimensions of fear, whereupon males are viewed as being stronger, bolder and "warriors", and showing fear and anxiety as emotions is viewed in a negative light (Meth, 2009; Tuminello & Davidson, 2011).

When first coming into contact with a mentally ill person, the participants experienced various forms of fear, ranging from fear that they might be physically harmed by the person who has mental illness to the fear of not knowing how to interact and relate to them. I must mention that the fear shown or displayed by the participants seemed to be constructed or perpetuated by negative stories or hearsay, "they *told me stories…some scary you know" "when I went to the ward I expected them to jump…things to happen"*. The concept of fear in relation to psychiatric nursing and or psychiatric clinical setting has been widely studied (Penn, 2008; Kragelund, 2010; Cleary & Happell, 2005; Hayman-White & Happell, 2005; Melrose & Shapiro, 1999).

Sadness was identified mostly in those participants who had relatives with mental illness and there was an element of helplessness about the situation they found themselves in. The three participants expressed emotions of sadness and frustration:

It was so sad for me…it was so bad emotionally…then to me it did not come nicely or right at the attitude she was showing cos now I was crying cos this is my brother you know **(Joy).**

The other days he feels bad…he misses his children and wife and that makes us very sad **(Nobuhle).**

Sometimes I also feel soo bad, you know like if that was my brother/father **(Zuko).**

The first comment was made when one of the participants was telling her story of asking for help for her brother from a police station. The second is an observation made by one participant about her uncle.

The confusion of not knowing what to do or how to act, or interact, with the person with mental illness may lead to frustration for the student. It has been identified that allocation to clinical areas, in general, can be a source of anxiety and frustration for a student, which can lead to stress (Melo, Williams & Ross, 2010; Edwards, Burnard, Bennett & Hebden, 2010). Furthermore, a student who has been allocated to a clinical setting and who also has to deal with a person with mental illness can become confused, as the physical skills that are defined for that expected clinical setting are not necessarily required for the person with mental illness (Clement, 1988; Penn, 2008). This is explained in the words of one participant who says "*there are these patients who are sick but not really sick….*" This statement denotes the confusion and frustration of wanting to help, but not knowing how to go about it.

4.3.3. "Lake/Dam…they look all the same to me" (Ignorance leading to stigmatising attitudes/statements as seen through derogatory terminology used, hand gestures, statements or stereotypes)

Ignorance in relation to mentally ill people was also identified in this study. This ranged from the choice of terminology used to describe a person with mental illness, to gestures and statements.

…his mind was disturbed, totally disturbed (hand-gestures, rolling of index finger around the ear)*…eh when somebody is mad…if you work with these people for a long long time you'll end acting like them* (**Themba**).

I also have an experience…was mentally disturbed…then one lady comes to me but she never put it right in Zulu she said, "mina angizange ngifundiswe ukusebenza neenhlanya." (I was not trained to deal with mad people: from a policewoman in the

police station)…*this person, this* ***punk****…maybe he never do it on purpose cos he is this* (hand –gesture as described above) *whatever* **(Joy).**

My uncle is sort of mentally disturbed… **(Nobuhle).**

They are like no, don't go near that one by yourself, maybe he'll attack you ,you know she'll hit you, so then we also had that…they won't allow him to sit with others **(Promise).**

It does play a certain role leading to this mental retard thing. Kuthiwa uyahlanya…uhlanya ngempela lo…the staff nurse approached the mad –man (they say he is mad…he is really mad this one…) **(Zuko).**

While it must be mentioned that participants might not be familiar with the 'correct' terminology and use derogatory terms in connection with mental illness, it is not only they that do it, but also more senior nursing staff and other members of the community. Shattell (2009:199) describes language *as 'a method of communication that is intended to transmit intended and unintended meanings'*. These unintended meanings can further perpetuate socially constructed negative perceptions regarding mental illness, which can have a great impact, not only on the persons with mental illness, but also on their interactions with the community and society at large. It can also have an impact on the nursing profession and ultimately the way people with mental illness are managed (Pinto-Foltz, Logsdon, 2009; Hasson-Ohayon, Levy, Kravetz, Vollanski-Narkis, Roe, 2011; Koekkoek, Hutschmaekers, van Meijel, Schene, 2011). The concept of stigma has been exhaustively discussed through theoretical and empirical research, and what comes up most is its intersubjectivity, which occurs through interpersonal communication, intersubjective space through

gestures, spoken words, attached and lived feelings and emotions (Yang, Kleinman, Link, Phelan,Lee, Good, 2007; O'Reilly, Taylor, Vostanis, 2009; Ross,Goldner, 2009). The literature also reveals that there is a relationship between stigma and culture, ethnocultural beliefs, religious beliefs, values and norms as these factors greatly influence stigma (Yang, Kleinman, Link, Phelan, Lee, Good, 2007; Collins, von Unger, Armbrister, 2008; Ross, Goldner, 2009; Mavundla, Toth, Mphelanr, 2009; Abdullah,Brown, 2011). The influence these factors exact may be negative or positive depending on the context.

The first statement in the above paragraph, "*I heard that if you work with these people for a very long, long time, you will end up acting like them*" denotes ignorance which contributes to stigma by association. This agrees with Halter's findings (2008) in her study of stigma by association. I noticed that the ignorance manifested is more of the socially constructed variety in the form of hand gestures (rolling of one's index finger around one's ear, denoting madness) and lack of knowledge about the correct terminology to use when referring to people with mental illness (*uhlanya*, meaning mad person, and *mentally disturbed)*. These are also perpetuated by the media (see chapter 1). Several studies have dwelt on negative stereotypes, ignorance and attitudes that lead to stigmatisation of mentally ill people (Schafer, Wood & William, 2010; Chambers, Guise, Valimaki, Botello, Scott, Stamiuliene, & Zanotti, 2010; Markstrom, Gyllensten, Bejerholm, Bjorkman, Brunt, Hansson, Leufstadius, Sandlund, Svensson, Ostman & Eklund, 2009; Waite, 2006).

4.3.4 Gliding through the waters (Making sense of experiences)

One of the main themes identified in this study is the wanting to understand, the quest for knowledge, as participants tried to make sense of their experiences. They wanted

to know more about those with mental illnesses, what caused their illness and how they should conduct themselves when dealing with these people.

*I don't know, they need help somehow, to me they need help, how I'm not sure but those are people…there's nothing that prepares you to go in the wards that helps you in education…then you interact with them…I heard others say that glue is some kind of a drug or whatever, but it does something like just maybe lose like thinking abilities…I was actually learning from them…it's not like I know what goes wrong, but to me they were such normal people…it's just that there is this particular thing, whatever has stressed them…***(Joy)**.

…every one of us has mental or abnormal genes in our body or system…one thing can trigger those genes in our bodies…can lead to this genes…when you are dealing with this mentally ill patients you must not do what they do I was so interested to hear their story and ask questions cos a mentally ill patient wants to be listened to …
(Themba).

So I was like so amazed the way they were doing things, you know they didn't go according to the routine of the ward …you expect to see sick people, who are sick but like you know normal…I believe it's a psychological thing… maybe they were traumatised…maybe they study too much…so I think maybe it's something to do with *something in the brain…* (**Promise**).

So ja, I understand that they are mentally ill, but there's something I don't know, where did everything go wrong…I was giving him food, he took one spoon, the second and the third and then he said 'staff lokukudla onginika kona kuyaphuma ngezandla' (the food you are giving me is getting out of my hands),I was having no idea ,what to

do, I don't know what happened ...I still have no idea but to me it was a kind of challenge, I wish I could learn more…I can't wait for that 6 months period to know really what's happening to that guy…

It's just that we don't understand each other the way we should…the experience that I had made me eager for more maybe it will help me to be what I or think I can be **(Zuko).**

In all the data transcribed, the resonating message is the need to search for knowledge. This is summed up in one simple statement, *"There is nothing preparing you in the classroom", "I need to know more."* Nursing education is aimed at training student nurses to become capable, competent and knowledgeable nursing professionals (Cleary, Horsfall & De Carlo, 2006; KZNCN rule book, 2005). Several studies have found that imparted knowledge and classroom exposure promoted or contributed to positive attitudes of students towards mental health problems (McLaughlin, 1997; Chan & Cheng, 2001; Penn, 2008), whereas negative attitudes have been associated with lack of knowledge (Markström, Gyllensten, Bejerholm, Björkman, Brunt, Hansson, Leufstadius, Sandlund, Svensson, Őstman & Eklund, 2009; Kragelund, 2010). The acquisition of knowledge contributes to therapeutic use of self, this is of utmost importance for students in a psychiatric setting (Penn, 2008). The author goes on to say that while this is important in a general setting, it is of paramount importance in psychiatric nursing as it forms the basis or hallmark of this speciality. Acquiring knowledge makes it possible for the student to deal with negative stereotypes and attitudes as highlighted above.

The participants showed more resilience, confidence and positive attitudes towards the end of the sessions, which could be attributed to the choice of methodology. They

began to show understanding and empathy towards people with mental illness, which was evidenced by the celebratory poems that they wrote and explained the meanings thereof. Empathy has been described as a communication tool in mental health nursing which is both valuable and humanistic (Tondi, Ribani, Botazzi, Viscomi & Vulcano, 2007; Williams & Stickley, 2010). This might be attributed to the choice of method in this study (Walsh, 2010) and that learning has taken place through the interaction itself (Bennett & Baikie, 2003).

4.3.5 Wait a minute. I see.. the..the shallow end! (Moments of Awakenings/realisations)

As the research progressed, a new theme was identified, which I refer to as 'the dawning of a new day'. These were the moments of awakenings and/or realisation that mental illness is just 'mental illness' and that the person is separate from the illness. This theme includes times when participants realised their inner strengths in dealing with negative perceptions and attitudes, as well as situations that they may have perceived as being overwhelming

While my mother was telling that, I used to think in a positive way about these people…I used to think not all of them are that bad, so I said to myself I have to listen to them, I have to try and understand.

I never said anything to him, I just sat down and said no I'm not here coming to fight with you. I have time to listen to their stories **(Themba).**

I agree with Themba, in that I also enjoy working with mentally ill people in a ward…but to my surprise it was so nice, it was just like any other ward…it was like 'wow' he can sing…he used to write it down, that was being organised and then that

was also like 'wow'…I mean really it's beyond my belief of what I expected in the ward, but you know it was great, I had a nice experience. They are telling me things I know…but it's like sooo 'wow' you know, it's, you know it's gre..at!

Mmhm, it's not what it all seems to be, I mean mental people will like be acting in different ways but they are humans **(Joy).**

…and so that was like 'hawu' cos then we started seeing them you know as normal people…so then we got more used to them and we didn't really see them as a problem…it's just that in the beginning you think that you are better than them somehow…you start changing your views.

The change was good…I realised that oh wow…I can appreciate someone who is different from me. So it was good. I think you must be able to create in your own mind, how to always know them. Yes, I enjoy the change, it was like an eye opening experience, it was a good change **(Promise)**.

Since I came to this field …I seem to be enjoy(ing) working with them. I was amazed just because of what I've been told about these people…that simply changed all the things that we thought about these people…they've got all the senses.

It feels good if ever I didn't know yet I would have told myself that this is whoever, an aggressive person, I'll go with that attitude…I tend to understand them, tend to enjoy being with them…it's just that they mustn't think people with mental illness are no where to belong…it feels good **(Zuko)**.

These moments of realisations/awakenings are a result of the deconstruction process that goes with the research method. These moments of strengths and realisations have

given rise to a change in attitude of participants, from being negative to positive, as they shed the fear and anxiety they had regarding nursing a person with mental illness. This process of deconstruction gives way to re-authoring, whereby the personal beliefs of the participants, which have been shaped by the cultural and societal beliefs of the community, are adapted. It has been found that being in contact with people living with mental illness during the period of training by mental health nursing and psychology students contributed to positive attitudes (McLaughlin, 1997; Song, Chang, Shih, Lin, Yang, 2005; Björkman, 2008; Chambers, Guise, Välimäki, Botelho, Scott, Staniulienė, Zanotti, 2010).

4.3.6 Do not touch him; he is one of ours

Another factor that emerged was that there seems to be a certain degree of acceptance and tolerance of a person with mental illness who is 'known' to the community, as compared to a person who is not known. This has been evidenced by the participants' responses to the question, "How do people in the community treat a mentally ill person?"

*He is coming from a well known family, well to do family, the community treat him so good because he is from a well-known family (***Zuko***).*

*Hayi (no) I am afraid of them…but the one who is my relative I don't have a problem…the community treats him very nice(ly) because they know him before, they used to tell him you were like this and that, he enjoys that (***Nobuhle***).*

*Everyone knows him, everyone knows his story and they understand, they are no longer frightened of him, they like him (***Themba***).*

*Everybody got used to him, like the community now they do not really worry about him, but in the beginning, they were like you know, that man from down there make sure if you are walking, walk opposite or run away (***Promise***).*

Four of the five participants, acknowledged that their fear of a mentally ill person gradually improved when they got to interact with or to “know” that person in the ward.

Then I started to be like close to these people, at first I would run away…because even in town people will tell you do not ever walk where a mentally ill person is walking. I mean really it is beyond my belief of what I had expected in the ward, but you know it was great I had a nice experience of working with mentally ill people (**Joy**).

I am used to interacting with them, I don’t fear them (**Themba**).

Somehow as you get to “know” them, you start changing your views, you start seeing them as normal (**Promise***).*

…really I was scared of eh, these mentally ill patients… I tend to understand them, tend to enjoy being with them **(Zuko).**

Whilst participants conceded that they fairly comfortable when interacting with a ‘known’ person with mental illness, their views were not the same when asked what they would do if they met a person in town who was mentally ill whom they did not know.

I don’t want to associate myself with those (**Promise***).*

*Me …no never I make sure I walk in the opposite side (***Nobuhle***).*

*I had an incident in town…he just spat on my face, he had a stick, it was like soo bad, my friend ran away, she thought she was gonna accompany me to hospital (when she came back) because that's what she thought was happening (***Joy***).*

While there is this general acceptance or tolerance of a "known" person with mental illness, it is not always complete acceptance, but rather an amusing indulgence of the person because of the stigma attached to mental illness. This form of stigma is based mainly on misinformation on the part of the communities (Hugo, Boshoff, Traut, Zungu-Dirwayi, Stein,2003).The stigma associated with mental illness leads to a form of social ostracism, which is linked to cultural and social beliefs (Mavundla, Toth, Mphelane, 2009; Lundberg, Hansson, Wentz, Björkman, 2009). Examples of this form of stigma can be seen in the following statements:

He does not mind what colour suit he wears, it can be yellow, green or white everyday, people laugh at him, some admire him, and he likes that, when they admire him (**Themba**).

This implies that the person with mental illness cannot even choose his own clothes properly. People laugh at his choice of colours because he is mentally ill, whereas their response would not be the same had the same colours been chosen by a so called 'normal' person.

In gatherings like weddings, like they won't allow him to come near where there is 'isithebe' (traditional serving tray-where food usually meat and alcohol is shared). They will give him like kwaRawondi (African mud-hut) like give him Zulu beer and meat, but they won't allow him to come and sit with others (**Promise**).

Traditionally, AmaXhosa and AmaZulu do not serve food on a tray. A dish of food or sometimes a large woven reed mat is used, and a beaker of *amarhewu/ amahewu* (fermented mealie meal porridge to drink) or *umqombothi* (traditional beer) is brought in front of the people. It is customary for the head of the household or the representative to address the audience before they eat or drink to explain the purpose of the gathering and to welcome the audience and make them feel respected and appreciated for coming. The head of the household will then be the first to drink from the beaker and take a piece of meat to show that it is not poisonous and that the people can now drink from the same beaker in a spirit of sharing (Kepe, 2001; Nokele, 2005; Zeeman, 2006; Van Warmelo, 2009). The participant in the above statement tells how the person with mental illness was not permitted to share the communal food and drink, but is given his own jug of beer and meat and put in a separate room. According to African culture, by not being allowed to partake in the *isithebe* means the person is not wholly accepted as part of the community (Kepe, 2001; Nokele, 2005). Each clan or subgroup in a community gathering has its own *isithebe*, which includes everyone, except for young children and, in case the case of the AmaXhosa nation, uncircumcised boys (Nokele, 2005).

He'll come to school just because his sister-in law is a teacher, may be we are struggling with maths, he'll sort it and we give him 20cents…that is the money he seems to know, even though he was at University studying medicine when he got sick **(Themba).**

If he goes to the neighbours, work for them, they'll give him clothes or maybe money, anything and he enjoys life (**Nobuhle**).

These findings are consistent with the concept of *ubuntu* (humanity) which is taken from the saying that "*umntu ngumntu ngabantu*" (a person is because of others). Tutu (2008) describes *ubuntu* as the belief in the universal bond of sharing that connects all humanity, the main factor being the interconnectedness between persons in the community. This concept is readily seen in rural villages, where villagers gather to take care of their own. *Ubuntu*, however, incorporates various aspects, another of which was explained by Dr Nelson Mandela, the first black President of the Republic of South Africa. He said that if a traveller stopped in a village to rest and, without asking, was given water or food, that constituted *ubuntu.* This makes the concept of *ubuntu* much broader and not limited to people you know. It also includes the element of trust, trusting that the person will not harm you.

The other factor which may have contributed to the acceptance of the 'known' person with mental illness is the integration of mental health services into the Primary Health Care and the general stream as per the objectives of the Mental Health Care Act (Mental Health Care Act 17 of 2002).

4.3.7 Weathering the storm: (Breaking free moments)

After the sharing of the stories, a final gathering of participants was held, firstly for the debriefing session and then the celebratory session. The participants were asked to bring to the celebratory session anything that had meaning for them. All four that attended had written poems which, when analysed, looked at moments of strength and unique outcomes. The poems showed understanding of what mental illness is all about and gave insights into which these people really are.

In her poem titled **"ME**", **Promise** suggests that fear and stigma hinder interactions with a person living with mental illness as she writes, *"wake up from the fear and stigma…I am a person just like you*". She also highlights the reality that mental illness can affect anyone by writing*"…its me your brother, your sister, your father"*. Her poetry shows understanding and empathy for a person with mental illness.

Joy's poem, entitled "**Words of a Human**", shows empathy towards a person with mental illness and highlights the need for acceptance. *"I am a human…give me some love, understanding and some motivation…do not run away…these are the words of a man suffering from mental illness, these are the words of a human"*.

Zuko's poem entitled **"Now I know"** reflects the dawning of understanding of how to relate or interact with a person with mental illness *"I understand that I'm not the only one in the mist of misunderstanding…now I know that its not the way we should handle them…this is not the way things should be…I never knew but Now I know"*.

Themba's poem entitled "**It's like I'm buried alive**" likens having mental illness to being buried alive, *"I wish someone can feel how I feel, can take me out of this hole that is so huge."* He looks at the stigma attached to mental illness and the need to be accepted.

(See appendices for the collection of poetry).

Unfortunately, participant number 2 (**Nobuhle**) could not attend the fourth and fifth sessions because of personal commitments so did not contribute any poetry.

4.4 Summary

In this chapter, I attempted to explain how the data was analysed, how narrative strings were picked up as present commonalities and major emerging themes were identified from the narratives.

The following chapter will look at the methods used and contains a discussion of the findings. It also includes the limitations of the study, the reflexivity and the recommendations.

CHAPTER 5

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

In this chapter, I will discuss the issue of researcher reflexivity in terms of the whole research process, the design used, the limitations of the study and, lastly, recommendations for nursing education, nursing practice, policy makers and nursing research.

5.2 Reflexivity as a research interviewer

Reflexivity forms an important aspect of qualitative research and the importance of scrutinising one's own values, experiences, moral standing as well as assumptions has been addressed by a number of qualitative researchers (Burk, 2005; Burk & Frosh, 1994; Wilkinson & Kitzinger, 1996; Steier, 1991).

According to Middleton, (2007: 122), *"Reflexivity in qualitative research requires that the researcher engage with the intellectual process of research while retaining some degree of awareness of how the researcher's point of view-personal experience, values, interests, knowledge, beliefs, moral qualities are brought to bear in shaping the form, content and outcome of the research process."* Self reflexivity has to take into account the similarities and/or differences between the participants and the researcher in terms of ethnicity, race, culture, age, gender and class as well as the research context within which these aspects are used or constructed (Wilkinson & Kitzinger 1996; Jorgensson, 1991; Burk, 2005; Tokpah, 2010).

I am an African female of the previously disadvantaged social class, and of Xhosa ethnicity. I was born and raised in a rural area, but have lived in urban areas for the past 18 years. Whilst I share the same ethnic group with only one of the respondents, this has not been an issue as IsiXhosa and IsiZulu are closely related and I have stayed and interacted with Zulu speaking people for 14 years. While I share the same age group with one participant, the rest are younger than me. Two out of the five participants were from the model 'C' schools and the others are from the traditional 'black schools'.

On listening to and examining the transcripts, it came as a shock to me how easily some of the participants had adapted to mental health nursing without having had the benefit of being taught about mental illness at college. By the end of the research they were all very positive saying that they were feeling good and felt better equipped to interact with a mentally ill person. I trained during a period where the psychiatric module was undertaken from the second year of training and I could not imagine dealing with a mentally ill person without having been taught the necessary skills. I recognised that the students were more capable than I realised and that I was restricting them with the fears I had when training. This is the poem I wrote to reflect this learning experience.

I am a mother hen

I am a mother hen

My feathers are symbols of strength and serenity

I am a mother hen

My feathers are the sanctuary of others

The heavenly haven of beauties such as my students

My wings are not to soar but to protect

For I am a mother hen

My feathers are symbols of warmth

But now I've realised sometimes I just have to let go.

5.3 Reflecting on the objectives of this research study

The objectives of this research project were to deconstruct the thinly described narratives of the individual, community and professional lives of the student nurses interacting with mentally ill individuals and to develop alternative narratives and unique outcomes in the professional and personal lives of student nurses. In my opinion, we managed to deconstruct these thinly described narratives. While not all participants fully agreed about the causes of mental illness, which is in line with cultural and societal constructs, all agreed that interaction with a mentally ill person was possible and differentiating a mentally ill person from the illness itself was possible. During this journey, the participants were able to re-author their own preferred stories by including their moments of strengths.

Although the research journey ended on a positive note, it felt somehow that this is just a pit stop, from which there are many roads and no sense of direction. I had expected to fold this research study in a neat and tidy package and keep it packed away in its compartment, but it's been like a train station, with so many railway lines going in different directions. I remind myself, however, that perhaps this is how qualitative narrative research should be, opening up new questions or new areas of inquiry.

5.4 Reflecting on the method used

Whilst it would be tempting to extol the virtues of narrative research, it would be remiss of me not to look at the method with a critical eye, as such action would affect the credibility of this mode of inquiry. Narrative research and narrative inquiry have their own potential perils and hazards.

Narrative research and narrative inquiry are relatively new methods of the qualitative approach and not as much is known about them as other better known traditional approaches. This is particularly so in the nursing and nursing education spheres.

Mishler, (1995), as cited in Bleakley, (2005), identifies potential problems first with data collection and interviewing. He gives an example of stopping the flow of the participants' talk, which then fractures the narrative. He also mentions the bias in selecting which parts of the interview should be used or reported. Bleakley (2005) goes on to advise the researcher to look at data collection and data generation as "*a medium for active construction of knowledge"* (Bleakley, 2005:537).

There are also the challenging aspects in the interpretation of data. How do you begin to interpret somebody else's subjective account of his life? (Lai, 2010; Bleakley, 2005; Savin-Baden & Van Niekerk, 2007; Moen, 2006). Although in chapter 4, I have given various approaches to analysing and interpreting data according to different scholars, this does not make it any simpler. Constant reflections and decisions need to be made about whose story it is (Savin-Baden & Van Niekerk, 2007:467; Riessman, 1993). Lai (2010) goes on to say that *"ultimately it's not about the traditions or philosophical assumptions of narrative inquiry that guide our research but it's our values, beliefs and personal philosophy that frame our perspective.*" (p. 82).

Several authors agree that certain attributes are central to the quality of qualitative narrative inquiry (Lincoln & Guba, 1994; Riessman, 1993; Bleakley, 2005; Kelly & Howie, 2007; Savin-Baden & Van Niekerk, 2007; Priest, Roberts &Woods, 2002; Moen, 2006; Lai, 2010). These attributes are prolonged critical engagement, honesty, trustworthiness, building of a trusting relationship, understanding of the concepts of credibility, high levels of ethical engagement and faithfulness. Bleakley, (2005: 539) puts it in a tongue in cheek way suggesting that *"perhaps the most important virtue of a narrative researcher is a stereotypically feminine attribute of sensitivity, not simply to research participant, but also to data."*

5.5 Limitations of the study

The most common limitation within a qualitative study is the size of the sample. This research focuses on the narratives of 5 students, which limits the research in terms of the extent to which it is possible to generalise the findings. The purpose of the study was not to generalize the findings to a bigger population, however, but to hear the specific stories of a few people within a particular context. Another limitation might be that English is not the mother tongue of the participants and they may have felt limited in the way they expressed themselves. It is possible that they may have been able to explain their experiences in a richer, more complex way had they participated in their own mother tongue. English was used within the groups because the medium of learning is English. However, much can be said about the value of using the students own language in psychiatric nursing education and more research could be done in this respect (Engelbrecht & Wildsmith, 2010). Time restraints also influenced the execution of the study; additional time may have led to augmented findings.

5.6 Recommendations

5.6.1 Nursing Education

The R425 programme, which is the 4 year Comprehensive Diploma in Nursing (general, community, psychiatric and midwifery) is structured in such a way in South Africa that the psychiatric module is offered during the second semester of the final year of training. The psychiatric module is also offered as a post-basic course (R212) for a period of 12 months (SANC). With the changes in the Mental Health Care Act (2002), student nurses doing the Comprehensive Diploma in Nursing get to be allocated and to interact with mentally ill persons before they are taught the mental health/psychiatric module.

Although this study ended on a positive note, I recommend that the curriculum be reviewed such that Mental Health Nursing is started earlier to give students the necessary skills to help them interact with mentally ill persons in the wards. The additions recommended include teaching the students about the causes of mental illness and the impact of the stigma associated with mental illness to the mental health care user. The above mentioned necessary skills to be taught may include communication with a mental health care user, and dealing with negative behaviours.

In-service training and education programmes in mental health should be implemented and conducted, not only for nurses in psychiatric institutions, but also for those in the medical wards to help broaden their knowledge and skills on how to manage a person with mental illness. This will help the students to deal with stressors in the clinical environment and reduce the stigma associated with mental illness.

The results of this study clearly show that familiarity with the person with mental illness decreases fear and has a positive influence on interpersonal interaction, the practice of allocating learners or exposing them to the person with mental illness is highly recommended as it helps give an understanding of mental illness. Nevertheless a platform should be created for students to debrief, talk and share their experiences, helping them to deal with the challenges they have in their training.

5.6.2 Nursing Research

The phenomena of negative emotions such as fear, anxiety and frustration relating to mentally ill people and student nurses have been looked at exhaustively in nursing research. It is, therefore, expedient to look at ways of dealing with these aspects in such a way that is beneficial for all the relevant stakeholders. In view of the findings of this study, I make the following recommendations:

- More research be undertaken to determine the impact of curriculum differences on emotions and ignorance.
- Exploring the method of narrative inquiry as a form of research, which will contribute to the existing body of knowledge regarding research methodologies.
- Further research on the use of narrative pedagogy in nursing education and its implications.

5.6.3 Nursing practice and management

For nursing practice and management I recommend:

- Clear guidelines to be set on the process of integrating mental health nursing in the general stream.
- Procedures and policies put into place on how to deal with psychiatric emergencies in the wards.
- Training to be conducted on mental health screening and the Mental Health Act, including awareness programmes in communities to deal with stigma.
- In-service education for nurses, especially for those who are not psychiatric trained. This will empower nurses with the necessary knowledge and skills, which will have an impact on the prevailing negative attitudes.

5.6.4 Conclusion

While the findings in the study indicate there is a need student nurses to be exposed or introduced to theory prior to nursing people with mental illness, non-exposure does not automatically translate to negative attitudes to nursing people with mental illness. I have noted, rather, that being in contact on a personal level with a person with mental illness, contributes towards the improvement of positive attitudes towards them. However, there is still a need for education and training to improve the skills necessary to deal with a person with mental illness. I have also observed that in spite of social and cultural background and community beliefs that play a part in perpetuating negative emotions such as anxiety and fear where a person with mental illness is concerned, community members show tolerance towards a person with mental illness in the community, hence the concept ‘one of ours’. However, these

positive emotions are not automatically applied when encountering a stranger who is mentally ill. The findings of this study have shown that gender does not necessarily have an impact on the way student nurses view a person with mental illness. Because social and cultural background, beliefs and negative emotions are so closely interlinked with relation to mental illness, the most effective option to combat the stigma attached to mental illness would be not only to provide education and training to student nurses, but to implement a programme that provides education for all nurses and ultimately the community or society at large. This constitutes multiple levels of education or the 'ladder effect' where education should be broken down in a step-by-step process. It is evident that community and cultural beliefs regarding causes of mental illness do play a huge role on the stigma attached to mental illness and this has a direct effect on the integration of mental health nursing into the general or primary health care stream. In accordance with the Mental Health Care Act of 2002, if in-service education and training was extended to some of the other governmental departments, such as South African Police Services, this may help to reduce the ignorance and negative attitudes that contribute to stigmatisation.

5.7 Summary

In this chapter, I have looked at the journey of narrative inquiry as a research method, and the challenges experienced. The chapter includes self-reflection, the limitations of the study and recommendations for nursing research, nursing practice and nursing education.

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PARTICIPANT INFORMATION FORM

Dear participant,

My name is Nolundi Radana working at Edendale Nursing Campus as a lecturer. I am currently studying for a Masters degree in Mental Health Nursing and as part of requirements, I am required to undertake research in an area that may be of interest to me and which falls within my scope of practice.

I will be making use of narrative inquiry in conducting research regarding the experiences of nursing mentally ill people in a medical ward.

I would like to invite you to participate in the narrative focus group interview with me and four other participants which I will be audio-taping. These conversations will be highly confidential and your privacy will not be compromised. The audio-tapes will be kept under lock and key. I will be the only person listening to these tapes. No personally identifiable details will be released, only averaged information. Please understand that your participation is voluntary and you are not being forced to take part in this study. The choice of whether you participate or not is yours alone. However I will appreciate it if you do share your experiences and feelings with me. If you choose to take part you will not be affected in any way. If you agree to take part, you may stop at any time and discontinue your participation. If you refuse to participate or withdraw at any stage, there will be no penalties and you will not be prejudiced in any way. In addition I believe you may benefit from these conversations as you will get the opportunities of discovering alternative unique outcomes as you engage in these focus group interviews. If you feel at any time during and after the study affected emotionally in a negative way by the process, be free to come to me so we can talk about the experiences, alternatively contact this person: Ms Josephine Towani,contact no: 0744415467;e-mail address:j.towani@gmail.co.za.

Should you agree to be part of this study, I will further request that you sign the attached consent form which indicates that you are familiar with the conditions stated above.

If you have any questions about this study, you may contact me at Edendale campus on this number: 033-3927576 or on cell number: 0785583504 e-mail address 209521224@ukzn.ac.za or nolundie@webmail.co.za.

If you have any questions about any aspect of this study, you may contact the ethics committee at this number: 031-2603587, e-mail address ximbap@ukzn.ac.za or my supervisor, Ms C.Engelbrecht at 031-2602513, e-mail address engelbrechtc@ukzn.ac.za.

Thank you,

Nolundi Radana

Signed: ______________________

Consent for research

I --------------------------------- - hereby agree to participate in research regarding my experiences in nursing mentally ill people in a medical ward. I understand that I participate freely and without being forced in any way. I also understand that I can stop this participation anytime should I wish not to continue and that this will not affect me negatively. The purpose of this study has been explained to me, and I understand that this is a research project whose purpose is not necessarily to benefit me personally. I have received the telephone numbers of a person to contact should I need to speak about any issues that may arise in this study. I also agree to the audio-recording of this interview for the purpose of data capturing. I understand that no personally identifying information or recording concerning me will be released in any form. I understand that these recordings will be kept securely in a locked environment and will be destroyed once data capture and analysis are complete.

Signature of participant: ______________________

date_______________________

(Adapted from Terreblanche, Durrheim & Painter, Research in practice, 2006:74-75)

Biographical and demographical details

Dear Participant,

May you please supply me with the information as below?

Age: ------------------------------

Gender: -----------------------------

Where were you born? --

Where did you go to school? -----------------------------------

Currently where do you live? ----------------------------------

In what area or town do you live when you are not studying? ------------------------------

Where does your family live-----------------------------

Is there history of mental illness in your family? :----------------------

Do you know of a person/s living with mental illness in your community? --------------------

For how long have you worked in the medical unit with a mentally ill person? -------------------

Have you ever worked with a mentally ill person before training? ------------------------------

Narrative interview schedule

The questions that I will ask will be aimed at taking apart the social or community and personal constructed beliefs about mental illness. I will be guided by the landscape of action and landscape of identity also known as landscape of consciousness questions as described by Michael White (1995:31). He describes landscape of action questions as questions that can be referred to the past, present and future and are effective in bringing about alternative stories or landscapes, the meanings thereof. He also describes the landscape of consciousness questions as questions that encourage persons to review the developments as they unfold through the alternative landscape of action. Landscapes of consciousness questions encourage the understanding, articulation and the performance of alternative preferences, desires, beliefs (White, 1991:131). I would assert that the landscape of consciousness questions is mainly future oriented.

Session 1 Life stories (narrative biography of each participant)

In this session there will be a general discussion on mental illness and general beliefs, life histories, surrounding mental illness. This will be more of an ice-breaking session which I will facilitate in the hope that the participants will open up. This session also includes the filling in of the biographical and demographic details.

At the end of this session I will give the participants homework, which will be to bring a story to the group of someone in their community who is living with mental illness.

The main question for these sessions will be: What are the dominant community and personal beliefs of the participants' regarding mental illness? Probing questions will then be used.

Session 2-Deconstruction (Community beliefs)

In this session I will ask the following questions which are aimed at taking or pulling apart the societal or community beliefs. I will link this session with the last one by first asking the participants to:

- Tell us (group) about the person in the community (homework)?
- How is the person treated in the community?
- Why the person is treated this way?
- What underlying societal or community beliefs does the community live by?
- How do they think the person feels?

Session 3 Deconstruction (Personal beliefs)

- What are your own beliefs about mental illness?
- What do you think shaped these beliefs?
- How has these beliefs affected your relationship with people living with mental illness in the community? In the ward?
- What experiences would you like to share regarding people with mental illness?
- What do these experiences mean to you?

The end of the session will be a role play aimed at externalisation of the problem. In this role play, one participant will be asked to volunteer to be a person living with mental illness, the other participants will be invited to ask questions about the feelings he/she experiences in living with mental illness as well as the challenges in interpersonal relationships.

Session 4 Unique outcomes and Alternative stories

- Can you think of an incident or a story in the ward that made you change your view of the person living with mental illness?
- What exactly changed your view of people with mental illness (also referring to the role play)
- How did this make you feel?
- How has the role play affected your view of mental illness?
- Do you see this as good or bad?
- How will it affect your relations with people living with mental illness?
- How do you think it will affect your future practice as a mental health nursing student, and a mental health nurse? In what way?
- Where do you see yourself or what hopes and dreams do you have regarding nursing a person with mental illness?
- What have you learned about the practises that you might want to warn others about?

Session -5 Celebration and feedback

In this session celebratory letters, poems, art/drawing or bring in a memento or a symbol which will have a meaning to him/her and what does it mean. My aim is not to be prescriptive, therefore the above mentioned will be suggestions.

35 Howard Road
Mayors Walk
Pietermaritzburg
3201
11 October 2010

ATTENTION: MR. X. XABA

KwaZulu-Natal Department of Health
Provincial Health Research Committee
Pietermaritzburg
3200

Dear Mr. X. Xaba

RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH PROJECT

I am a lecturer (mental health) at Edendale campus. I am currently completing my Masters degree (Mental Health) at UKZN School of Nursing and conducting this research study as part of my completion of my degree.
I am requesting permission to collect data from a purposive sample of second year student nurses at Edendale Campus.

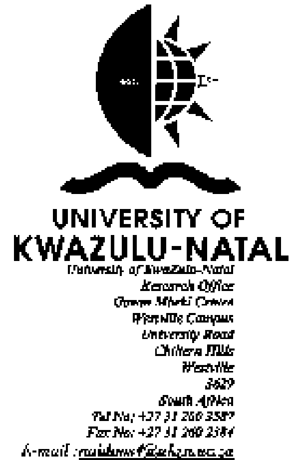
Please find herein attached a copy of the research proposal, ethical clearance letter from UKZN and a letter of support from Kwazulu-Natal College of Nursing.

RESEARCH TITLE: Exploring student nurses' narratives on nursing mentally ill people in a medical ward in the Umgungundlovu District.

Thank you
Nolundi Radana

Student number: 209521224
Contact number: 0785583504
Email address: 209521224@ukzn.ac.za/nolundie@webmail.co.za

Research supervisor: Ms C.Engelbrecht
Contact number : 031-2602513
Email address : engelbrechtc@ukzn.ac.za



University of KwaZulu-Natal
Research Office
Govan Mbeki Centre
Westville Campus
University Road
Chiltern Hills
Westville
3629
South Africa
Tel No: +27 31 260 3587
Fax No: +27 31 260 2384
E-mail : [illegible]

14 September 2010

Mrs N Radana
35 Howard Road
Maynrs Walk
PIETERMARITZBURG
3201

Dear Mrs Radana

PROTOCOL: Exploring student nurses' narratives on nursing mentally ill people in a medical ward in the Umgungundlovu District
ETHICAL **APPROVAL NUMBER: HSS/0980/2010** M: **Faculty of Health Sciences**

In response to your application dated 09 September 2010, Student Number: **209521224** the Humanities & Social Sciences Ethics Committee has considered the abovementioned application and the protocol has been given **FULL APPROVAL.**

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Professor Steve Collings (Chair)
HUMANITIES & SOCIAL SCIENCES ETHICS COMMITTEE

SC/sn

cc: Ms. C Engelbrecht (Supervisor)
cc: Mr. S Reddy

Postal Address:
Telephone: Facsimile: Email: Website: www.ukzn.ac.za
Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference: HRKM 156/10
Enquiries: Mr X. Xaba
Telephone: 033 395 2805

Dear Mrs N. Radana

Subject: Approval of a Research Proposal

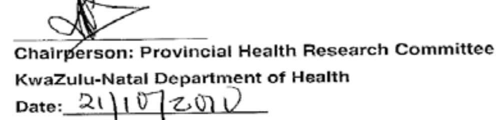
1. The research proposal titled **'Exploring student nurses' narratives on nursing mentally ill people in a medical ward in the UMgungundlovu District'** was reviewed by the KwaZulu-Natal Department of Health. The proposal is hereby **approved** for research to be undertaken at Edendale Nursing College Campus.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact.

Yours Sincerely



Chairperson: Provincial Health Research Committee
KwaZulu-Natal Department of Health
Date: 21/10/2010

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

KWAZULU- NATAL COLLEGE OF NURSING
P/Bag X9089, Pietermaritzburg, 3200
Tel.: (033) 264 7800, Fax: (033) 394 7238
e-mail: lulama.mthembu@kznhealth.gov.za
www.kznhealth.gov.za

Enquiries: Mrs. S. Maharaj
Telephone: 033 – 264 7806
Date: 11 October 2010

Principal Investigator:
Ms Nolundi Radana (209521224)
School of Nursing
University of KwaZulu-Natal

Dear Sir/Madam

RE: PERMISSION TO CONDUCT RESEARCH AT EDENDALE CAMPUS

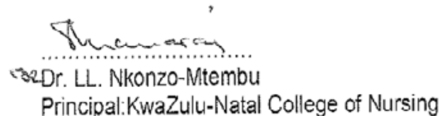
I have pleasure in informing you that permission has been granted to you by the Principal of the KwaZulu-Natal College of Nursing to conduct research on the "Title of the research study". ***Exploring* student's narratives on nursing mental ill people in a medical ward in the Umgungundlovu District**

Please note the following:

1) Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.

2) This Research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3) Please ensure this office is informed before you commence your research.
4) The KwaZulu-Natal College (Edendale Campus) will not provide any resources for this research.
5) You will be expected to provide feedback on your findings to the Principal of the KwaZulu-Natal College of Nursing.

Thanking You.
Sincerely



Dr. LL. Nkonzo-Mtembu
Principal:KwaZulu-Natal College of Nursing

uMnyango Wezempilo. Departement van Gesondheid
Fighting Diseases, Fighting Poverty, Giving Hope.

HEALTH
KwaZulu-Natal

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
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Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference: HRKM 156/10
Enquiries: Mr X. Xaba
Telephone: 033 395 2805

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For any additional information please contact.

Yours Sincerely

Chairperson: Provincial Health Research Committee
KwaZulu-Natal Department of Health
Date: 21/07/2010

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

Attention: Ms S.Maharaj

35 Howard Road
Mayors Walk
Pietermaritzburg
3201
04.10.2010

The Principal
KwaZulu-Natal College of Nursing
211 Pietermaritz Street
Pietermaritzburg
3200

Dear Dr L.L. Nkonzo-Mthembu

RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH PROJECT

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Thank you
Nolundi Radana

Student number: 209521224
Contact number: 0785583504
Email address : 209521224@ukzn.ac.za/nolundie@webmail.co.za

Research supervisor: Ms C.Engelbrecht
Contact number : 031-2602513
Email address : engelbrechtc@ukzn.ac.za

KWAZULU- NATAL COLLEGE OF NURSING
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Principal Investigator:
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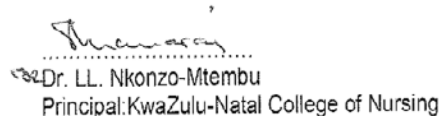

Dr. LL. Nkonzo-Mtembu
Principal:KwaZulu-Natal College of Nursing

uMnyango Wezempilo. Departement van Gesondheid
Fighting Diseases, Fighting Poverty, Giving Hope.

35 Howard Road
Mayors Walk
Pietermaritzburg
3201
04.10.2010

The Principal
Edendale Nursing Campus
Private Bag x 9099
Pietermaritzburg
3200

Dear Mrs N.C. Majola

REQUEST FOR A PERMISSION TO CONDUCT A RESEARCH PROJECT

I am a student at the University of KwaZulu-Natal. I am doing a Masters Degree in Mental Health Nursing. As part of my Masters Degree, I am required to conduct a research project.

Research Title: Exploring student nurses' narratives on nursing mentally ill people in a medical ward in the Umgungundlovu District.

I hereby request a permission to conduct my study in your Campus in October 2010.

Please find herein attached a copy of the ethical approval letter from the above mentioned institution and a copy of the research proposal.

Thank you
Nolundi Radana

……………………..
Student number : 209521224
Contact number : 0785583504
Email address : 209521224@ukzn.ac.za/nolundie@webmail.coza

Research supervisor : Ms C.Engelbrecht
Contact number : 031- 2602513
Email address : engelbrechtc@ukzn.ac.za

HEALTH
KwaZulu-Natal

EDENDALE NURSING CAMPUS
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29 Havelock Road, Pietermaritzburg
Telephone : 033 392 7566
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www.kznhealth.gov.za

19 October 2010

Mrs. N. Radana
35 Howard Road
Mayors Walk
Pietermaritzburg

REQUEST TO CONDUCT RESEARCH AT EDENDALE NURSING CAMPUS

Protocol: "Exploring student nurse's narratives on nursing mentally ill people in a medical ward in the Umgungundlovu district"

Your letter dated 04.10.10 refers.

We are pleased to inform you that the permission is granted provided:

- Confidentiality is maintained at all times
- Your research does not interfere with smooth running of the Campus
- Proper consent is obtained from the participants

Thank you

Yours sincerely

Dr N.V. Mkhize
(Chairperson Research committee)

Mrs N.C. Majola
(Campus principal)

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

WORDS OF A HUMAN

LOOK AT THE BRIGHTER SIDE

YES, CHALLENGES I HAVE

WHY DO I HAVE TO HIDE

I AM HUMAN AND HAVE GOALS

A LITTLE HELP, A LITTLE PUSH TO THE RIGHT DIRECTION

CAN YOU NOT HELP AND SHOW ME THE ROAD

GIVE ME SOME LOVE, UNDERSTANDING AND SOME MOTIVATION

DON'T RUN AWAY I MAY HEAL WITH MY VOICE, A GOOD SONG WILL DO

DON'T RUN AWAY I MAY HEAL WITH MY VOICE, WORDS OF WISDOM WILL DO

I DON'T WANT TO MAKE A FEE

JUST PUT YOURSELF IN MY SHOES

RELATIONSHIPS HAVE BEEN DESTROYED BY THIS ILLNESS

I HAVE TO PUT BACK THINGS THE WAY THEY WERE

HELP ME BACK TO WELLNESS

THESE ARE THE WORDS OF MAN SUFFERING FROM A MENTAL ILLNESS

THESE ARE THE WORDS OF A HUMAN

COMPILED BY :

ME...

Wake up from the fear and stigma
I am a person just like you and all the other people.

I can walk I can talk I can sing I can dance
I am still the person I was just mentally ill ...

Mentally ill you might say!!
With a facial expression displaying fear, concern and shock all at once.

Calm down I'll say relax it's me your brother your sister your mother your father, your family member, your flesh and blood... calm down please
I am a person just like you and all the other people
I try to voice my feelings but everyone turns away or runs left or runs right
I try to reach out for help but I get the cold shoulder
I feel alone I feel useless I feel trapped.. please may you rescue me with your love, your concern and your understanding of people like me.
Open your mind open your thoughts, listen to me please - dont throw me away, please dont let go of me
Hold my hand and help me
If I fall, bend down and lift me up
If I fail help me rectify my mistakes
Help me get my life back... after all
I'm a person just like you and all the other people.

You can even say I'm special and unique if you like... I wouldn't mind at all.

Yours Truly

Me ♡

It's like I am burried alive.

I wonder when does mental illness go to an end.
It all started as "ectasy" or over excitement and actually I did enjoy
each and every minute of it was enjoyable, my friends called me
Skhokho "the Hero" but today a zero. I wish mental illness can
come to an end. It's like I am burried alive.
I can not blame on witchcrafty because I understand the cause
but moving away from it is impossible. From morning to afternoon
I smoked, from monday to Friday I did smoke, I enjoyed myself
with dagga, "wunga" alcohol, mandrax etc, eventually my state of mind
changed completely. It's like I am burried alive.

I wish one can come and take away this burden I am carrying.
The odour is now my best friend, I see the unseen, I hear the
unhearable, I taste my own kind of taste, I have no one no
shoulder to lean on. Anxiety is my daily bread, I eat from bins.
Where ever I go people chased me, though I can not stop taking drugs.
I vividly remember what I used to be but there is no turning
back, I miss my wife especially my children but their whereabouts
is not known now it's like I am burried alive.

I wish someone can feel how I feel, can take me out
of this hole that is so huge. Sleeping under the veranda in winter
with no blanket my stomach tuned the same song.
From "Hero" to zero that what I am, People grouped me as
belonging to a crowd of victims, wounds and cracked bitts heels
are evidence of my sufferings, I was brighter in complexion than
I am now. I now belong to the crowd of unforgiveable, the
crowd of losers, the crowd of hopelessness
THANKS God you have never ever been burried alive.

And you better know that your
Understanding is the best therapy
Than diagnostically proven that
He/She is mentally retarded but
You as a learned person
you know so much better than that.

At least should know that
even though the change has come
but the time you doesn't leave

Did you ever think that
though she is what she/he is
deep down, she still the one
with all the good that every man has
I never know but now I know

Compiled by: !

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KwaZulu-Natal

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Dear Mrs N. Radana

Subject: Approval of a Research Proposal

1. The research proposal titled **'Exploring student nurses' narratives on nursing mentally ill people in a medical ward in the UMgungundlovu District'** was reviewed by the KwaZulu-Natal Department of Health. The proposal is hereby **approved** for research to be undertaken at Edendale Nursing College Campus.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact.

Yours Sincerely

Chairperson: Provincial Health Research Committee
KwaZulu-Natal Department of Health
Date: 21/07/2010

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