UNIVERSITY OF NATAL

CLIENTS' PERCEPTIONS OF THERAPEUTIC INTERACTION WITH NURSES AT ESCOVAL HOUSE COMMUNITY PSYCHIATRIC CLINIC IN DURBAN

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DEDICATION

This study is for you Nokuphiwa Ngcamu. Life in South Africa could not be the same if it did not mean you as a friend.

DECLARATION

I declare that this dissertation is my own original work and that all other sources of references have been acknowledged.

M. T. BVUMBWE

Signature ..... Date 14th October 2003

This Thesis has been examined and approved for submission.

GUGU MCHUNU

Supervisor ..... Date 17th November 2003

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ABSTRACT

The objective of this study was to explore clients' perceptions and expectations of therapeutic interaction with nurses at Escoval House Community Psychiatric Clinic in Durban. Following the shift of psychiatric care from institutionalised care to community based psychiatric care, it was anticipated that the findings of the study would help to sensitise the primary health care nurses and community psychiatric nurses on how clients perceive the way nurses interact with them. This would help the nurses to ensure satisfactory interactions that would be therapeutic and enhances clients' recovery and well-being. The study utilized Human Relations Counselling Model in exploring the clients' perceptions.

An exploratory descriptive survey was used to conduct the study. The study combined both qualitative and quantitative methods for the purpose of triangulation. Ten participants were involved in a focus group and one- hundred and sixty clients participated by filling in questionnaires. Simple random sampling method was used to select participants for both the focus group interview and those who filled in the questionnaires.

Data from the focus group was analysed manually using content analysis. Data was presented by participants' direct quotes. Data from the questionnaires was analysed using Statistical Package for Social Sciences (SPSS). For the quantitative data analysis, frequencies and percentages were used to analyse the data. Findings of the study were presented in tables and graphs.

Although previous studies on clients' satisfaction have reported clients' satisfaction with mental health service delivery, the findings of this study have revealed that gaps still exist in quality of care delivered to these clients. Findings show that there were mixed perceptions on the way nurse interact with clients during clients' monthly attendances.

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CHAPTER ONE

INTRODUCTION

BACKGROUND OF THE PROBLEM

There has been a significant change in the focus of psychiatric/mental illness management from long stay care in acute hospital settings to managing the clients in the communities in which they live (Strachan, 2000 (a)).

Previously, people with mental illness were kept in the hospital for long periods of time until they got better, because, for years, the treatment of mental illness focused on symptom reduction. Although that is a worthwhile goal, simply diminishing the severity and frequency of symptoms does not guarantee the successful reintegration of clients into the general community, which should be the ultimate aim of mental illness treatment and management. Instead, the focus should be on complete, or near-complete, recovery, in an effort to reintroduce these individuals into society (Aquila, 2000). This change in focus has resulted in a shift from in-patient hospital care to comprehensive psychiatric services to clients in their own communities. It is now the role of the community psychiatric nurses to provide care to discharged clients (Levine & Perkins, 1997).

Studies have shown that community mental health care is the most relevant approach for the care of the mentally ill (Abiodum, 1990; Uys & Middleton, 1997). The shift in the locus of care from mental institutions to the community in the last three decades has significantly changed the life conditions of people with mental illness. Ngubane & Uys (1994) and Freeman (1992) argue that the integration of psychiatric/ mental health care into the primary health system will improve coverage of the population. It will also reduce the cost of health care, as the primary health care clinics staff will provide psychiatric/ mental health care. Services will be accessible and economical. The rehabilitation of clients will be improved since families will be actively involved (Ngubane & Uys, 1994).

Community health nursing involves responsiveness to the needs of service users, and thus advocates partnership and empowerment (Crowe, 1997). Community psychiatric care promotes clients' autonomy. Clients have the opportunity to plan and to live as any other individuals do in community care. When clients' autonomy is compromised, clients develop feelings of hopelessness and helplessness. Clients feel alienated and often identify with the role of "passive client" when their expectations are not met. Feelings of hopelessness and helplessness have been found to be strong barriers to healing and rehabilitation in mental health care (Carling, 1995).

It is the objective of the South African government to create a health system capable of delivering quality health care to all its citizens efficiently and in a caring environment (R.S.A., 1997 (a)). The South African government acknowledges that mental health promotion and the provision of services have been neglected in the past. Available services are neither appropriate nor accessible to the majority of the population (R.S.A., 1997 (a)). A similar situation obtains in the United Kingdom, where community mental health services throughout the UK have historically had a tendency to neglect people with severe and enduring mental illnesses (Faulkner, Field & Muijen, 1994; Lelliott, Audini & Darroch, 1995). A recent survey of the English National Health Services (NHS) Trusts has concluded that services targeting people with severe and enduring mental illnesses are patchy (Schneider, Carpenter & Brandon, 1999).

Successfully improving and promoting the psychosocial well-being of all communities is an essential ingredient in the Reconstruction and Development Programme (RDP) that the government of South Africa is implementing. Community psychiatric clinics have been established with the purpose of providing community based therapeutic services to mentally ill individuals (Strachan, 2000 (b)). Such services include monitoring and evaluating clients' progress as well as managing clients' existing problems (Burns & Cohen, 2000).

The principle governing the provision of mental health care was that comprehensive and community-based mental health and related services (including substance abuse prevention and management) should be planned and co-ordinated at the national, provincial, district and community levels, and integrated with other health services (RSA, 1997(a)). In the United States of America the social philosophy underlying community mental health emphasizes better access to high-quality care for all Americans and allocation of more resources to community treatment (Test, 1992; Stein & Santos, 1998). Emphasis is being placed on mental health/ psychiatric care that will be delivered at a community level in both the United States of America and South Africa. An important principle in the organization of mental health care is its integration into primary health care. The fundamental role of primary care for the entire health system in any country was clearly stated in the Alma-Ata Declaration (WHO, 1978). Primary health care acts as a filter between the general population and specialized health care, and provides an entry point into the specialised health care system (WHO, 2001). Community health nurses, then, cannot overlook mental health care in community clinics.

The Department of Health (2000) proposed a set of standards for the care of individuals with mental illness. These standards emphasise that services should promote and provide care for users based upon humane and respectful interaction and relationships and the need for social integration and support. The environment and structure in which treatment and support occurs should promote mental health goals, community integration and service accessibility. Users and their family members should be involved in the planning, implementation and, where possible, the evaluation of their treatment and the services. The service should promote community participation and development that benefits and addresses the needs of users and their caregivers.

As one of the strategies to promote community participation in health care delivery, the government of South Africa came up with the Batho Pele (people first) principles. Within these principles the government states that citizens should know the level and quality of

public service they are to receive and know what to expect. Citizens should be treated with courtesy and consideration. In the patients' rights charter, patients have the right to confidentiality and privacy, informed consent, to exercise choice in health care, and to participate in decision making that affects their health (Department of Health, 2000).

Sibeko & Greeff (1995) in a study of psychiatric nurses' communication with psychiatric clients in an acute hospital in Transvaal, South Africa, reported that most of the times when a patient tried to approach a psychiatric nurse, he or she was turned away. These authors suggested that the nurses were busy to attend to the client or they did not allow themselves the opportunity to interact with the clients or they made a habit of turning the clients away with the excuse that they were busy. The patients then were unable to communicate their needs and problems with regard to their internal and external environment. Sibeko & Greeff (1995) also noted that psychiatric nurses also tended to concentrate on a structured hospital routine that allowed very short periods of nurse- patient interactions.

People with mental illness thus receive little help with the most important aspects of their illness, possibly resulting in poor compliance and increased psychological morbidity (Macpherson, Jerrom & Hughes, 1996). Community psychiatric nurses can improve this negative outcome by better assessing clients' needs and providing education particularly to elicit clients' understanding and expectations regarding their illness (Koppel & McGuffin, 1999).

In community psychiatric clinics, interviews enable clients to furnish biopsychosocial information to provide the ground for appropriate interventions (Staab & Hodges, 1996). A detailed interview of psychiatric clients has therapeutic benefits beyond the assigning of an appropriate diagnosis. These benefits are achieved through working with the clients so that they can understand the nature of their problems, conditions and illness. Successful treatment approaches that enhance wellness and reduce disability are best facilitated within a therapeutic partnership between the clients and their nurses. Ultimately, preventing relapse is

dependent upon nurse- clients shared goals, shared agreements and a dynamic and responsive treatment contract (Wilson, Hobbs, Osborne & Archie, 1996).

In most cases psychiatric clients attend community psychiatric clinics on a monthly basis. A monthly supply of medication, assessing the effectiveness of the medication and organizing admission and psychosocial education are some of the interventional services at these monthly therapeutic interactions (Uys & Middleton, 1997).

A comprehensive therapeutic interaction is vital for a full understanding and satisfaction of the clients' needs for their specific illnesses. The nurses' better understanding of individual client's factors related to clients' perceptions may lead to better addressing of clients' expectations, and would thus improve quality of care and raise satisfaction outcomes (Elame, 2001).

Evaluation in the community settings usually differs from in-patient evaluation because of less frequent interviews i.e. once every month (Strachan, 2000 (a)), and less involvement of other professionals. Community psychiatric nurses have less opportunity to observe the clients' behavior directly and to implement protective interventions where necessary. Therefore, during the monthly attendance at the community psychiatric clinics, community psychiatric nurses need to reassess the clients' needs comprehensively and intervene appropriately. The ability of the community psychiatric nurses to understand what is important to the clients and what will give them meaning in life is essential to enhance hope and assist the clients to achieve their goals (Byrne, Woodside, Landeen, Kirkpatrick, Bernardo & Pawlick, 1994).

Studies elsewhere have revealed that short visit times are detrimental to the diagnosis and treatment of mental health disorders in community psychiatric clinics (Kroenke, 1997; Eisenberg, 1992). Clients perceive things such as spending enough time with the nurse and not feeling rushed during the visit and having the nurse teach them about illness, medications and treatment as attributes of perceived quality health care (Byrne, 2001).

Clients want client-centered care that explores the clients' main reason for their visit, concerns and need for information (Stewart, Brown, Weston, McWhinney, McWilliam & Freeman, 1995). Without an understanding of the clients' needs and their illness condition, there is uncertainty about the impact of mental health education programmes in terms of meeting the specific needs of clients (Macpherson, 1995).

Client centered therapeutic interaction influences clients' perception towards health care services. Clients perceive that their visit is client centered when they are involved in the planning of their care (Moira, Brown, Donner, McWhinney, Oates, Weston, & Jordan, 2000).

In a study by Radwin, cited in Schreiber (1999), clients described the desire for their nurse to establish rapport with them and to individualize their case so that their feelings were taken into consideration during treatment. Clients' active involvement in decision making about their treatment options increases their feeling of being valued and results in greater effectiveness of treatment (Coulter, Entwistle & Gilbert, 1999). Feeling valued as an individual and feeling comfortable are important indicators of clients' positive perception (Elame, 2001).

Studies reveal that clients have negative perceptions about the services they receive. Most of their complaints are strictly linked to not feeling valued. Holliger and Buschmann (1993) reported that most of the nurse- patient interactions seem to be superficial and task-oriented, limiting the amount of social interaction (Nolan, Grant & Nolan, 1995; May 1990). Sheppard (1993) relates clients' satisfaction and perceptions of the services they receive to nurses' interpersonal skills. Clients perceive such skills like communication, empathy, listening, openness and genuineness as important concepts for their satisfaction.

Clients have the right to respect, human dignity and privacy. Clients must be provided with care, treatment and rehabilitative services that enhance the users' capacity to develop to the full human potential and ensure integration into the mainstream of community life (RSA, 2000). The care, treatment and rehabilitation services administered to mental health care users

must be proportionate to their mental health status and may intrude only as little as is reasonably possible to give effects to the appropriate care, treatment and rehabilitation. Studies have demonstrated that discriminatory attitudes towards clients vary and come from varied directions. Ill-treatment toward clients comes from health practitioners as much as from the general population (Carling, 1995; Michener, 1998).

Studies have shown that clients complain that nurses show their power by speaking authoritatively, by ignoring the clients' status (Hewison, 1995) and by taking over or dictating the clients' care, allowing them no responsibility for themselves (Waters, 1994; Kenny, 1990). Clients complain that they are not valued as important in the provision of the services for their illness (Leete, 1988 as cited in Carling, 1995). For effective community psychiatric services, there is a need to improve clients' perceptions of the interaction that they encounter with nurses at the clinics. This improvement would be possible if community psychiatric nurses met clients' expectations.

Failure to elicit relevant information about symptoms and worries can result in inaccurate diagnoses, inappropriate treatment advice and therefore poor outcome such as drop outs from treatment (Zastowny, Roghmann & Cafferata, 1989). Davis & Fallowfield (1991) emphasize that as a result of poor communication the accurate exchange of information between the client and the community psychiatric nurse is likely to be severely limited, resulting in the probability that treating or advising the client appropriately diminishes. Poor communication is associated with non-compliance, resulting in poor outcome.

PROBLEM STATEMENT

Community psychiatric clinics, as the first level of contact of individuals, the family and community to the national health system, need to be responsive to the service users. People have the right and duty to participate individually and collectively in the planning and implementation of their health care (WHO, 1978). The relationship between nurses and the

health care service users in these community based primary health care clinics must then promote maximum service utilisation.

Relapse due to treatment non-compliance and dissatisfaction with the client-nurse interaction is a serious problem in psychiatric therapy, as well as a dangerous stumbling block to the reintegration of clients into the community. Commitment to the concept of reintegration and the establishment of relationships for people with serious and persistent mental illness are key first steps toward successfully avoiding relapse (Aquila, 2000).

Continuity of mental health services utilisation largely depends on consumers' perceptions of and satisfaction with their interaction with their service providers. Many individuals who live with the diagnosis of mental illness neither recover nor improve (Modrow, 1996). Studies show that 70% of the clients who live with the diagnosis of Schizophrenia are non-compliant with medication treatment. These clients explained their therapeutic non-compliance by citing an unsatisfactory nurse-client relationship (Torrey, 1995).

After failures to meet their expectations and needs to keep their illness in check, clients sometimes relapse into psychosis and behave in bizarre ways that attract the attention of the police (Harrington, 1999). Failure to meet clients' expectations leads to a sharp increase in the number of mentally ill individuals in other settings i.e. the streets due to relapse (Leibovish, 1997).

Monitoring and evaluation of the quality of service delivery to clients through their views of interaction with service providers is an integral part of professional practice. Mental health services have been accorded inadequate attention by researchers in South Africa (RSA, 1997 (b)). There is relatively little research evidence regarding the exploration of clients' perceptions of and expectations towards their interaction with community psychiatric nurses in community psychiatric clinics. For the health care service to deliver effective health care service, it has to evaluate the services that it renders in order to improve where needed. For

this reason, the researcher saw the importance of exploring the perceptions and expectations of therapeutic interaction between the clients and the community psychiatric nurses at Escoval Community Psychiatric Clinic from the clients' perspective.

AIM OF THE STUDY

The aim of the study was to explore clients' perceptions and expectations of therapeutic interaction with nurses at Escoval House Community Psychiatric Clinic in Durban.

OBJECTIVES OF THE STUDY

The broad objective of the study was to explore the nature of therapeutic interaction with regard to clients' perceptions and expectations at Escoval House Community Psychiatric Clinic.

The specific objectives of the study were:

- To explore clients' perceptions of therapeutic interaction with the nurses at the clinic;
- To describe clients' expectations of therapeutic interaction at the clinic during their monthly attendance;
- To provide recommendations for therapeutic interaction from the clients' perspective.

RESEARCH QUESTIONS

The study was aimed at answering the following research questions:

- How do clients perceive the therapeutic interaction between them and the community psychiatric nurses at Escoval House Community Psychiatric Clinic?
- What are the clients' expectations during this interaction at the Escoval House Community Psychiatric Clinic?
- What recommendations do clients have for therapeutic interaction at the clinic?

SIGNIFICANCE OF THE STUDY

Almeida (2002) conducted a study in Durban on consumer satisfaction with mental health service delivery. In this study, the satisfaction levels of consumers with the mental health service delivery in Durban were described. Findings of the study showed that

consumers were satisfied with the service delivery. Results indicated how consumers perceived the quality, general satisfaction, effectiveness of services, acceptability and amount, length or quantity of services and outcome of service covered by the programme.

In this present study, the researcher built on Almeida's study by exploring clients' perceptions of therapeutic interaction with nurses at Escoval House Community Psychiatric Clinic. The findings of the study will help community psychiatric nurses to understand clients' perception of therapeutic interaction with nurses at community psychiatric clinics. This is important because treatment continuity depends on clients' perceptions of their interaction with the nurses.

The study would provide information to community psychiatric nurses which they could relate to the nature of their interaction with the clients, to create a client-friendly environment that will meet the principles of Batho Pele at the clinic. Exploring clients' perceptions and expectations towards therapeutic interaction at the clinic would help to improve service delivery. Such improvement is in line with the government's objective to deliver effective health care service to persons with mental illness.

As the Government of South Africa has adopted primary health care principles and practices as a strategic approach to guide the transformation of its health system, this study should help both primary health care nurses and community psychiatric nurses to understand how clients perceive therapeutic interaction at the clinics. Understanding the factors that predict poorer treatment outcomes in the community health care delivery system should aid providers in improving a treatment approach that would ensure maximum utilization of the services by the community (Phillips, 2000). The findings of the study would also help to emphasise the need for a community based primary health care and community psychiatric nursing training that focuses on appropriate interpersonal skills by the nurses.

DEFINITION OF CONCEPTS

The following instrumental concepts have been presented to ensure consensus between reader and researcher.

- Client's perception is human experience, human judgment, appraised subjectively by an individual, regarding the extent to which care received has met certain expectations. It is how the clients value and regard their care (Bluementhal, 1996).
- A Community Psychiatric Nurse is a qualified registered nurse working with individuals with mental illness in the community or community clinics.
- Therapeutic means having or exhibiting healing powers, tending to cure or restore to health.
- Therapeutic interaction is the interaction that takes place between the clients and the community psychiatric nurses at clinics during monthly interviews with an aim of healing or restoring to health.

THEORETICAL FRAMEWORK

A number of theoretical frameworks and models were reviewed in an attempt to put the study into context. The Interpersonal Relations Model, Sherwood's Therapeutic Caring Model and Human Relations Counselling Model were reviewed. The researcher used the Human Relations Counselling Model to study clients' perceptions of therapeutic interaction with nurses at Escoval House Community Psychiatric Clinic, because the study shares the valuable with those in the framework.

INTERPERSONAL RELATIONS MODEL

Community mental health care, as in any other nursing practice, occurs within a relationship between the nurse and a client. Much of the planning for, and evaluation of, practice may occur outside the relationship but the main work goes on in an interactive process whose participants are nurses, clients and family members (Peplau 1987).

Nursing is therapeutic because it is a healing art, assisting an individual who is sick or in need of health care (Peplau, 1987). Nursing is viewed as an interpersonal process because it involves interaction between two or more individuals with a common goal. The attainment of this goal, or any goal, is achieved through a series of steps following a sequential pattern as the relationship of the nurse and client develops in these steps. The nurse can choose how she or he practices nursing by using different skills and technical abilities and by assuming various roles. Peplau (1987) identifies four sequential phases in interpersonal relationships:

(a) Orientation

(b) Identification

(c) Exploitation

(d) Resolution

Each of these phases overlaps, interrelates, and varies in duration as the process evolves toward resolution. In the same way, community mental health nursing care varies according to individual clients' needs. Different roles are assumed during the various phases in the

process. All aim at reaching resolution, which is to enable clients to live a satisfactory and independent life.

As this study is looking at the clients' perceptions of therapeutic interaction with the nurses, Peplau's model can be used because it is through this interpersonal relationship that clients' perceptions will be generated.

Each individual may be viewed as a unique biological, psychological structure. Peplau states that each person comes with preconceived ideas that influence perceptions and it is these differences in perceptions that are so important in the interpersonal process. Therefore, in nurse – client interaction, the way the client perceives the interaction would be different from the way the nurse will perceive the same interaction.

In the orientation phase, the client has a felt need which may not be readily identifiable or understood by the individual involved. The nurse needs to assist the clients in realizing what is happening to them. The orientation phase is affected by the attitudes of clients and nurses about giving and receiving care from a reciprocal person. The nurse's and clients' religion, race, education, preconceived ideas and expectations play an important part in the nurse-client interaction. Within the orientation phase of therapeutic relationships, communication skills have proved to be the most reliable predictor of concurrent relationship satisfaction (Peplau, 1987).

During the identification phase clients respond selectively to people who can meet their needs. Identification occurs when the nurse facilitates the clients' expression of whatever feelings are experienced and remains able to provide the health care needed. This expression without rejection permits the experiencing of illness as an opportunity to reorient feelings and strengthen the positive forces of the personality. Clients tend to respond to this experience as either an independent participant in the interaction with the nurse, an independent person in isolation from the nurse, or a person who is helplessly dependent upon the nurse. It is for this reason that all avenues of nurse-client interaction be explored in this study.

In the exploitation phase, some clients may make more demands than when they did when they were seriously ill. Some may take an active interest and become involved in self-care, whilst some may fluctuate between dependence and independence.

A therapeutic interaction must be maintained by conveying an attitude of acceptance, concern and trust. The nurse encourages the clients to recognise and explore feelings, thoughts, emotions and behaviours by providing a non- judgmental atmosphere and a therapeutic emotional climate. Nurses must help the client to develop a sense of hope.

The last phase, resolution, involves the termination of therapeutic interaction and the dissolving of the links between the nurse and the client. This permits the generation and strengthening of the ability to meet one's own needs and to channel energy towards the realization of potentialities. As long as the nurse-client interaction does not completely get dissolved, the nurse needs to empower and entrust the authority to the client. Nurses have the duty to help clients meet their basic needs and realize their potential capability in self care activities. These duties will generate good experience for clients because this last phase has a lot of importance in the client's mind. Considering that the care of clients has shifted to community based care, there is need that the nurses ensure that the resolution phase is been effectively passed through. It is at this stage that most clients will express their satisfaction with the contact that they had with the nurse.

This theoretical framework was not chosen for the study because it deals with an interaction in general. It only gives the phases of the interaction. The clients in the interaction described in the study have gone through most of the stages. This Model however, lacks aspects of therapeutic interaction that the study is looking for.

SHERWOOD'S THERAPEUTIC CARING MODEL

Sherwood's therapeutic caring model is characterised by nurse-client interactions that are linked by four essential patterns and explanatory themes. This model is put into practice by the nurses' knowledge and interventions, which in turn lead to the attainment of therapeutic health outcomes for the clients. Sherwood's Therapeutic Model provides a framework for rendering nursing care to clients in clinical settings and in their community. It also provides a means to measure outcomes of caring. Clients' perceptions for this study will be studied in connection with the four essential patterns and explanatory themes as explained in Sherwood's Therapeutic Caring Model.

Healing Interactions

Sherwood's first pattern deals with the therapeutic interaction that occurs between nurse and client and is illustrated by the themes of trust and belief between nurse and client. The model emphasizes providing care to clients taking into consideration that they are individual beings. In this respect, individualised care is accorded by the nurse's awareness of the client's situation and needs. To provide individualised care the nurse must perceive and value the uniqueness of the individual client. Satisfaction with therapeutic interaction is also dependant on the availability of the nurse to the client. It requires the nurse to be vigilant in surveillance of the client's needs and to provide a supportive and protective environment for the therapeutic interaction to occur (Sherwood, 1997).

Sherwood (1997) states that the nurse's focus on the client is manifested by the nurse's availability, receptivity and respect for the individual. Showing concern for clients' well being and having the time to sit and talk and listen to clients are ways nurses manifest commitment. Empathy, providing support and comfort, and preservation of the client's dignity are the ways that the nurses show commitment to the care they render to the client (Sherwood, 1997).

Nurses' Knowledge

Nurses' knowledge as a second pattern in Sherwood's model applies to nurses using their understanding of decision-making, human behaviour, cognitive knowledge and personal attributes when relating to the client. Using their knowledge to assess situations and clients, nurses adjust their behaviour to relate to the client in an individual and personalised manner. By showing concern and hope for the client's welfare, the nurse confirms the worth of the client (Sherwood, 1997).

The nurse's responsibility in the observation, monitoring and anticipation of clients' physical and psychological needs is influenced by the nurse's cognitive knowledge (Sherwood, 1997). Cognitive knowledge is characterised by competent effective decision making, need prioritisation, planning and resource management.

Nurses require more than knowledge and skills to be able to provide an effective therapeutic interaction. A nurse may possess knowledge and skills but choose not to use them. To be truly competent in their interactions nurses must have the confidence and commitment to use the knowledge and skills s/he possesses, the willingness to be guided by her/his conscience and the courage to be compassionate.

Intentional Response Pattern

The third of Sherwood's (1997) patterns is the intentional response pattern. This pattern relates to helpful interventions nurses perform on behalf of patients. These interventions are achieved by goal directed actions and are also aided by the nurse's competent clinical skills and knowledge, which encourage the client's trust and belief in the nurse. The nurse in this respect needs to involve the client in formulating goals if the interaction is to be meaningful to the client. The nurse must get to know the clients and the clients' needs and use his/her knowledge to determine how best to address these needs. Sherwood (1997) claims that for clients to trust and believe in the nurse they must feel safe, welcome and confident in the care they are given. As nursing is an interactive process, to develop trust and believe in the nurse,

clients must feel safe and confident in the interaction with the nurse.

The manner in which the nurse intervenes within the interaction with the clients leads to the development of trust and confidence in the care received (Sherwood, 1997). These interventions include sitting with and talking and listening to patients, helping relieve stress, doing 'extra' things, helping with pain management, and being friendly and offering help. Information giving and teaching, such as the nurse explaining the illness process, operation, procedure, progress or what the client can expect, in a manner and language the client can understand, are valuable interventions nurses use (Sherwood, 1997).

Therapeutic Outcomes

The fourth pattern described by Sherwood (1997) is therapeutic outcomes. This pattern is related to caring interventions and therapeutic patterns that make clients feel better. Sherwood writes that therapeutic outcomes are the goals of caring. They are achieved by resolving the affective and physical needs of the client. Resolution of affective and physical needs leads to the therapeutic outcomes of patient autonomy, empowerment, security, comfort, relaxation and peace (Sherwood, 1997).

Sherwood (1997) states that caring interventions and interactions aid the development of a caring environment in which the client can trust and therefore derive comfort from the nurse, thus engendering hope in their own ability to 'get through the experience'. Sherwood (1997) describes the connection between nurse and client that is based on interpersonal communication and caring interventions:

'People respond as approached: knowing how consumers perceive nursing care delivery will provide approaches to produce desired results. More than just feeling and acting, caring requires an informed awareness of the recipients of care...'(Sherwood, 1997). This is why this study will help to provide knowledge to nurses on how clients feel about the interaction that clients have with nurses at the clinic. The perceptions of clients of therapeutic interaction will probably affect the way they respond to the care they receive from the nurses.

The researcher did not choose Sherwood's Therapeutic Caring Model because the model only discusses about the activities that should be involved in the healing interactions. The model deals with all aspects of therapeutic interaction between a nurse and a client. This model is useful for the study as it discusses variables used in the study. But it was not the most ideal for this study.

HUMAN RELATION COUNSELING MODEL

The Human Relations Counselling Model has three integrated dimensions of counselling. These dimensions are stages, skills and issues (Okun, 2002). Counselling is an interactive process in which a counsellor assists a client to come up with solutions to a problem. In the same way nurse-client interaction at psychiatric clinics is aimed at helping the client to return to maximum functioning in the community. The Model's three dimensions apply to therapeutic interaction between the nurses and the clients. The Model is grounded on several theoretical assumptions. Firstly people are responsible for and capable of making their own decisions. Secondly people are controlled to a certain extent by their environment. Thirdly behaviours are purposeful and goal directed. People feel good about themselves when other view them as capable of making their own decisions. People continually need positive confirmation of their own self- worth from significant others.

The first dimension of the model is stages. In stages as a dimension, there are two factors within the helping process. These are relationship and strategies.

Relationship

As the nurse interacts with the clients, the nurse needs to develop rapport, trust, honesty and empathy. Development of a warm, trustful relationship between the nurse and the client is a basic condition for the success of any therapeutic interaction. Naturally this interaction depends on one's theoretical view of people, behaviour and the world. Every time the clients come to the clinic, interaction starts with the initial contact between the nurse and clients. It is at this point that the nurse builds an interaction that should be perceived and appreciated by the clients as a client-centred therapeutic interaction. The nurse provides an atmosphere that will make the clients comfortable, relaxed and free to air out their concerns. A climate should be provided for the nurse to explore concerns and to begin to identify underlying as well as apparent concerns. In this way the clients begin to understand their concerns and their implications for living and start to clarify their needs and expectations of the therapeutic

interaction in order to facilitate self-exploration, self- understanding and choices of action. The success of the interaction is crucial to the mutual determination of appropriate goals and objectives.

Strategies

Within the therapeutic interactions, there is need that the clients be involved in the choice of the courses of action to be taken as interventions for their illness. This comes after client- centred goals and objectives are mutually decided. The nurse should acknowledge the clients' opinions and show that the clients are also capable of contributing to the decisions made on the treatment. As the interaction goes on, the clients should be able to realise that they are part of the whole process. The nurse should not take all the power and authority as this makes the client to be passive recipients of care. The nurse should show commitment to this interaction. Roach (1992) defined commitment as a '...complex affective response characterized by a convergence between one's desires and one's obligations, and by a deliberate choice to act in accordance with them'. Within this therapeutic interaction, nurses should be committed to respect human rights and dignity, ensure the integrity of the nurse-client relationship, and enhance the quality of professional knowledge and its application. The nurse works to ensure alleviation of personal distress and suffering, at same time fostering a sense of self that is meaningful to the person(s) concerned by increasing personal effectiveness.

The second dimension of the Model is skills. The Human Relations Counselling Model points out that communication skills i.e. hearing verbal messages, perceiving nonverbal messages and responding to verbal and non-verbal messages, are required to effect the two stages of helping that have been discussed above. The Model assumes consistency between the nurse's verbal and non-verbal messages. In therapeutic interactions the nurse should always be conscious of verbal and non-verbal messages.

Hearing verbal messages

The cognitive and affective content of the nurses' statements are apparently underlined in verbal messages. As the nurse communicate any message, it gives the clients an understanding of the feeling communicated by the nurse. Understanding the real message is usually secondary to the feelings communicated. The nurse uses appropriate language and provides the clients with the required information needed for their understanding of the illness. Information on the illness and how to manage it is appropriate and has always been demanded by the clients and their care-givers.

Perceiving non verbal messages

Within therapeutic interactions, non-verbal messages are conveyed through body language, vocal tones, facial expression and other cues that accompany verbal messages. The nurses should be aware of how nurses present themselves during therapeutic interactions. They should give enough time to the clients to explain their problems. At the same time they should also have enough time to explain important information for the clients' understanding of their illness and treatment. Among the non-verbal cues that clients will pick up from an interaction with the nurse are the nurses' ability to be receptive, show empathy, hope and to be calm. Such perceived non-verbal cues affect the outcome of the interaction. Basically the clients are encouraged to utilise the services if they are satisfied with the interaction with the nurses.

Responding

The Model states that responding requires immediate, genuine, concrete and empathic reaction to verbal and non-verbal messages. The clients' decision to continue coming to the clinic acts as the reaction to therapeutic interaction they have with the nurse. If nurses treat clients with confidentiality, clients would find it easy to show their problems and needs to the nurse. If the nurse does not show any sympathy for the clients, clients lose hope for their future.

Issues is the third dimension in The Human Relations Counselling Model. Issues, as explained by the model, cover such things like sexism, racism, ageism and poverty. Issues also covers matters of ethics, training and practice as well as the personal values and attitudes of the nurse. Clients as individuals have their own beliefs, values and attitudes. By exposing and clarifying these issues, nurses are able to promote a therapeutic interaction that does not interfere with its aims. Responsive listening skills are effective techniques for discovering and exploring such issues.

Values and topics

Nurses should understand that clients as individuals have their own values. Nurses should therefore not impose their values on the clients. As nurses respect their clients' values, clients feel part of the interaction and will be encouraged to participate in their care. A nurse interacting with clients should be conscious that nurses' values get communicated to clients.

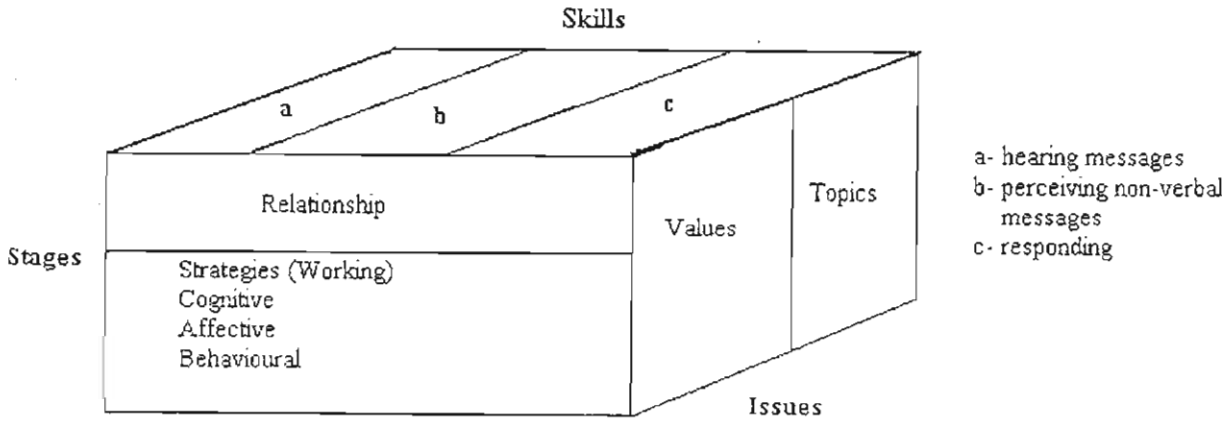


Fig 1: Human Relations Counselling Model

This model applies to an interaction between two people; it concentrates on helping relationship in interactions. In the study the interaction that is being explored

covers a wide range of reasons and aims. The Model shares almost all the variables that the study would like to focus on e.g. relationship, strategies that the nurse uses in an interaction. It also mentions the skills that are of importance in a therapeutic relationship e.g. client involvement and participation and information giving. Within the model, it is stated that the nurse develops rapport, trust, honesty and empathy. The study will uncover these aspects as regards to how clients perceive them within the client's interaction with the nurses. For these reasons the researcher saw that this Model could be utilized for the study.

CHAPTER TWO

LITERATURE REVIEW

This chapter reviews some relevant studies in the area of clients' perceptions of therapeutic interactions and mental health care service delivery, in an attempt to determine what is already known about the topic.

The major concepts that were reviewed were nurse's attitudes, clients' involvement in clients' care, interpersonal communication, information giving and nurse's commitment. Literature on clients' satisfaction and therapeutic outcomes of nurse- client interactions was also reviewed.

Institutionalization/ Community Psychiatric Care

In the past, mental health care was to a large extent custodial and based on medical therapy. Occupational therapy and in- and outpatient psychotherapy and counselling were the main focus of mental health care. Presently mental health services programmes are run as vertical programme and are looking forward to a comprehensive approach as the primary health care philosophy suggests (RSA, 1997(a)).

Mental health care has changed from the institutionalisation of individuals suffering from mental disorders to a community care approach backed by the availability of beds in general hospitals for acute cases. This change is based both on respect for the human rights of individuals with mental disorders and on the use of updated interventions and techniques (WHO, 2001). Community-based care means that the large majority of clients requiring mental health care should have the possibility of being treated at community level. Mental health care should not only be local and accessible, but should also be able to address the multiple needs of individuals. It should ultimately aim at empowerment and should use efficient treatment techniques that enable people with mental disorders to enhance their self-help skills, incorporating the informal family social environment as well as formal support mechanisms. Community-based care (unlike hospital-based care) is able to identify resources

and create healthy alliances that would otherwise remain hidden and inactivated (WHO, 2001).

Clients discharged from psychiatric wards (in either general or specialized hospitals) can be effectively followed up by primary health care nurses and doctors. It is clear that primary health care plays a major role in countries where community-based mental health services do not exist. Community psychiatric clinics as part of the primary health care delivery outlet also play a big role in psychosocial rehabilitation. Through the clients' interaction with the community psychiatric nurses, clients are linked to rehabilitative services. Psychosocial rehabilitation is a process that offers the opportunity for individuals who are impaired, disabled or handicapped by a mental disorder to reach their optimal level of independent functioning in the community. It involves both improving individual competencies and introducing environmental changes (WHO 1995).

Efforts to enhance the involvement of local communities include disseminating accurate information about mental disorders and using community resources for specific initiatives. Shifting care from institutions to the community itself can alter community attitudes and responses, and help people with mental illness lead a better life (WHO, 2001). The main objectives are consumers' empowerment, the reduction of discrimination and stigma, the improvement of individual social competence, and the creation of a long-term system of social support. Psychosocial rehabilitation is one of the components of comprehensive community-based mental health care. Psychosocial rehabilitation enables many individuals to acquire or regain the practical skills needed to live and socialize in the community, and teaches them how to cope with their disabilities. It includes assistance in developing the social skills, interests and leisure activities that provide a sense of participation and personal worth. It also teaches living skills, such as diet, personal hygiene, cooking, shopping, budgeting, housekeeping and using various means of transport. Community psychiatric nurses are the key players in the psychosocial rehabilitation of clients in their communities.

South Africa Health System Objectives

The White Paper for the Transformation of Health System in South Africa states that the central theme of the government health care policy is to encourage the national health services and the community services to change the way they relate to those who use them (R.S.A., 1997 (a)). The government is aiming to create a health service that is accountable to users, that is responsive to their needs and in which users have a greater control over what happens to them. To achieve this, health care providers are advised to involve users both in service planning and evaluation, and in decision-making relating to their own treatment and care. Clients' perception towards services is an important aspect of service quality in determining treatment continuity and treatment outcome (Holcomb, Parker & Leong, 1998). The White Paper states that all South Africans should be equipped with the information and the means to identify behavioural change conducive for improvement in their health. It emphasises the need for people to have an opportunity to participate actively in various aspects of the planning and provision of health services i.e. community based mental health care services as well as substance abuse management and rehabilitation.

Clients' Perceptions on Care

Farrell (1991) conducted a study in one large general teaching hospital and one acute psychiatric teaching hospital in South East England. Patients were drawn from two medical and two acute psychiatric wards in each hospital respectively. The study aimed at examining the extent to which nurses' perceptions of their patients' needs corresponded to the patients' view of their own needs. The emphasis on individuality and partnership in nursing care presupposes accurate perceptions by the nurse of the patients' needs and difficulties. Farrell (1991) reported that the few studies that have been done suggest that nurses are not very accurate in estimating their patients' needs. The findings showed that the majority of the correlations between patients' needs and the nurses' perceptions of patients' needs were low

and many correlations were negative. This indicated that nurses hold opposite views to those of their clients.

These findings are consistent with those of Eddington, Piper, Tanna, Hodkinson & Salmon (1990) who showed that nurses are less attuned to clients' subjective assessments of well being and happiness than their level of behaviour dependency. Dew, Salmon, & Webb (1989) suggested that it would appear that nurses hold stereotypes about patients when assessing clients' needs. Farrell (1991) suggested that nurses would only know what their patients' preferences are by continuing to develop the necessary interpersonal skills for accurate assessment of clients concerns.

Young, Minnick & Marcantonio (1996) conducted a study in an acute general ward in Midwestern Region in the United States of America. The study aimed at determining the importance that clients, nurse and nurse managers placed on aspects of care and measured nurses' care values based on their perceptions of their clients' and nurse managers' care value and their desire to meet these expectations. Results of the study indicated that there was a gap between clients' actual values and what health care professionals perceived as clients' values. Health care professionals' perceptions of what clients expect regarding selected aspects of clients-centered care and their motivation to meet these expectations does not closely approximate to the values their clients placed on these aspects (Lynn and McMillen, 1999; Von Essen & Sjoden, 1991; Williams, 1998).

There is need for a comprehensive, systematic community psychiatric health service that will meet clients' needs and expectations (Sharon, Dingman, Williams, Fosbinder & Warnick, 1999). This can only be achieved if the clients speak effectively about their problems and needs. Clients feel valued simply by participating in their care regardless of the outcome of the illness. Macleod-Clark & Latter (1992) reported that greater compliance is a benefit of clients' participation.

Nurses' Attitudes

There is need for a therapeutic relationship between the community psychiatric nurse and the client since an interpersonal and trusting relationship is an important factor in client perception (Elame, 2001). The nurse is usually seen more frequently and more constantly than any other health providers in delivery of mental health services at community psychiatric clinics. Conditions are right for intimacy that will enable clients to engage in dialogue about what is most troubling, and how such problems can be dealt with (Kadner, 1994). Hunter (1990) found out in an interview with John Bowlby that what is described as developing a therapeutic relationship is actually the encouragement of a level of intimacy. Studies have supported the importance of intimacy, associating it with valuing the individual, good rapport, commitment and responsiveness of the nurse (Elame, 2001). This implies that the nurse understands the humanness and value of all clients and their family members and treats them with respect.

Hewison (1995) conducted a study to examine the way nurses use language and the effect this has on clients. Findings showed that nurse-client interactions were superficial, routinized and related to tasks. It was found that nurses exert a lot of control over interactions.

Studies have reported negative attitudes from nurses towards clients. Despite the realisation of clients' rights, reality strongly indicates that nurses still display negative attitudes towards clients (Carling, 1995; Michener, 1998; Heginbotham, 1998). Studies reveal that clients have negative perceptions towards the services they receive because of nurses' non-verbal messages. Holliger and Buschmann (1993) reported that most of the nurse- patient interactions seem to be superficial and task oriented, limiting the amount of social interaction (Nolan, Grant & Nolan, 1995; May 1990). Sheppard (1993) relates clients' satisfaction and perceptions of the services they receive to nurses' interpersonal skills. Clients perceive such skills as communication, empathy, listening, openness and genuineness as important concepts for their satisfaction.

Clients' Involvement/ Participation

Persons with mental illness usually have some idea of what they want. For many years community psychiatric nurses and mental health services providers have had a belief that seriously ill people were too ill to participate in their own treatment because they had bad judgement or were too unmotivated. In the past, mental health systems were based on the belief that people with severe mental illness did not recover, and that the course of their illness was essentially a deteriorative course, or at best a maintenance course (Anthony, 2000). Nurses thought that they had to make decisions for them, plan and carry out their treatment for them and view them as people who could just follow orders service providers (Cegala, McClure, Marinelli & Post, 2000). In the development of the treatment service model, Smith & Birchwood (1990) stressed the importance of needs- led, goal- defined interventions for psychiatric clients and their relatives.

Inadequate involvement of consumers in their care suggests that mental health professionals in psychiatric settings are influenced strongly by myths about illness, diagnosis and the success rate of treatment (Palmer-Erbs & Anthony 1995). There appears to be an assumption that reflects societal views that the mental health consumer is not capable of understanding information that would affect their decision making or participation in their own care (Crowe, O'Malley, & Gordon, 2001).

Mental health professionals have traditionally minimized the value of clients' satisfaction (Ricketts, 1992). It has been suggested that this minimization has occurred because professionals assume that consumers' judgement is so impaired that they do not have a sophisticated knowledge of treatment options, and that the concept of consumer satisfaction brings a false commercial quality to the therapeutic relationship. Such patriarchal reservations regarding consumers' ability, intelligence and rights perpetuates the imbalance of power that has traditionally permeated mental health services.

Substance use disorders are prevalent among persons who have severe and persistent mental illness (Regier, Farmer, Rae, Locke, Keith, Judd & Goodwin, 1990). Although many persons with diagnosis of substance use disorder participate in psychiatric treatment, many do not recognise their substance use as problematic. Evidence suggests that the vast majority of clients who have substance use disorders are ignorant of the need for change (Prochaska, DiClemente & Norcross, 1992). Most clients with substance use disorder diagnosis exhibit low levels of readiness to change their substance abuse (Carey, Purnine, Maisto & Carey, 2001; Ziedonis & Trudeas, 1997).

Browelea (1987), as cited in Jewell (1994), views clients' participation as getting them involved or being allowed to become involved in a decision making process or the delivery of services, or the evaluation of a service or even simply to become one of the number of people consulted on an issue or matter. Participation can thus be seen as a collaborative process that involves the empowerment of clients (Bearley, 1990). Nurses should regarded clients as people who can be able to decisions. This view presupposes that clients need to be central to decisions that affect their health and well being (Waterworth & Luker, 1990). Treatment programmes that actively engage the consumer, such as those with outreach and with home visits programmes may be more successful than the office based out patient programmes in helping the seriously mentally ill to remain in the community (Sullivan & Spitzer, 1997).

Information Giving

Information exchange is the fundamental basis by which clients participate in therapeutic interactions and engage in shared decision-making. Information exchange is recognized as the primary basis by which community psychiatric nurses are able to make accurate diagnoses and effective treatment recommendations (Frederikson, 1995).

Macpherson, Jerrom, & Hughes (1996) suggest that clients with mental illness have specific needs and concerns that are not always met by the health personnel. The most cited reasons for not meeting the needs of clients relate to the nurses' inadequate understanding and

consideration of these needs.

Provision of client-centered care relies on knowing the clients' perspective of their needs. Misunderstanding clients' values and expectations may impede provision of quality services (Gage, 1994). Young et al (1996) related client-centered care to four aspects i.e. physical care, clients' participation, teaching the clients about their condition and pain control.

Chien, Kam & Lee (2001) conducted a cross sectional study to identify the specific needs of Chinese clients with schizophrenia. The study aimed at examining important educational needs of the schizophrenia clients who had been discharged from a psychiatric hospital and who had follow- up treatment in an out patient clinic in Hong Kong. In the study clients gave high importance to gaining information about mental illness, strategies for improving social relationships and solving daily problems. Assessment of mental health consumers' perceptions of their specific educational needs and educational curricula tailored to the clients' expressed needs appeared essential. The goal of health education is to understand health behaviours and to translate knowledge into relevant interventions and strategies for health enhancement, disease prevention and management of chronic illness. Clients expect that nurses will provide information about progress, as well as advice, explanations and guidance concerning their illness (Elame, 2001). Clients most commonly required further information on the effects of treatment and prognosis and recovery.

In South Africa, studies show that there is lack of knowledge about mental illness. Studies also show that there is poor understanding of mental illness by the community. Thus many people do not use the mental health services provided. Families of individuals with mental illness are also sometimes stigmatised by the community because of this lack of knowledge and understanding (R.S.A., 1997 (b)). Jones, Pearson, McGregor, Gilmour, Atkinson, Barrett, Cawsey & McEwen (1999) found similar results in a study of cancer patients which indicated that most patients wanted as much information as possible appropriate to their personal needs and circumstances.

Clients' education should provide adequate clinical information to clients, increasing understanding of their illness condition and encouraging healthy behaviours. A full understanding and satisfaction of clients' needs in relation to specific illness has played an important part in the development of psychiatric education programmes.

Every consumer has the right to information that a reasonable customer in the consumers' circumstances would expect to receive without asking (Health & Disability Commission, 1999). Clients themselves need to be educated about the disorder to enable them to become active partners in the management of their own illness. Smith and Birchwood (1990) showed that clients with mental illness have expressed dissatisfaction with only receiving general information related to their illness and treatment from the mental health professionals. This is similar to findings that clients have a strong desire for practical advice concerning how to cope with the symptoms of their illness (Lockwood & Marshall, 1999).

Health education aims to enhance wellness and decrease disability. It attempts to actualise the health potential of individuals, families, communities and societies. Education regarding clients' illness is considered important both for clients and for community members including other professionals. The importance of education to the client about the illness should not be limited to symptoms and symptom control (Kirkpatrick, Landeen, Bryne, Woodside, Pawlick & Bernardo, 1995). It should also include how clients can make their lives independent and productive.

Gott and O'Brien (1990) investigated nurses' perceptions of their health education role within a clinical practice. The findings concluded that nurses in acute settings were entrenched in routine and task oriented care systems. Gott and O'Brien (1990 pointed out that principles of health education and health promotion, such as empowerment, partnership and collaboration, had yet to find their way into professional culture in hospital care, as against community psychiatric care. Macleod- Clark, Wilson- Barnett, Latter & Maben (1992) suggested that because hospital based nursing culture has a strong medical focus, it is difficult

for nurses to see themselves as health promoters. Community psychiatric care on the other hand enhances mental health promotion and illness recovery in clients. More emphasis is placed on health promotion strategies in community psychiatric care through primary health care than is seen in hospital settings (McBride, 1994). Though many of the needs of people with mental illness have yet to be met by the community mental health system, major innovations have been made in the areas of community treatment and rehabilitation (Shankar & Collyer, 2002).

Communication

Communication is a central theme in nursing. Nurses depend upon their communicative skills to be able to understand and meet the needs of their patients. If communication fails, patients' needs may remain unmet, their socialisation process could be disturbed and compliance may decrease which may increase stress on nurse and the clients (Staab & Hodges, 1996).

Although it is widely accepted that communication is essential in nurse-client interaction, communication between nurses and clients is often inadequate (Oliver & Redfren, 1991). Holliger and Buschmann (1993) demonstrated that clients do not give enough information to nurses during interactions because most of the nurse-client interactions seem to be is limited and focuses on hospital routines. Poor communication between nurses and clients inhibits maximum involvement of clients to their nurses. Recent models of nurse- client communication emphasize information exchange in promoting partnership between a health care worker and a client (Cegala et al, 2000).

Studies indicate that many clients could benefit from being encouraged to ask questions as a way of training communication skills. For example, clients typically do not ask nurses questions, even though virtually all clients claim they want as much information as possible (Beisecker & Beisecker, 1990). Kaplan, Greenfield, Gandek,

Rogers & Ware (1996) noted that good communication between the nurses and the clients results in measurably better health outcomes. Clients who were trained to discuss and ask about their conditions were more compliant with treatment recommendations, especially behavioural treatments and follow up appointments, than clients who had no opportunity to take part.

Effective health care and health promotion are guided by relevant health information. Communication is clearly the primary process used in health care to disseminate and gather relevant health information (Kreps, 1988). For example relevant health information guides effective diagnosis of health care problems. Health care providers inevitably depend on interpersonal communication to gather information directly from clients and from those who are familiar with the clients' lifestyles. Similarly, health care professionals depend on communication to provide their clients with information about prescribed treatment strategies, illness and its outcomes.

Relationship Environment

Jones (1998) conducted a situation analysis of mental health care in Mount Frere, Eastern Cape Province in the Republic of South Africa, in order to explore the perceived mental health needs of the community, and the needs and perceptions of health workers. Jones (1998) also wanted to conduct an audit of the currently available mental health resources. The results of the study indicated that some of the working psychiatric nurses in South Africa complained that they were stigmatised by the other staff because of the nature of their work. This stigma has resulted in lack of teamwork and support when mentally ill patients came for help. Many nurses with psychiatric training are thus reluctant to provide mental health care. Inadequate facilities and drug shortages frustrate the nurses and sometimes prevent them from providing the quality of care for which they are trained.

Nurses can facilitate clients' cooperation with treatment by developing interpersonal skills that improve the quality of the therapeutic relationship. Active listening, appropriate non- verbal communication and empathy greatly enhance the interaction (Corrigan, Liberman & Engel, 1990).

Kadner (1994) reviewed the concept of therapeutic intimacy in nurse client interactions. Intimacy is a subjective relational experience of trusting self- disclosure to which the response communicated is empathy (Wynne & Wynne, 1986). Intimacy can be defined as a reciprocal relationship in which innermost thoughts and feelings are shared. Intimacy is here conceived of as equally favouring social relationship. Continuation of a relationship is not a precursor to intimacy.

The existence of intimacy within a dynamic relationship has been found to be a more important predictor of positive health outcomes during traumatic life changes than any other type of socially supportive relationship (Wortman & Conway, 1985; Brown, 1986). Within the stress and coping paradigms, intimacy is a confiding relationship between two people and has been repeatedly cited as a critical variable in facilitating psychosocial resilience (Sheehy, 1986; Kadner, 1989).

Decrease in intimacy is one of the major problems of people with a painful experience like mental illness. Nurses would seem especially well-trained to engage in intimacy-fostering interactions with clients. These interactions could be especially helpful to clients who are experiencing this pain, as pain often results in others backing away from them, or in the person with pain withdrawing from others. The loss of intimacy is thus a further burden to the client, in addition to the already negative realities of the pain itself (Bral, Shaughnessy & Eisenman, 2002).

Psychiatric nurses are educated to "listen altruistically"(Kadner, 1994). Psychiatric nurses are also educated for privileged intimacy governed by professional ethics. The loss of interpersonal intimacy is a major lifestyle change, which most professionals never address.

The nurse is in a position, based on the nature of the nurse's job and the skills possessed, to help clients regarding problems of intimacy. The mutual exchange of ideas and feelings, the feeling of being important in one's care, can result in a person feeling greater dignity and respect (Schaffer, 1999).

If primitive fear remains unrecognised and unspoken, the client may be impeded from carrying out interventions needed to resolve current health difficulties. While non- verbal cues are usually more revealing than verbalized communication the clearness and authenticity of a message is enhanced when it is spoken and explained by the speaker (Duck 1986). A confiding relationship cuts through the superficiality of acquaintanceship and promotes a more accurate assessment of a client's psychological and emotional therapeutic readiness. Intimacy enables the client to engage in dialogue about what is most troubling, rather than conduct a lonely inner monologue of apprehension and despair (Kadner, 1994).

The essence of intimacy is believed to be self- disclosure of personal information with the expectation of understanding and acceptance (Kadner, 1994). Within the intimate relationship are empathy, compassion, attachment, trust and transference. Timmerman (1991) identified four conditions of intimacy as trust, closeness, self-disclosure and reciprocity. Negative self-disclosure, that is information about unpleasant experiences in one's memory, has been identified as more intimate than positive self- disclosure (Howell & Conway, 1990). The nurse-clients relationship provides conditions that are right for intimacy, since the nurse is accessible to the clients in a vulnerable situation. Implicit in this is the belief that revealing one's true feelings and thoughts to someone responsible for one's care should promote clearer understanding and communication.

A community psychiatric nurse has to develop a close therapeutic relationship with the clients. It is important to maintain this relationship in order to identify reasons for treatment resistance. Through continual assessment, the community psychiatric nurse should be able to understand the clients' behaviour (Forman, 1993). The ability of a community psychiatric

nurse to understand what was important to the clients and what would enhance clients' satisfactory life was essential to enhance hope. Understanding of the clients' behaviour would also help the community psychiatric nurse to assist the clients to achieve their goals. Trusting relationships allow the clients freedom to have wishes and goals acknowledged and supported (Byrne, Woodside, Landeen, Kirkpatric, Bernardo & Pawlick, 1994).

Therapeutic Outcomes

A client is more likely to be honest and forthcoming with a caregiver who is trusted (Kadner, 1994). A trusting relationship contributes to valid assessment, planning and interventions because the nurse and the clients are more involved with each other. Important details that may have a direct impact on the clients' health status may be left out in non-intimate relationships.

Dissatisfaction with services has been related to clients dropping out of treatment (Zastowny, Roghmann & Cafferata, 1989). Clients' satisfaction is relevant to nursing because nurses often are the ones who have the most time and close contact with clients. If clients are dissatisfied with their interaction with the nurse they may neglect important follow up care. Clients' negative perceptions about how they interact with the nurse could affect the clients' utilisation of services. Nurses have a great influence on their clients' outcome as they are in a position to change care that they render and promote more satisfying clients' experiences (Hostulter, Taft & Snyder, 1999).

Data indicates that poor treatment attendance (Teesson & Gallagher, 1999) and compliance (Owen, Fisher, Booth & Cuffel, 1996) among clients with substance use disorders suggest that greater attention should be paid to problem recognition and treatment engagement (Osher & Kofoed, 1989). Thus there is need to develop therapies to increase motivation to reduce or cease substance use.

Studies have revealed that many consumers of mental health care suffer needlessly as a result of being given wrong medication or the wrong dosage of the right medication. This

suffering arises from incorrect prescribing due to incorrect diagnosing of their conditions (Blaska, 1990). Incorrect diagnosis comes in because of poor interactions that do not allow openness on the part of the clients.

Conclusion

A satisfactory interaction between a nurse and clients is vital for positive clients outcome. Nurses should value clients' opinion so that clients should feel part of the treatment process. Clients' participation in their care enhances the clients feeling of being valued and of being part of the process. Clients' participation in client-nurses interaction yields maximum results when nurses provide clients with necessary information about the clients' conditions. Community psychiatric nurses should ensure that clients are partners in the care the clients receive.

CHAPTER THREE

METHODOLOGY

INTRODUCTION

This study combined both qualitative and quantitative methods in order to attempt to describe clients' perceptions towards therapeutic interaction.

Qualitative researchers attempt to study human actions, feelings, experiences and perceptions from the participant's insider perspective. (Babbie, 2001) stated that qualitative research is distinguished from quantitative research in terms of the following

(a) research is conducted in the natural setting of social actors;

(b) a focus on process rather than outcome;

(c) the primary aim is an in-depth (thick) description and understanding of actions and events;

(d) the main concern is to understand social action in terms of its specific context;

(e) the research process is often inductive in its approach, resulting in the generation of new hypotheses and theories

(f) the qualitative researcher is seen as the main instrument in the research process. More emphasis is placed on describing and understanding of such perceptions.

Quantitative researchers emphasise the quantification of findings. Quantitative studies derive data through the measurement of research variables. Nunnally & Bernstein (1994) define measurement as consisting of rules for assigning numbers to objects to represent quantities of attributes. The quantitative method would be used to measure the clients' perception towards therapeutic interactions (Babbie, 2001).

Triangulation

The study combined qualitative and quantitative methods for the purpose of triangulation. Triangulation is the use of multiple methods or perspectives to collect and interpret data about some phenomenon, to converge on an accurate representation of reality (Polit & Hungler,

1999). Triangulation is one strategy used against the threat to data validity and credibility. Duffs (1993) identifies four basic types of triangulation. These are:

Data Triangulation

Data triangulation is the type of triangulation in which information is collected from a variety of data sources for the study.

Investigator Triangulation

In this type of triangulation, several different researchers or evaluators are used to collect data.

Theory Triangulation

In this type multiple perspectives are used to interpret a single set of data.

Methodological Triangulation

Methodological triangulation involves using multiple methods to study a single problem. It is the commonest form of triangulation. This study will utilise methodological triangulation. Methodological triangulation will help to overcome the deficiencies that flow from using one method only. Triangulation will also help to enhance the validity and reliability of the study (Babbie, 2001). In this case triangulation will ensure the richness and basic coverage of the truth of the data collected (Polit & Hungler, 1999).

RESEARCH DESIGN

An exploratory descriptive survey was chosen for this study. Clients' perception of therapeutic interaction at Escoval House Community Psychiatric Clinic is subjective, so this approach attempted to understand the reality of the perceptions as perceived by the clients. 'Survey' refers to the collection of data directly from the study subjects, usually by questionnaire or interview (Dempsey & Dempsey, 1996). A survey is an activity in which the investigator gathers information from a selected population to examine the characteristics, opinions and intentions of the population. Descriptive studies could be used to identify problems with current practice, or justify current practice or to determine clients' experiences

(Polit & Hungler, 1999).

POPULATION

The study population were all clients who attend the Escoval House Community Psychiatric Clinic (EHCPC) and its satellite clinics. EHCPC is located in Ethekwini Health District of KwaZulu Natal Province. According to the monthly records for EHCPC, the clinic serves a population of 3256 clients on a monthly basis. Of this population 2744 clients attend EHCPC. All these clients live in the Durban city centre. Psychiatric clients in the community visit the clinic that is nearest to them once a month (Strachan, 2000 (a)). The clinic has community psychiatric nurses, a social worker, a psychologist and psychiatrists. Community psychiatric nurses run the clinic. They assess clients and dispense medication and refer clients to different services i.e. hostels and workshops.

Community psychiatric nurses from the clinic also serve the satellite clinics i.e. Austerville, Sherwood, Amanzimtoti and Newlands East Clinic. Each of these satellite clinics has a different date on which it operates. Austerville Clinic operates every Tuesday and has a population of 137 clients. Sherwood clinic operates once monthly on a Wednesday with 49 clients attending the clinic. Amanzimtoti clinic operates once a month on a Friday with a population of 123 clients. Newlands East operates every Wednesday and serves a population of 203 clients. To ensure that findings could be generalized to the whole population served by Escoval House Clinic, data was also collected from clients from these satellite clinics.

SAMPLE AND SAMPLING METHOD

A simple random sampling method was utilized in this study. Simple random sampling selects participants using a probability method. It allows selection of clients from the population in such a way that findings can be generalized to the total population. All clients have an equal chance of being involved in the study (Babbie, 2001).

Sampling for the study took place in two ways. Firstly, sampling for focus groups was done. One clinic was randomly selected. Five papers were put in a small box. On one of these

papers was written 'participate'. Then after mixing these papers well, the five staff representing each clinic picked one paper each. Clients from the clinics represented by a nurse who picked a paper written, "participate" were randomly selected to participate in the focus group.

On a single day at the selected clinic, a single number was assigned to each client attending that day. A table of random numbers was then used to select participants for the sample (Babbie, 2001). Ten clients who matched the selected numbers on the random table were selected as participants for the focus group. A small number of participants in a focus group allowed the researcher to host the group easily (Krueger, 1990).

Secondly, clients were selected to take part in responding to the questionnaire. At each of the clinics, clients attending that particular day were randomly selected. A single number was assigned to each client. A table of random numbers was then used to select participants for the sample. Clients who matched the numbers on the random table were selected as participants. Because some clients were mute and others were so acute that they could not appropriately communicate, simple random sampling continued until the desired number of clients who could be able to communicate was reached. A total of 160 clients were selected to participate in this study. The researcher believed that the population of clients attending Escoval House Community Psychiatric Clinic and its satellite clinics was homogeneous as they all share the same type of illness i.e. mental illness.

DATA COLLECTION AND INSTRUMENTATION

Data was collected from clients attending Escoval House Community Psychiatric Clinic and its satellite clinics. A survey study may use questionnaires that yield readily coded answers. An interview schedule with open-ended questions might also be used to collect data in order for participants to clarify and explain their perceptions regarding the interaction (Thomas, 1990).

Data was collected in two ways, namely, focus group interview and questionnaire.

Focus group interview

A focus group was conducted at one of the clinics that was selected randomly. Steward & Shamdasani (1990) describe a focus group as a purposive discussion of a specific topic or related topics taking place between individuals with similar backgrounds or interests. Focus group interview is the most popular strategy applied in social and behavioral sciences. Focus group interview is a method that allows the researcher to examine the points of a number of individuals as they share their opinions/ concern about a topic (Dempsey & Dempsey, 1996).

Preparation and conduct of focus groups

As explained earlier in sampling, clients were selected using a simple random method. This also helped to generalize the idea in the responses to the other clinics (Dempsey & Dempsey, 1996). Selected clients were requested to come back to the clinic the next day for the focus group interview. The focus group took approximately one hour. A focus group was conducted to gain more confidence in the responses.

Focus groups are vital because they can be conducted at a relatively modest cost and in a relatively brief time. They allow the researcher to assess the participants' worldviews, permit considerable probing and shed light on the nature of the topic under discussion (De Vos, 1998).

At the focus group, the researcher attempted to create an atmosphere of trust, friendliness and openness with the participants. Participants were welcomed and the researcher introduced himself to them. The purpose of the focus group was explained to the participants when the consent form was read to them. Participants were requested to feel free and be honest during discussion. They were advised that no names would be used and that the study was for academic purposes only.

Participants sat in a circle to ensure maximum opportunity for eye contact with the researcher as well as the other participants. Ground rules were set during the introduction.

Participants were made aware that the views and opinions of each participant would be valued and that they did not need to reach consensus on the topic (De Vos, 1998).

An interview schedule was used. The researcher used a series of self-developed questions to keep the group focused on therapeutic interaction (Appendix I). An interview guide was appropriate because it provided the structure within which the group members interacted (Steward & Shamdasani, 1990). The focus group was tape recorded to make sure that data was effectively captured.

Questionnaire

A self- developed questionnaire was used to collect quantitative data (Appendix I). Because some clients did not know how to read or write, the researcher read the questions to the clients one at a time. Then the researcher coded the responses from the clients on the questionnaires. Almost all the clients attending these clinics were English speaking i.e. white clients, Indian and Coloured. Very few of the clients were Africans, so the expectation was that if an African client was selected and did not speak or understand English, a translator would be used to translate the questions for the client. The participant's responses would then be translated back to the researcher in English and the responses would be coded as for any other participants.

A closed room was used to reduce fear and to encourage openness and honesty from participants. The questionnaire for this study contained three sections. Section A consisted of demographic data. Data from this section helped to analyze whether these attributes determine the type of interaction that exists between the registered nurses and the clients. Section B consisted of closed ended questions containing multiple scaling responses ranging from never to always. For each question, clients were asked to choose from the range according to their perception of the therapeutic interaction. Clients were asked to do the same in section C. Section C expected clients to range responses on how they expect the nurses to behave during therapeutic interaction with them. The choices ranged from strongly agree to strongly

disagree.

Closed ended questions were used because they provide great uniformity of responses and are more easily processed (Babbie, 2001). Closed ended questions allowed respondents to give answers that were standard, and easily compared from person to person.

During data collection, some clients did not give answers to all the questions on the questionnaire. There were some questions that were not rated. These unanswered questions tend to be missing values in some of the tables.

VALIDITY AND RELIABILITY OF THE INSTRUMENTS

Validity

Validity refers to the extent to which a data-gathering instrument measures what it is supposed to measure (Dempesy & Dempsey, 1996). The interview guide and the questionnaire would be valid if they were able to obtain data that was relevant in explaining clients' perceptions and expectations of therapeutic interaction at the clinic. Face validity was evaluated by giving the interview guide and the questionnaire to four registered nurses at the clinic who read them and looked at the measuring technique and decided whether in their opinion it measured what it was supposed to measure (Kidder, Smith & Judd, 1991). Questions that turned out not to measure what the study was supposed to explore, were then restructured and corrected.

Reliability

Dempsey and Dempsey (1996) states that a measuring instrument is reliable if it consistently measures whatever it is supposed to measure in the same way each time it is administered. Babbie (2001) defines reliability as a matter of whether a particular technique, applied repeatedly to the same object would yield the same results each time. In measuring reliability of an instrument, there are three aspects that have received major attention. These are stability, internal consistency and equivalence. This study utilized the internal consistency approach to estimate its instruments' reliability.

A pilot study was also done for the study. Polit and Hungler (1999) define a pilot study as a small- scale version, or a trial run, done in preparation for a major study. Researchers who develop their own instrument typically subject it to rigorous test before using it in their study. The pilot study helped the researcher to evaluate and refine the instrument. Pilot study serves many other purposes, including identifying any parts of the instrument package that were difficult for the particular population of participants to read or understand, or that had been misinterpreted by them (Polit & Hungler, 1999). It also helps to identify any parts of the data collection package that the participants find objectionable or offensive.

Modifications and corrections were made based on the pilot study. Ambiguous and unclear questions were restructured to make sure that they made sense to the clients.

DATA ANALYSIS

Responses from the focus group were analyzed manually. Content analysis was used to analyze the data. Content analysis examined words and phrases within a wide range of texts or from participants' own opinion. A researcher makes inference from the presence and repetition of certain words and phrases in the responses (Babbie, 2001). Responses were analyzed over and over again. Specific characteristics in the clients' responses to the questions were objectively and systematically identified. Important themes and concepts were identified as they emerged from the data. Groups of phrases that explain an aspect of therapeutic interaction were grouped together to form a theme. Sub-themes emerged from the data as they formulate an explanation of the theme.

Categories of information to be included in the analysis were established as they relate from the sub-themes. Categories were scored and scaled and comparisons were made (Dempsey & Dempsey, 1996). The final categories were presented.

Data from the questionnaire was analyzed using Statistical Package for Social Sciences (SPSS). SPSS is a computer package for analyzing quantitative data. It uses statistics, that is the science of compiling facts or data of potentially numerical nature to reveal important

information about phenomena (Thomas, 1990). "SPSS statistical description is employed to:

(1) generalize from the sample statistics to population parameters;

(2) to clarify comparisons in a set of data;

(3) to summarize data from surveys and make inferences about a study population based on data gathered from the sample" (Thomas, 1990; p 55).

This study analyzed data using descriptive statistics to describe and synthesize data. Frequency distributions and percentages were employed for the analysis of the study. Correlation between clients' expectations and their perceptions was analyzed.

ETHICAL CONSIDERATIONS

The research proposal was presented to the University of Natal Research Ethics Committee. Permission to conduct a study was sought from the Director, Department of Health for KwaZulu Natal, and was granted. After getting approval from the Director, permission was also sought from the Nursing Services Manager of Escoval House Community Psychiatric Clinic for the study to be conducted at the clinic. Permission was also granted.

After being randomly selected, participants were informed that they are to be part of the study. For the focus group, participants were informed that they would take approximately 45 minutes to participate in the discussion. Participants who participated in filling the questionnaire were informed that they would take about one hour to fill in the questionnaire. Consent letters were read to both clients who filled in the questionnaire and those who participated in the focus group. Then, before participating in the study, clients were asked to sign the consent letter. Verbal consent was asked from clients who could not read or write.

No names were used on the questionnaire to ensure that clients remained anonymous. Privacy and confidentiality was observed by interviewing the clients in a closed vacant room. Clients were also informed that findings of the study would be for academic purposes only. The researcher kept the questionnaires. Responses were not accessible to any other person at

the clinic to ensure the confidentiality of the clients' responses. One respondent at a time was allowed in the room to ensure privacy.

CHAPTER FOUR

RESULTS

Introduction

This chapter presents findings of the study. These findings seek to answer the research questions stated in chapter 1. The chapter presents findings for demographic analysis for both participants in the focus group and those who filled in questionnaires. It will also present the results of the clients' responses on perceptions and expectations of therapeutic interaction with nurses at the clinic. The chapter will also present the clients' recommendations.

QUALITATIVE DATA ANALYSIS

The analysis of qualitative data was guided by the Human Relations Counselling Model and the interview guide.

Responses from the focus groups were tape-recorded, and then transcribed into text form for the process of analysis. Patterns were identified through the process of coding. Themes, sub-themes and categories were developed as they emerged through the process of analysis.

Sample realization

This section attempts to describe the demographic characteristics of participants for the focus group. The population for the study were all clients who attend Escoval House Community Psychiatric Clinic and its five satellite clinics. The focus group took place at one of these clinics.

Participants for the focus group were randomly selected using a simple random method. The focus group comprised ten participants (100%). There were four female (40%) and six male participants (60%). The age range for the participants was 21- 35 years. Participants were predominantly Coloureds (80%) with two of them (20%) being Africans. They were all willing to participate in the focus group for almost an hour.

PRESENTATION OF FINDINGS

Findings have been presented in two themes, namely, clients' perceptions of therapeutic interaction and clients' expectations of therapeutic interactions. Within these themes, a number of sub-themes emerged and these were: nurse- client relationship, strategies, and therapeutic outcomes. Findings will be presented under categories that were identified within these sub-themes. Findings in this section will be presented in a narrative form.

Theme 1: Clients' Perceptions of Therapeutic Interaction

This theme focused on how clients perceive their interactions with the nurses at the clinic. Three sub-themes emerged under this category, namely nurse-clients relationship, strategies and therapeutic outcomes.

Sub-theme 1: Nurse–Client Relationship

From the data on clients' perceptions it emerged that as nurses interact with clients, nurses develop rapport, and empathy. Findings of the study show that the nurses develop a considerable good relationship with their clients. A good nurse-client relationship is identified by the nurse's attitudes, the nurse's commitment and the nurse's involvement of clients in their own care. Such relationships help the clients to develop trust and honesty towards the nurse.

Category 1: Nurses' Attitudes

Clients perceived a number of attitudes that the nurses demonstrate to them during monthly interactions. The majority of the clients felt that nurses show them respect during the interaction. They reported that nurses use clients' names to address them during monthly visits at the clinic. Clients reported that nurses respect the clients' dignity and they observe clients' privacy. The clients also reported that the nurses are friendly to them. The majority of the clients reported that the nurses are polite, though a good number of them also reported that the nurses shout at them when clients make mistakes.

Participants' quotes showing nurses' attitudes were as follows:

They receive and greet us when we come to the clinic

Nurses are nice to us. They are very friendly.

.....others see you as very important and necessary.

They are so friendly and loving. Every time I visit the clinic they tell me that they missed me. I feel so good and part of them.

Every time I go to the clinic, they take me into a room where they ask some questions before giving me my treatment. I feel they give us privacy.

They address us by our names. This is respect to us. They call every one by the name they like.

Nevertheless other participants reported that nurses do not respect them nor do nurses show any concern for their well-being. The following quotes show these findings:

But they don't greet everybody. For example when you are late they shout at you. Sometimes nurses even send you back to come the following day.

I also remember when I placed my file on a wrong place one nurse shouted at me like a child.

They are very frightening because when you miss treatment you cannot tell them that you did not take the treatment. They shout at you.

Sometimes the way they speak to us is not polite. I remember one day they told me that if I don't get well it is my business. This came in when I missed one monthly attendance.

At the same time there are other nurses who behave as if you are wasting their time. They just rush out things so that they can go.

Some nurses are unapproachable. You can't ask them a question they will show no interest to respond. They always say they are busy and they want to help others so that they can go home.

Nurses respect us as people although sometimes when things are not fine they shout at you.

Category 2: Nurse's Commitment

Within the sub-theme of nurse – client relationship, nurse's commitment emerged as a category. The nurse's commitment was indicated by her availability to the clients.

Clients reported that nurses did not give them enough time to talk about their problems. They reported that they felt rushed. Findings of the study indicated that there were mixed feelings about how clients perceived the nurse's commitment.

Findings of study show that nurses' availability relates to the period that the clients wait before they are reviewed when they come to the clinic. Within some of the responses, nurses' availability is also directly related to how much time nurses give clients during interactions. Findings indicate that clients are not given enough time to explain their problems. Clients reported that they feel rushed by the nurses. Participants gave the following comments to indicate nurses' availability:

When you come with your card, they take too much time to bring your file. This makes us wait for a long time before they interview us.

At the same time there are others who behave as if you are wasting their time. They just rush out things so that we should also go.

They should make sure that they help us in time and not make us wait for so long.

I don't like when it is tea break. They all go to tea break and leave you waiting.

.....They say they are busy and they want to help others so that they can go home.

.....This forces them to be in a hurry to finish. So they don't give us enough time for our problems.

Category 3: Client Involvement/ Participation

Clients' involvement also emerged as a category within a sub-theme of relationship. A good client-nurse relationship that involves the clients in decision-making ensures that the clients feel part of the process. The findings of the study show that clients reported that most

of the times nurses do not involve them in decision making or goal formulation regarding the clients' treatment. Findings of the study show that clients want to be equipped to deal with their problems. Clients reported that nurses do not involve them in planning for their next visit. Rather nurses just give the clients a date when they are supposed to come back to the clinic.

The following are the quotes from the participants show their views on client involvement or participation:

But sometimes, others see you as very important and necessary. They ask you as to what decision should be made in regard to treatment.

More important is that they should look at us not as children but as people who can also make decisions and are grown ups. Most of us are married and we take care of other people so nurses should not take us as children.

Nurses should help us to have authority of what we can do to get well. They should equip us with knowledge so that we can make decisions regarding our well being.

They should always ask us our opinion on issues before they decide for us.

I feel I need to be asked when I will feel comfortable to come again for repeat instead of just be given a date when they even do not know whether I will be free or not.

Sub-theme 2: Strategies

Findings indicate that nurses deal with clients' problems during monthly interactions. Through their professional training, nurses learn how to deal with clients' problems. Clients come to the clinic with a number of problems that they expect nurses to help the clients solve. Within therapeutic interaction, nurses also use the strategy of progress evaluation and monitoring to ensue that the interventions and treatment given to clients are effective and result in clients' well being. It also emerged under the sub-theme of relationship that information giving is vital to problem solving and health promotion. Information giving is another strategy that nurses use to equip clients with skills to manage their own problems and

live satisfactorily in their communities.

Category 1: Problem solving

Problem solving emerged as a category under the sub-theme of strategies. Within this category, a number of areas were identified, namely, employment or income, progress monitoring and evaluation, and information giving. Some clients reported that they had gained access to income generating activities e.g. employment at Sherwood Workshop. Clients also emphasised the advantage of their progress being monitored and evaluated as part of the way nurses helped clients to solve their problems. Clients indicated that knowing their progress was one of the steps in solving their problems, as this helped the nurses to intervene appropriately.

These findings are expressed well in the following quotes:

The clinic referred me to Sherwood Workshop- Challenge. So going to the clinic helped me to be sent to Challenge Workshop where I can work and earn some money.

Sometimes you can get advice on how you can make your life profitable and independent.

We also meet social workers at the clinic to discuss some of the social problems that we are facing in our everyday life i.e. financial problems.

We are able to receive disability grants through recommendations from the clinic.

I joined Challenge because I was attending clinic and nurses felt that I could benefit from Challenge.

Category 2: Progress Monitoring and Evaluation

Mental health consumers often suffer from side effects of their medication. These side effects sometimes make clients unable to work for a living. For example drowsiness makes the clients lie down all the time. Findings of the study show that nurses utilize the monthly visits to identify these adverse effects that clients experience because of medication. Clients also reported that their progress was monitored at the monthly visits. Nurses are able to find out if a particular treatment or intervention is assisting to improve the conditions of the

clients. Clients reported that nurses are able to change treatment if it was not helping the clients. The following quotes indicate the above findings:

They are able to decide whether or not to change or stop treatment during monthly interactions.

Nurses are able to know what our problems are.

Nurses and doctor are able to know whether treatment is helping me or not.

Nurses are able to identify whom they can visit in their houses through monthly interaction.

If you have a problem with medication you report at the clinic and they change your medication so that you should not have side effects. So it is important to come to clinic if you have side effects.

At the clinic they are able to know if you are improving or not.

Category 3: Information Giving

Findings of the study show that there were mixed perceptions regarding nurses providing information to clients and their family members. Most of the clients showed that nurses gave them information about their illness. The clients reported that they were able to deal with some of their problems because they had knowledge of their illness. The following quotes show findings on information giving:

Nurses help us to solve our problems or give us information on how to deal with our problems.

Through monthly interaction we know what our problems are and how to take care of ourselves.

We have knowledge of what we are suffering from through attendance at the clinic every month.

Some clients, however, reported that nurses did not provide them with necessary information about their illness. They reported that clients were ignorant of their illness because they could not ask nurses what the clients needed to know because nurses did not

show interest in responding to clients' questions. Clients indicated this by the following quotes:

People are also ignorant of their illness because they cannot ask the nurses for information due to the way they respond to questions. If all nurses were polite then we could not have problems to ask for information about our illness.

Category 4: Fostering of Hope and Encouragement

Findings have also indicated that nurses use the strategy of hope fostering to encourage clients to work towards their recovery and well being. Findings show that when nurses instil hope in clients, clients feel strengthened that they will get better. Findings also show that clients feel that nurses are committed when the nurses themselves have hope that the clients will get better. The following quotes reflect the above findings:

One thing that I noticed is that nurses look at me as someone who can be better than what I am now.

.....nurses show that they care i.e. every time I come to the clinic they encourage me to talk about treatment so that I should get well.

I developed trust in the nurse and I feel safe to be given injections by the nurses so I no longer fear injections.

Nurses express that we will be better if we continue taking our medication. They give enough encouragement and support.

Clients also reported that when nurses take their time to encourage them, it shows that nurses are committed to client care. Findings indicated that nurses encourage clients to work towards well being. Clients reported that nurses always encourage them to take their medication. The quotes below indicate these findings:

They always encourage me to continue treatment so that one day I should go back to work.

They encourage us to take medication.

The way nurses treat me I feel encouraged that I will be fine one day and be able to go back

to work.

I am encouraged to ask questions so that I can know what my problem is.

When nurses do not treat clients well, most of us lose trust in them and get discouraged about coming for treatment.

Nurses are committed to help us. They encourage us to take medication. They visit our homes when they see that we are not coming for treatment to find out what is stopping us from coming to receive treatment.

Sub-theme 3: Therapeutic Outcomes

Clients' interaction with nurses during monthly visits results in a number of things. Clients' perceptions on how nurses treat them have an influence on how clients use the services and how they can deal with their own problems (empowerment). Findings of the study show that clients had their own perceptions regarding how they would be affected by the way nurses interact with them. Two categories emerged under the sub-theme of therapeutic outcomes, and these are service utilization and client empowerment.

Category 1: Service Utilization

Findings show that the way nurses interact with clients has a direct impact on how clients utilize the psychiatric services at the clinic. Clients reported that continuity in service utilization is greatly determined by how they feel about the way they are being treated by the nurses. Clients also reported that they develop trust in the nurses if the nurses' interaction with the clients is satisfactory. The following clients' responses indicate some of the outcomes of nurses' interaction with clients in relation to service utilization:

People stop coming for their monthly visit when nurses do not respect them. People only know that they will be helped if nurses respect them.

This makes us not to tell them what our personal problems are.

If there is a good relationship, you can trust the other person with anything. Now if at every small mistake that one makes, they shout at you, how can you trust them?

As for me their behaviour affects the way I interact with them. When I come to the clinic and they are interviewing me, I respond in brief so that I should just take treatment and go.

From my experience of the illness, with poor support, one is likely to be poor in getting well. Now nurses are the next people that someone suffering from mental illness counts on. If they frustrated us then it means taking our hope of getting well away from us.

When nurses do not treat clients well, most of us lose out trust in them and get discouraged to come for treatment.

Category 2: Empowerment

A category of empowerment emerged from the responses that participants gave regarding therapeutic outcomes. In therapeutic interactions, nurses empower their clients so that they deal with some of their own problems. Nurses give information and impart knowledge to clients so that the clients can participate in problem solving and management of their problems. Clients' responses show that they are not adequately equipped to deal with their own problems. They reported that most of the times nurses thought clients couldn't make decisions regarding their treatment. Empowerment in clients starts with having knowledge of their illness. Findings of the study show that most clients are ignorant about their illness. Findings also show that clients do not know how to manage their problems. Following are participants' quotes showing empowerment as an outcome of therapeutic interaction:

Nurses should help us to have authority over what we can do to get well. They should equip us with knowledge so that we can make decisions regarding our well-being.

Most of the times they think you cannot make a wise decision. In most cases they just make decisions for you. For example they just give you a date for the next visit without asking if you will be busy or not.

People are also ignorant of their illness and cannot manage their own illnesses because they cannot ask the nurses for information due to the way they respond to questions. If all nurses were polite then we could not have problems to ask for information about our illnesses.

I feel confident that I can take care of myself after knowing what my problem is from the nurses.

Theme 2: Clients' Expectations of Therapeutic Interaction

Clients reported what they expected to find when they come to the clinic to interact with the nurses. These expectations included having a good relationship with the nurses, having their problems identified and their problems solved. Clients also expected that nurses should give the clients information regarding their illness. They also expected nurses to be committed to their clients. Clients reported that they expect nurses to involve them in the management of their problems and illness.

Sub-theme 1: Nurse – Client Relationship

Clients reported things such as being greeted when they came for interaction, being made comfortable and feeling free as indicators of a good nurse – client relationship. They also regarded being treated with respect and confidentiality, nurses' use of appropriate language, showing empathy and giving and fostering hope as a therapeutic nurse- client relationship. Findings also indicate that in a good nurse-client relationship, clients are valued as important contributors to their care. Clients' involvement in their care emerged as an important aspect in nurse-client relationships. Findings of the study show that clients expect a good nurse – client relationship at the clinic to comprise a good nurse attitude, nurse's commitment and clients' involvement in their care.

Category 1: Nurses' Attitudes

Clients reported that they expect nurses to show a pleasant and friendly attitude towards them. They expect that nurses should greet them when they arrive at the clinic. Findings of the study indicate that clients expect that nurses should be receptive and be able to communicate politely with them. They also expect that nurses should respect them.
The following quotes best describe clients' expectations regarding nurses' attitudes:

They should change the way they communicate to us. They should take us as grown ups because it upsets you when you are treated as a child.

They should stop shouting at us when we do something wrong.

They should ensure that they are putting us first.

Nurses are expected to have patience.

They are expected to be calm and polite when talking to people.

They should welcome us and make us feel there are people who will help us with our problems.

I expect them to be polite and trustworthy.

Category 2: Nurses' Commitment

Clients reported that they expect nurses to be committed to caring for clients, and that nurses should always be available to clients. Clients indicated that they expect nurses to ensure that clients do not wait for too long before they are attended to. Clients also feel that being given enough time to explain their problems by the nurses is an indication of nurse's commitment. The following quotes indicate clients' expectations about nurses' commitment:

They should give us enough time when we come to the clinic to explain our problems; I feel this will help to improve our interaction.

.....When coming here there should be enough nurses so that they can take their time with us.

They should give us enough time to discuss our problems.

At least they could make sure that when we come to the clinic we don't stay for a long time waiting to be interviewed and be given medication.

Category 3: Client Involvement / Participation

Findings of the study show that clients expect nurses to involve them in the management of their problems. They want to have autonomy on decision-making and goal formulation regarding their treatment. Clients reported that nurses should consider them as people who

can make their own decisions, and that nurses should not just impose decisions on them. The following quotes explain clients' expectations on client involvement:

Nurses are supposed to help us solve our problems.

They are supposed to involve us in our treatment. They should always ask us when we could come for another repeat.

They should always ask us our opinion on issues before they decide for us.

I feel I need to be asked when I will feel comfortable to come again for repeat instead of just be given a date when they do not know whether I will be free or not.

They should make us feel responsible for our recovery by ensuring that we know what to do to get well.

They are expected to ensure that we can take care of ourselves in their absence.

Sub-theme 2: Strategies

Category 1: Problem Solving and Identification

Clients indicated that they expected that nurses should identify what the clients' problems are as they visit the clinic every month. They reported that they expected nurses to identify clients' problems through observations, lab tests or blood samples and interviews. This was expressed in the following quotes:

We are also supposed to come to clinic to make sure that nurses and doctors evaluate our progress.

Nurses are supposed to take our blood pressures and blood samples.

We are supposed to tell nurse what our problems are……

Nurses are supposed to examine us and see our progress.

They should ask us what we are not happy about. They should find out how we feel about what is happening at the clinic.

Category 2: Progress Monitoring and Collection of Medication

Clients visit the clinic every month so that nurses and doctors can monitor and evaluate their progress. Findings of the study show clients expect that nurses should follow up the clients' progress through interviews to ensure that treatment or interventions are helping the clients.

Clients indicated that they are supposed to come to the clinic to receive or collect medication every month. Findings show that routinely clients go to the clinic to collect medication or receive injections.

Clients indicated their expectation on progress monitoring and treatment collection by the following quotes:

We are supposed to come to clinic so that nurses can evaluate our progress.

Nurses are supposed to take our blood pressure and blood sample.

Nurses are supposed to examine and see our progress.

When we go to the clinic we are supposed to meet nurses so that we can collect our repeat medication.

I go to the clinic to collect medication and have my injection.

A lot of people come to the clinic just to collect treatment.

We are supposed to come to collect medication from the clinic.

Category 3: Information Giving

As per the findings of the study, clients expect that nurses should give health education and give information to clients regarding their illness, treatment and management of their illness and problems. The following quotes are what the clients reported:

Just as what they do at other hospitals nurses are supposed to give health education to clients. Of course sometimes we have health education especially when there are students from the nursing colleges.

We are supposed to learn about our illness and how we can manage it.

We are supposed to know about our treatment and their bad effects i.e. drowsiness.

I suppose we are also expected to understand the causes of our illness.

.....and give us information on how to deal with our problems.

Nurses are expected to ensure that their clients know what they are suffering from.

They should try to tell us the truth if we will get better or not.

Sometimes if we could be told our problems I think we could not be so stressed as we always are when coming to the clinic.

Clients' Recommendations of Therapeutic Interaction

Findings indicated that clients had recommendations as to what they thought nurses could do to improve the nurse client interaction at the clinics. Clients reported that it would be very important if they were involved in quality evaluation of the care they receive at the clinic. Clients indicated that they should always be asked their opinion about their care. Clients also identified that a number of problems might result from shortage of nurses. They indicated that clients might not be given enough time because nurses are rushing to finish with the big number of clients allocated to only a few nurses. Clients recommended that nurses should organise themselves so that there are enough of them when coming to clinic. Clients reported that this would give them enough time to interact with each client.

The clients also reported that clients should be made aware that nurses are also human beings who have different personalities. They indicated that it should be a mutual interaction in which both nurses and clients should work together to satisfy each other. Clients also recommended that nurses should not forget that they are dealing with people with mental illness. They suggested that nurses should understand when interacting with clients that clients do not make some mistakes deliberately. The following quotes indicate clients' recommendations about therapeutic interaction:

Personally I think there should be a lot of this type of research so that as you said nurses should be able to know how we feel about them so that they can change where they are not

doing well.

They should always ask our opinion on issues before they decide for us.

There should be a change in the way they communicate to us. They should take us as grown ups because it upsets you when you are treated as a child.

Clients should always be made aware that they should look at nurses as people who have different behaviors too.

If they can give us enough time when we come to clinic to explain our problems, I feel this will help to improve our interaction.

They should stop shouting at us when we do something wrong.

Nurses should ensure that they are putting us first. They should give us enough time to discuss our problems.

QUANTITATIVE DATA ANALYSIS

Introduction

This section will present the findings for demographic analysis for the participants who filled in questionnaires. It will also present results for the clients' responses on perceptions and expectations of therapeutic interaction with nurses at the clinic. Quantitative data was collected using a questionnaire (Appendix 1). Data was collected by asking the participants the questions in the questionnaire. The researcher filled in participants' responses by circling and marking the responses that the respondents gave as their perceptions and expectations of therapeutic interaction. Data from the questionnaire was analysed using SPSS. Descriptive statistics were used to analyse data. Data was analysed into frequencies and percentages.

Findings from the respondents will be presented in figures e.g. tables and graphs.

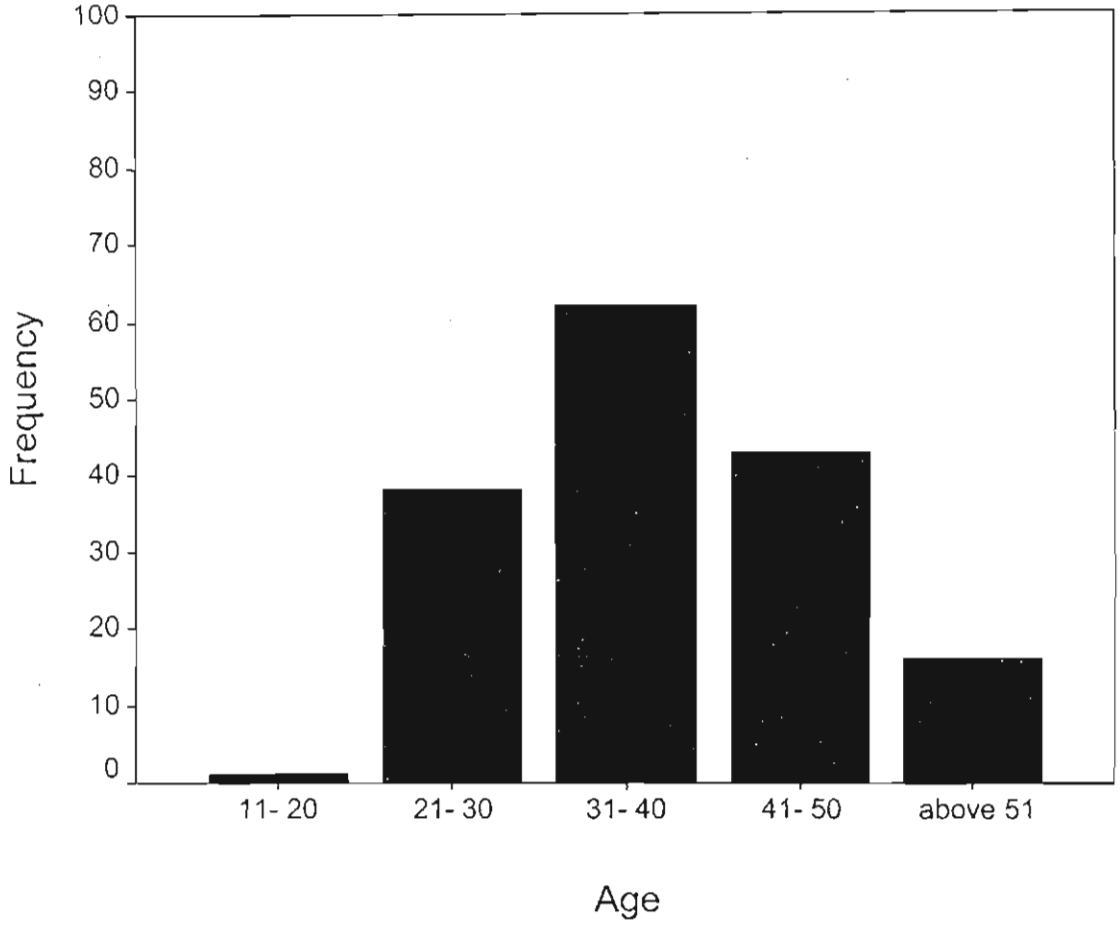
Sample realization

The sample consisted of one hundred and sixty participants all of whom completed the questionnaires, though some left some questions unanswered.

Age

Participants were supposed to indicate which age range they belonged to on the questionnaire. There was only one participant (0.6%) who was under the age range of 11- 20. There were 38 participants (23.8%) within the age range of 21- 30 years. Findings of the study show that there were 62 participants (38.8%) in the age range of 31- 40. Forty-three participants (26.9%) were aged between 41- 50 years. Sixteen participants (10%) were aged above 51 years.

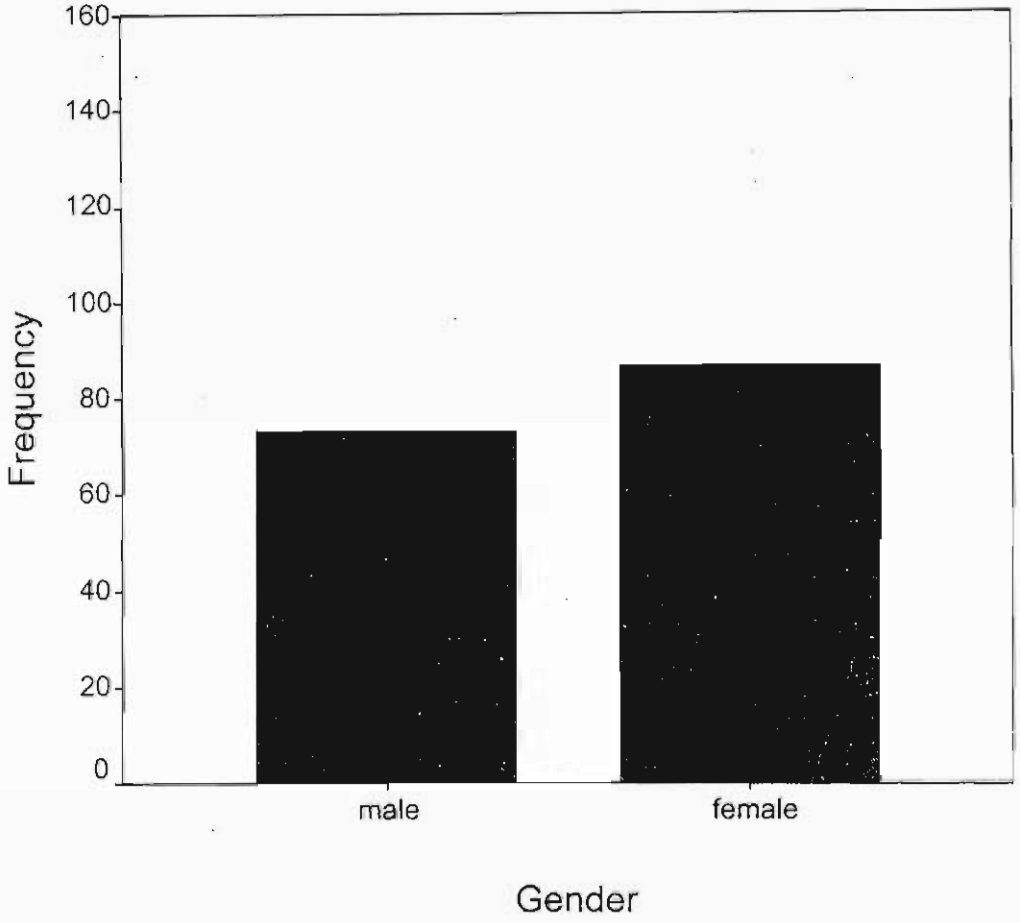
Figure 2: A graph showing age distribution.



Gender Distribution

Findings of the study show that of one hundred and sixty participants, 87 participants (45.6%) were female and 73 (54.4%) participants were male.

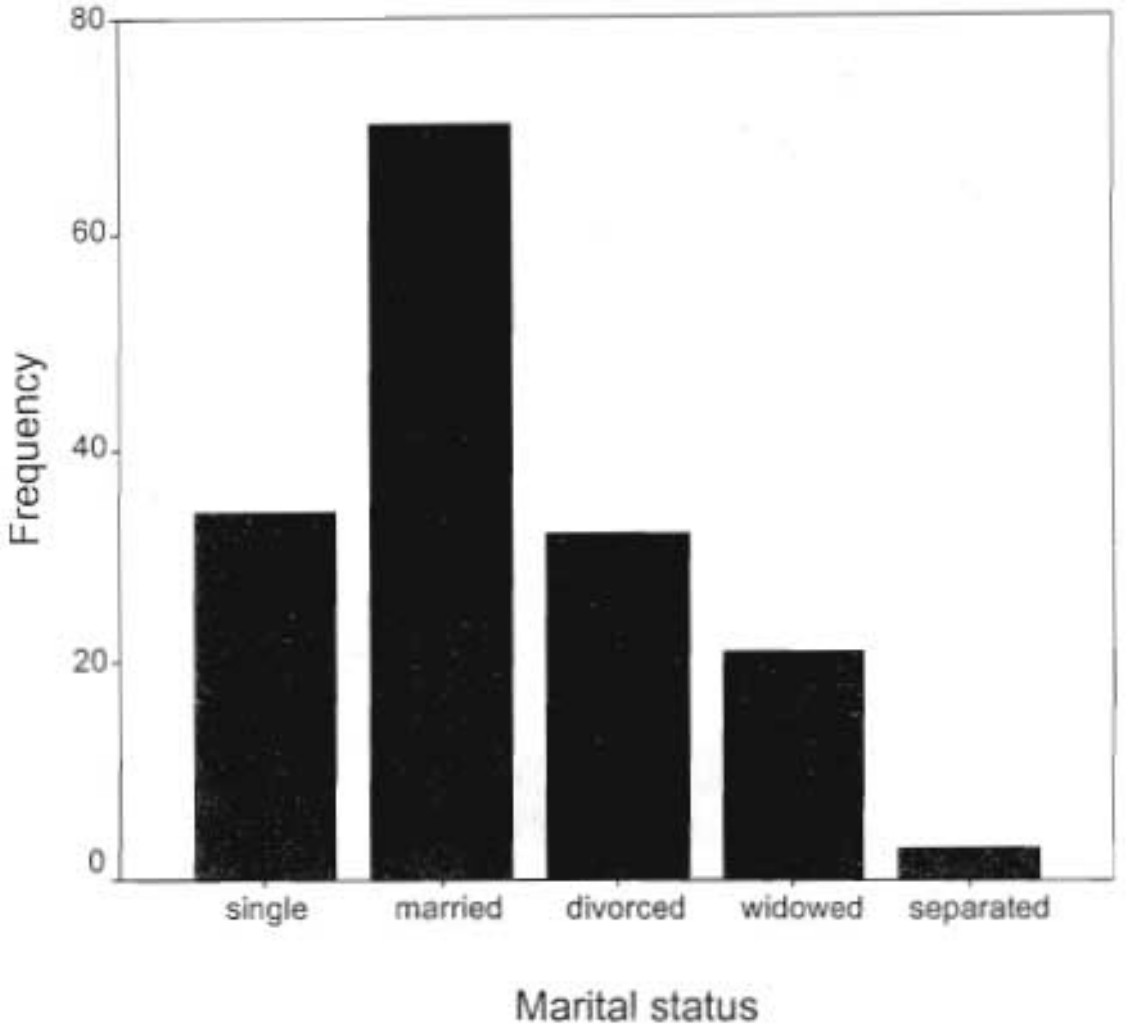
Figure 3: A graph showing gender



Marital Status

Findings show that 70 participants (43.8%) were married. Findings indicated that 34 participants (21.3%) were unmarried. There were 32 participants (20%) who were divorced. Twenty-one participants (13.1%) were widowed and finally three participants (1.9%) were separated from their spouses.

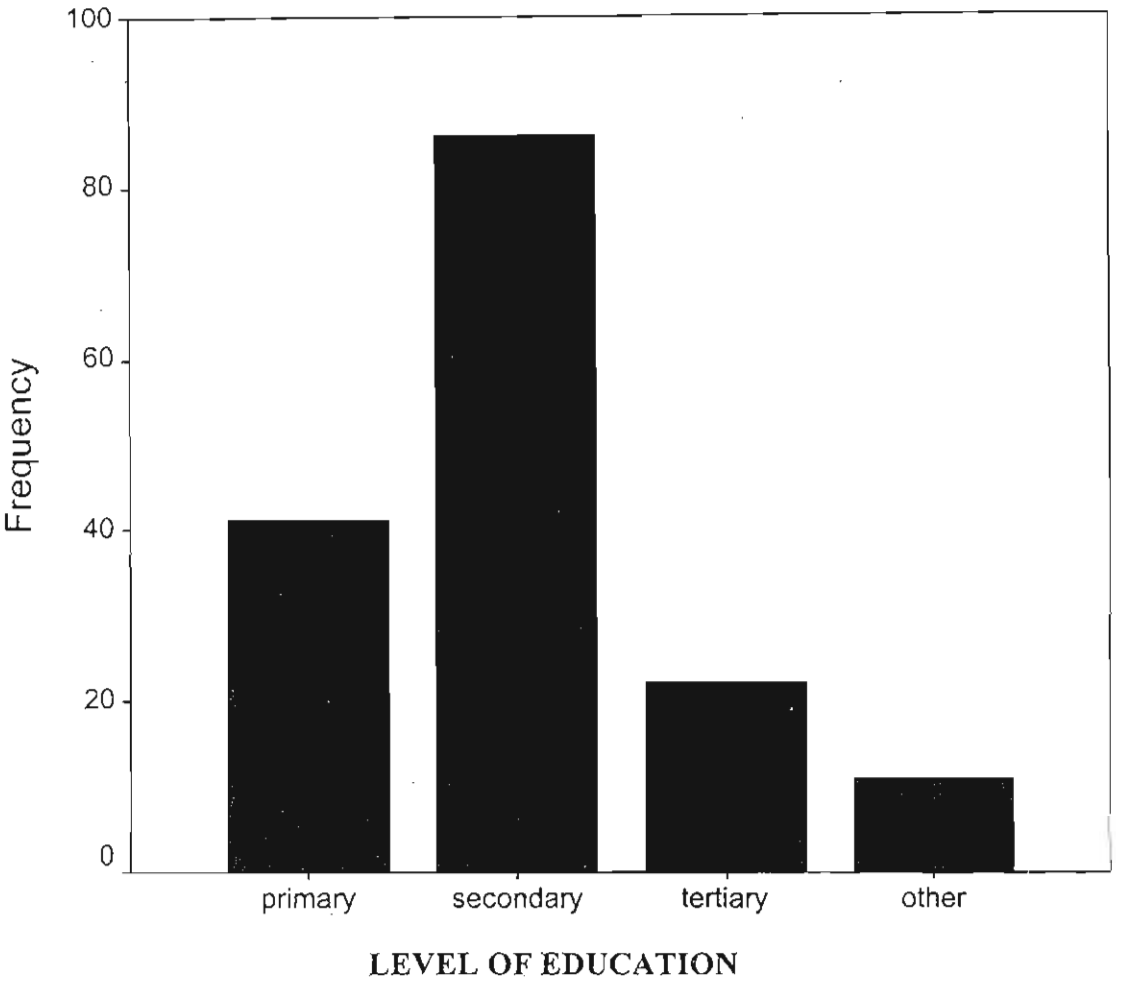
Figure 4: A graph showing results on marital status



Educational Background

The majority of the participants, 86 (53.8%), reported to have reached secondary school education. Forty-one participants (25.6%) stopped at primary school level. Twenty-two of them (13.8%) reached tertiary education whilst eleven participants (6.9%) reported to have done some sort of training other than tertiary education.

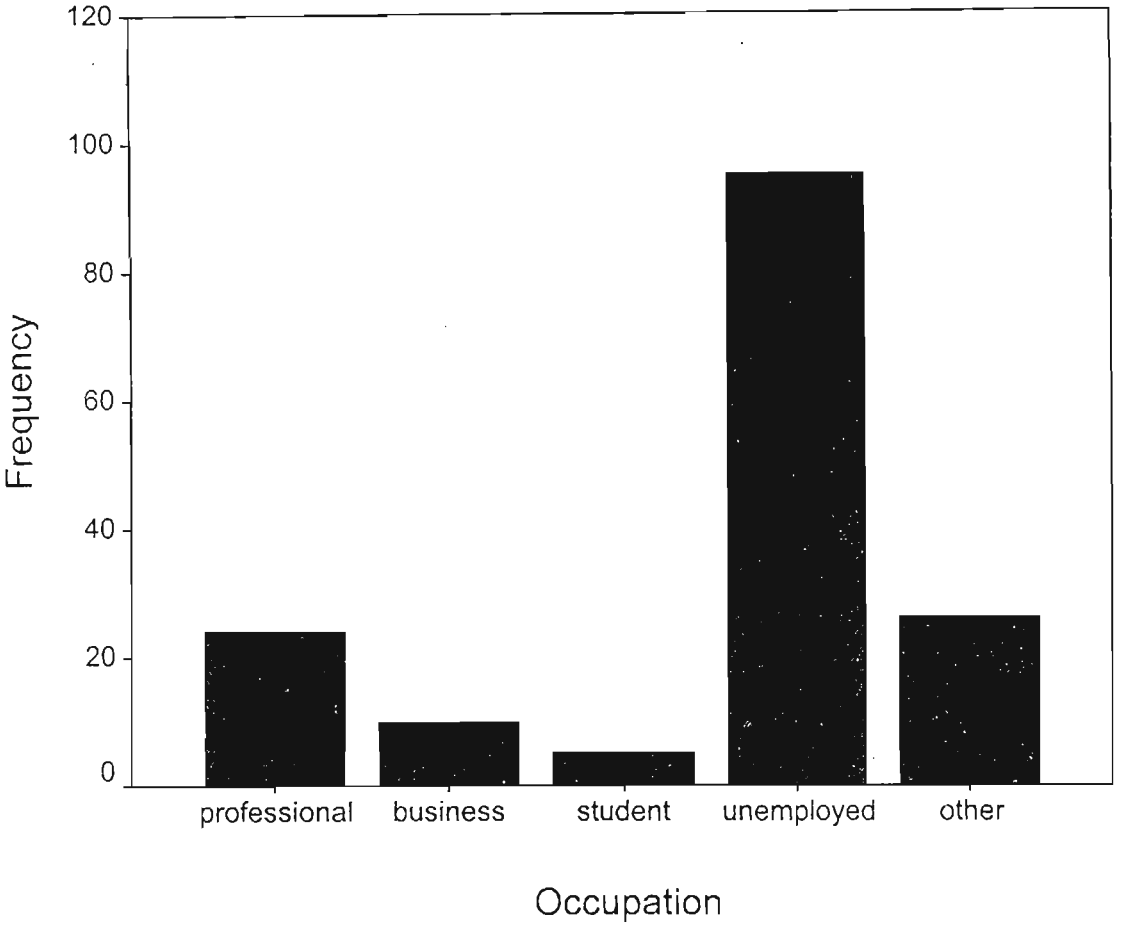
Figure 5: A graph showing educational level of participants



Employment Status

Ninety-five participants (59.4%) were unemployed. Twenty-four participants (15.0%) were employed as professionals. Ten participants (6.3%) were involved in businesses. Five participants (3.1%) were students. Twenty-six (16.3%) of total sample population were either retired or involved in part-time contracts.

Figure 6: A graph showing occupation of participants



Findings have been presented under two broad areas, namely, clients' perceptions and clients' expectations. Within these broad areas, the findings have focused on the following areas: relationship, strategies and therapeutic outcomes. Findings will be presented under variables identified within these sub-themes. Findings in this section will be presented in tables showing frequencies and percentages.

Clients' Perceptions of Therapeutic Interaction

Nurse- Client Relationship

Findings of the study show that the nurses develop rapport with their clients. Nurses' attitudes and nurses' commitment and clients' involvement in their care indicate the type of therapeutic interaction that exists between the nurses and the clients at the clinic.

Nurses' Attitudes

Clients perceived a number of attitudes that the nurses show as they interact with clients

during monthly interactions. The majority of the clients felt that nurses show respect to them during the interaction. They reported that nurses address them by their names. Clients reported that nurses respect the clients' dignity, and observe clients' privacy. The clients also reported that the nurses are friendly to them. The majority of the clients reported that the nurses are polite though a good number of clients also reported that the nurses shout at them when they make mistakes.

Nevertheless a few (3.8%) reported that the nurses do not respect them nor do they show any concern for their well-being. These negative responses may arise as a result of personality clashes between nurses and clients, or may come from clients who have defaulted treatment and who have been reproached for this by the nurses.

Clients who filled in the questionnaire rated nurses' attitudes depending on the way the nurses present themselves to the clients. Findings indicate nurses' attitudes ranging from the way nurses approach clients, how polite nurses are, and the way they speak to the clients. The way nurses observe clients' privacy and confidentiality; the way nurses show empathy and nurses' calmness are indicated under nurses' attitudes.

Table 1: Findings on clients' perceptions of nurses' attitudes to clients.

	Never	Occasionally	Sometimes	Always
They encourage me to feel free and comfortable	29 (18.1%)	32 (20%)	45 (28.1%)	54 (33.8%)
Nurse introduce themselves to me	66 (42.6%)	41 (26.5%)	21 (13.5%)	27 (17.4%)
Nurses address me by name	6 (3.8%)	16 (19%)	35 (21.9%)	103 (64.4)
Nurses treat me and my family members with respect	6 (3.8%)	9 (5.7%)	35 (22%)	109 (68.6%)
Nurses treat me with confidentiality	9 (5.7%)	17 (10.8%)	28 (17.7%)	104 (65.8%)
Nurses are calm and polite	12 (7.7%)	12 (7.7%)	26 (16.8%)	105 (67.7%)
Nurses use appropriate language	7 (4.4%)	16 (10.1%)	21 (13.1%)	115 (72.3%)
Nurses show empathy	6 (3.8%)	16 (10%)	36 (22.5%)	102 (63.8%)

Nurses' Commitment

Within client- nurse relationship, nurses' commitment emerged as a variable. Nurses' availability to clients was an indicator of nurses' commitment. Clients reported that nurses do not give them enough time to talk about their problems. Findings of the study show that clients have mixed feelings about how committed nurses are. Nurses' availability as an indicator of their commitment is related to how much time nurses give clients during interaction. Findings also relate nurses' availability to how long clients wait before nurses attend to them when they come to the clinic for review.

Table 2: Findings on nurses' commitment.

Table 2: Findings on Nurses' Commitment

	Never	Occasionally	Sometimes	Always
Nurses encourage me to ask questions	51 (32.3%)	50 (31.6%)	24 (15.2%)	33 (20.9%)
They give enough time to talk about my problems	45 (28.3%)	48 (30.2%)	27 (17%)	39 (24.5%)
Nurses listen to my problems	35 (22.3%)	31 (19.7%)	42 (26.8%)	49 (31.2%)
They show interest in helping me out of my problems	34 (21.7%)	32 (20.4%)	33 (21%)	58 (36.9%)
They encourage continuity in medication use	20 (13.1%)	1 (0.7%)	13 (8.5%)	119 (77.8%)

Client Involvement/ Participation

This variable relates to the fact that there are other interventions that the nurse does for his/her clients within the nurse-client relationship. These goals are achieved by goal directed actions. The nurse in this respect needs to involve the clients to formulate goals if the relationship is to be meaningful to the clients.

Clients reported that most of the time nurses do not involve them in making decisions or formulating goals for their treatment.

Findings of the study show that nurses do not equip the clients to deal with their problems. Clients reported that they have no autonomy on decision-making and goal

formulation regarding their treatment. Clients reported that nurses do not involve them in planning for the next visit. Clients reported that nurses impose a date on the clients when they should come back to the clinic.

The following table shows findings on clients' responses in relation to the aspect of client involvement and participation.

Table 3: Findings on client involvement/ participation

	Never	Occasionally	Sometimes	Always
They encourage me to take part in decision making about my treatment	60 (38.2%)	42 (26.8%)	15 (9.6%)	40 (25.5%)
They involve me in planning for the next visit	90 (57%)	26 (16.5%)	18 (11.4%)	24 (15.2%)
Nurses encourage my family members always to accompany me to clinic	59 (37.8%)	47 (30.1%)	29 (18.6)	21 (13.5%)
Nurses involve my family members in decision making about my treatment	86 (54.4%)	29 (18.4%)	19 (12%)	24 (15.2%)
They acknowledge my contributions and opinions.	41 (26.6%)	34 (22.1%)	19 (12.3%)	60 (39%)
They encourage discussion about solutions to my problems	25 (16.2%)	38 (24.7%)	21 (13.6%)	70 (45.5%)

(c) Strategies

Clients come to the clinic with a number of problems that they expect nurses to help them solve. Findings of the study show that nurses do help clients to deal with these.

Problem solving

Problem solving emerged as a category under the sub-theme of strategies. Within problem solving, a number of areas were identified, namely, progress monitoring and evaluation, and information giving. Findings show that nurses monitor and evaluate clients' progress as part of the way nurses solve clients' problems.

Table 4: Problem solving

	Never	Occasionally	Sometimes	Always
Nurses advise on strength and weaknesses	79 (50.3%)	33 (21%)	16 (10.2%)	29 (18.5%)
Nurses suggest alternative solutions to problems	55 (36.2%)	16 (10.5%)	10 (6.6%)	71 (46.7%)
Nurses encourage discussion on solutions to problems	25 (16.2%)	38 (24.7%)	21 (13.6%)	70 (45.5%)

Information Giving

Findings indicated that there is poor information giving by nurses to clients during theraon. Clients reported that they are not informed about the purpose of their visits to the clinic. Most of the clients indicated that they come to the clinic just to collect treatment.

Clients indicated that nurses do not give them information regarding their illness. They also reported that nurses do not provide the clients' family members with necessary information about the their illness, nor do they encourage clients to ask questions about their illness and how to manage the illness.

Table 5: Findings on information giving

	Never	Occasionally	Sometimes	Always
Nurses inform me about the purpose of the visit	70 (45.8%)	39 (25.5%)	23 (15%)	21 (13.7%)
Nurses ask me if I understand whatever we are discussing	51 (32.3%)	43 (27.2%)	24 (15.2%)	40 (25.3%)
Nurses give me information about the illness	67 (42.4%)	42 (26.3%)	20 (12.7%)	29 (18.4%)
Nurses keep family members informed of my progress	91 (58%)	32 (20.4%)	8 (5.1%)	26 (16.6%)

Clients' Expectations of Therapeutic Interaction

Findings show that there are a lot of issues that clients expect should happen in therapeutic interaction when they visit the clinic. Clients reported that they expect to find a good nurse-client relationship that will help nurses to identify clients' problems. Clients also reported that they expect nurses to help the clients to solve their problems. Clients also expected to be given information regarding their illness. They also expected nurses to be committed to their clients. They reported that they want to participate in the management of their problems and illness.

Nurse-Client Relationship

Clients reported that a good relationship is indicated by the nurses' attitudes and commitment to provision of clients' care. They also reported that within good nurse-clients interactions, nurses are expected to involve clients in planning for their care. Clients expect that clients should participate in their treatment.

Nurses' Attitude

Findings of the study show that clients indicated that to be greeted by the nurses when they come for interaction, and to being made to feel comfortable and free were indicators of good nurses' attitudes. They also looked at being treated with respect and confidentiality, nurses' use of appropriate language, nurses showing empathy and giving and fostering of hope as a manifestations of a therapeutic relationship. Clients reported that they expected nurses to address them by their names. The way nurses approach clients also displays good attitude. Clients expected that nurse should use appropriate language. They expected nurses to be polite and calm when dealing with the clients. Findings of the study show that clients expect a welcoming attitude from the nurses.

Table 6: Findings on what the clients expected of nurses' attitudes

I expect nurses to:	Strongly Agree	Agree	Not Sure	Dis-agree	Strongly Disagree
greet me before interaction	77 (48.1%)	61 (38.1%)	18 (11.3%)	2 (1.3%)	2 (1.3%)
encourage me to feel free and comfortable	86 (54.1%)	67 (42.1%)	-	6 (3.8%)	-
introduce themselves to me.	63 (39.4%)	68 (42.5%)	2 (1.3%)	22 (13.8%)	5 (3.1%)
address me by name	84 (52.8%)	45 (28.3%)	18 (11.3%)	10 (6.3%)	2 (1.3%)
treat me and my family members with respect	90 (60.4%)	53 (35.6%)	-	-	6 (4%)
treat me with confidentiality	116 (75.8%)	29 (19%)	7 (4.6%)	-	1 (0.7%)
be calm and polite	114 (74%)	39 (25.3%)	1 (0.6%)	-	-
use appropriate language	123 (77.4%)	35 (22%)	-	1 (0.6%)	-
show empathy	111 (69.8%)	47 (29.6%)	1 (0.6%)	-	-

Nurses' Commitment

Findings indicate that clients look forward to a relationship that is characterised by nurses' commitment. Clients expect nurses to show interest in helping them with their problems. Giving clients enough time to explain their problems indicates how nurses are committed to helping the clients. More than fifty percent of the clients expect nurses to be supportive and receptive to clients. They indicated that nurses should listen to their problems.

Table 7: Clients expectations on nurses' commitment

I expect nurses to:	Strongly Agree	Agree	Not Sure	Dis-agree	Strongly Disagree
show interest in helping me with my illness and problems.	105 (65.6%)	47 (29.4%)	6 (3.8%)	1 (0.6%)	1 (0.6%)
give enough time to talk about my problems	78 (48.8%)	75 (47.2%)	5 (3.1%)	-	1 (0.6%)
listen to my problems	90 (56.6%)	63 (39.6%)	1 (0.6%)	5 (3.1%)	-

Participation/ Involvement

One of the approaches that nurses employ when helping clients with their problems within the nurse-clients relationship is to involve them in their interventions. Clients reported that there is need that goals should be mutually planned and formulated between the nurses and the clients.

Clients feel that nurses should give them a chance to participate in decision making regarding their treatment. Clients expect that nurses should involve them in coming up with solutions to client problems. They also expect that their family members should be involved in the management of the clients' illness, as well as decision making regarding their treatment.

Table 8: Findings on clients' expectations on clients' involvement/ participation

I expect nurses to:	Strongly Agree	Agree	Not Sure	Dis-agree	Strongly Disagree
encourage me to take part in decision making about my treatment	91 (57.2%)	47 (29.6%)	2 (1.3%)	18 (11.3%)	1 (0.6%)
involve me in planning for the next visit	112 (70.4%)	41 (25.8%)	-	5 (3.1%)	1 (0.6%)
encourage my family members always to accompany me to clinic	56 (35.2%)	38 (23.9%)	4 (2.5%)	36 (22.6%)	24 (15.1%)
involve my family members in decision making about my treatment	43 (27%)	44 (27.7%)	7 (4.4%)	46 (28.8%)	19 (11.9%)
acknowledge my contributions and opinions.	95 (60.1%)	56 (35.4%)	6 (3.8%)	1 (0.6%)	-
encourage discussion about solutions to my problems	98 (63.6%)	43 (27.9%)	11 (7.1%)	1 (0.6%)	1 (0.6%)
encourage family involvement in my mental health promotion.	62 (40.3%)	49 (31.8%)	4 (2.6%)	30 (19.5%)	9 (5.8%)

Strategies

Problem Solving

In dealing with clients, there are specific strategies that are of vital importance to ensure that nurses effectively deal with clients. Findings show that clients expect nurses to help them with problem solving skills. They indicated that they want nurses to ensure that their problems are identified and solved. Findings show that clients expect nurses to provide alternative solutions to their problems. They expect nurses to discuss with clients' family members in order to come up with solutions to clients' problems.

Table 9: Findings showing clients' expectations on problem solving

I expect nurses to:	Strongly Agree	Agree	Not Sure	Dis-agree	Strongly Disagree
show interest in helping me with my illness and problems.	105 (65.6%)	47 (29.4%)	6 (3.8%)	1 (0.6%)	1 (0.6%)
encourage discussion about solutions to my problems	98 (63.6%)	43 (27.9%)	11 (7.1%)	1 (0.6%)	1 (0.6%)
involve my family members in decision making about my treatment	43 (27%)	44 (27.7%)	7 (4.4%)	46 (28.8%)	19 (11.9%)
encourage discussion about solutions to my problems	98 (63.6%)	43 (27.9%)	11 (7.1%)	1 (0.6%)	1 (0.6%)
suggest alternative solution to my problems	99 (64.3%)	47 (30.5%)	6 (3.8%)	1 (0.6%)	1 (0.6%)
encourage continuity of medication	114 (74%	37 (24%)	-	2 (1.3%)	1 (0.6%)

Information Giving

As per the findings of the study, clients expect that nurses should give health education and give information to clients regarding their illness, treatment and management of their illness and problems. Clients expect nurses to inform them about the purpose of their visits. They want to be encouraged to ask questions during these interactions. Clients reported that they expect nurses to give information to their family members about their illness.

Table 10: Findings on clients' expectations on information giving

I expect nurses to:	Strongly Agree	Agree	Not Sure	Dis-agree	Strongly Disagree
inform me about the purpose of interaction	94 (58.8%)	46 (28.8%)	12 (7.5%)	8 (5%)	-
encourage me to ask questions	90 (56.6%)	51 (32.1%)	7 (4.4%)	8 (5%)	3 (1.9%)
ask if I understand whatever we are discussing	83 (52.2%)	59 (37.1%)	8 (5%)	7 (4.4%)	2 (1.3%)
give information about the illness	83 (52.5%)	66 (41.8%)	6 (3.8%)	2 (1.3%)	1 (0.6%)
give my family members information about my illness	52 (33.8%)	47 (30.5%)	9 (5.8%)	34 (22.1%)	12 (7.8%)

Fostering of Hope

Findings show that clients expect that nurses should instill hope in the clients. Sometimes clients do not see the important of taking treatment. They lose hope as to whether they will get well or not. Findings show that clients want nurses to keep on giving them hope and encouraging them to work towards their well being.

Table 11: Findings on clients' expectations on hope fostering.

I expect nurses to:	Strongly Agree	Agree	Not Sure	Dis-agree	Strongly Disagree
give and foster hope	102 (66.2%)	47 (30.5%)	5 (3.2%)	-	-

Comparison between Focus Group and Questionnaire Responses on Perceptions

There were differing perceptions from the clients regarding therapeutic interaction from the focus group participants and those who filled in the questionnaire. For example some clients in the focus group emphasized that nurses do not greet them when they come to the clinic. This was contrary to the participants who filled in the questionnaire. Ninety six percent of them reported that nurses always greet them on their arrival at the clinic.

Clients reported similar responses in some of the questions on clients' involvement and participation. The majority of clients in the focus group reported that nurses do not involve

them in decision-making. Sixty percent of those who filled in the questionnaire reported that nurses do not involve them in decision-making regarding their treatment. They reported that they are just given a date for the next visit without being involved in the planning as to whether the clients could feel comfortable to come again on that particular date.

The findings were very similar on information giving. Participants from the focus group reported that nurses do not give them information about their illness. 67 % of participants who filled in the questionnaire indicated that nurses do not give them information about their illness. Both participants in the focus group and those who filled in the questionnaire reported that nurses do not inform them about the purpose of their visit. They reported that family members are not given information about the clients' illness.

Table 12 below compares major findings between the focus group and the questionnaire results on some of the categories identified within clients' perceptions.

Categories	Focus Group Results	Questionnaire Results
Receptivity	The majority of them reported that: *They are frightening. Others are unapproachable. You can't ask them a question they will show no interest to respond.*	54% reported that nurses encourage them to feel free and comfortable. 68.6% reported that nurses treat them with respect.
Availability	Almost half of the clients reported that: *they should make sure that they help us in time. They don't give us enough time for our problems. I feel rushed*	51% reported that nurses do not give them enough time to talk about their problems as compared to 39% who reported that they feel they are given enough time.
Information giving	A lot of clients were quoted saying: *nurses give us information on how to deal with our problems. We have knowledge of what we are suffering from through attendance at the clinic.*	67 % reported that nurses never give them information about their illness. 91 % indicated that family members are not informed about the clients' illness.
Politeness	Most clients reported that most of the time nurses shout at them. Nevertheless they reported that nurses use their names to address them.	67.7% reported that nurses are calm and polite. 72.3 % reported that nurses use appropriate language.
Client involvement	The majority of the clients reported that nurses do not involve them in their treatment. *They should always ask us our opinions before deciding for us. They should ask us as to what decision should be made regarding out treatment.*	60% reported that nurses never encourage them to take part in decision making. 90 % indicated that nurses never involved them in planning for the next visit.

Categories	Focus Group Results	Questionnaire Results
Problem identification/ solving	Some clients reported that the clinic helped them to find an income generating activity. *Sometimes you can get advice on how to make your life profitable and independent. We also meet social workers at the clinic to discuss some of the social problems that we are facing in our everyday life i.e. financial problems.*	71 % of participants reported that nurses suggest alternative solutions to problems. 70 % indicated that nurses encourage discussion on solutions to problems.
Fostering of Hope	Clients reported that nurses foster hope. *Every time I have a problem I come to clinic with hope that I will be helped with my problem. One thing that I noticed is that nurses look at me as someone who can do better than what I am now.*	98 % reported that nurses give them hope.

Comparison between clients' perceptions and expectations of therapeutic interaction.

Clients' perceptions were explored by asking the clients to range their perceptions of whether nurses do a particular duty, task or not. Clients were asked to range their perceptions from "never to always". These ranges mean that an activity is never performed by the nurses or is always done by the nurses. Clients were also required to indicate whether they agreed that they expected nurses to perform a particular activity or not. They were asked to indicate from the range whether they strongly agreed with a statement or strongly disagreed with a statement in the questionnaire. The following table indicates the findings of the study in regard to correlation between clients' perceptions and clients' expectation. For the clients' perceptions, clients were required to chose from the following options: never, occasionally, sometimes and always. Clients' expectations response choices were strongly agree, agree, not sure, disagree and strongly disagree. The percentages displayed in this table reflect the highest percent for that particular statement.

Table 13: Comparison between clients' perceptions and clients' expectation

	Clients' perceptions	**Clients' expectations**
Nurses greet me before interaction	60 % - always	48.1%- strongly agree
They encourage me to feel free and comfortable	54 % - always	54.1%- strongly agree
Nurses introduce themselves to me	66 % - never	42.5%- agree
Nurses inform me the purpose of interaction	45.8%- never	58.8%- strongly agree
Nurses address me by name	64.4 %-always	52.8%- strongly agree
Nurses encourage me to ask question	51% - never	56.6%- strongly agree
Nurses ask if I understand whatever we are discussing	32.3%- never	52.2%- strongly agree
Nurses give information about the illness	42.4%- never	52.5%- strongly agree
They give enough time to talk about my problem	51 % - never	48.8%- strongly agree
Nurses listen to my problems	49 % - always	56.6%- strongly agree
They give advice on my strengths and weaknesses	50.3% - never	50.3% - strongly agree

	Clients' perceptions	Clients' expectations
They encourage me to take part in decision making about my treatment	38.9 % - never	57.2%- strongly agree
They involve me in planning for the next visit	59 %- never	70.4%- strongly agree
They show interest in helping me with my illness and problems	58 % - always	65.6%- strongly agree
Nurses encourage my family members always to accompany me to clinic	37.8%-never	35.2%- strongly agree
Nurses involve my family members in decision making about my treatment	54.4%- never	28.8%- disagree
Nurses give my family members information about my illness	58%- never	33.8%- strongly agree
Nurses treat me and family members with respect	68.6 %-always	60.4%- strongly agree
Nurses treat me with confidentiality	65.8 %-always	75.8%- strongly agree
Nurses are receptive	74 % - always	65.6%- strongly agree
Nurses are supportive	93 % - always	68.2%- strongly agree
They acknowledge my contributions and opinions	39 %- always	60.1%- strongly agree
They encourage discussion about solutions to my problems	45.5 %-always	63.6%- strongly agree
They always suggest alternative solutions to my problems	46.7%- always	64.3%- strongly agree
They encourage continuity in medication use	77.8 %-always	74%- strongly agree
They encourage family involvement in my mental health promotion.	82 % - always	40.3%- strongly agree
Nurses are calm and polite	67.7%-always	74%- strongly agree
Nurses use appropriate language	72.3%- always	77.4%- strongly agree
Nurses show empathy	63.8%- always	69.8%- strongly agree
Nurses give hope	98 % - always	66.2%- strongly agree

From the table it shows that there are other aspects of clients' expectations that are not being met by the nurses at the clinic. For example clients (57.2%) expect that nurses should involve them in decision making, yet 38.9% indicated that they are never involved.

CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter will present the discussion of the findings of the study. Interpretation of the results in relation to previously done studies and the conceptual framework will be done. As Hall and Hall (1996) suggest, conclusions will be drawn as to how far the objectives of the study have been met. Recommendations for the community psychiatric nurses will then be made.

The objectives of the study were

(a) to explore clients' perceptions of therapeutic interactions with nurses at the clinic.

(b) to determine clients' expectations of therapeutic interaction at the clinic during their monthly attendance.

(c) to determine how the clients' perceptions of therapeutic interaction affect their utilization of the services at the clinic.

(d) to provide recommendations for the interaction from the clients' perspective.

DISCUSSION OF FINDINGS

Demographic Data

Findings of the study do not show any relationship between demographic data and clients' perceptions. Clients' perceptions did not vary according to age, gender, educational level or occupation. This is consistent with the findings from the study conducted by Almeida (2002) on consumer satisfaction with mental health service delivery in Durban.

Vincente, Vielma, Jenner, Mezzina and Lliapas (1993) also stated that levels of satisfaction, attitudes and opinions rarely relate to the personal variables. A lot of past studies have also repeatedly found that there is no significant relationship between clients' perceptions of service environment and variables such as age, race, gender, marital status or occupation (Lebow, 1982; Damkot, Prandiani & Gordon, 1983).

(1) **Relationship**

Findings of the study have shown that nurses at the clinic develop good rapport with their clients in interaction during the monthly attendance. Clients reported that nurses greet them and ask them to feel free and comfortable (table 1). Clients have also reported that nurses develop a trusting relationship with the clients because they receive necessary respect from the nurses. Clients reported that a client – nurse relationship should encourage client involvement and participation. These findings are consistent with the objectives of South African Government that states that clients have the right to respect, human dignity, and privacy (RSA, 2000).

Nevertheless within the nurse –clients relationship, some clients reported that nurses have a poor attitude towards them. These clients reported that the nurses never greeted the clients nor show them respect. Clients further reported that nurses do not involve clients in their care. This is detrimental to clients' progress. For example, Torrey (1995) reported that poor relationship is one of many explanations for non-compliancy with medication among clients.

The Human Relations Counselling Model points out that as the nurses interact with the clients, they need to develop good rapport, trust, honesty and empathy. Interaction starts with the initial contact between a nurse and the clients. It is at this point that the nurse builds an interaction that should be perceived and appreciated by the clients as a client-centred therapeutic interaction.

The White Paper for the Transformation of the Health System in South Africa states that the central theme of government health care is to encourage the National Health Services and the community services to change the way the services relate to those that use them (RSA, 1997 (a)). Farrell (1991) reported that the few studies that have been done suggested that nurses are not very accurate in estimating their clients' needs. Nurses can only know what their clients' preferences are by continuing to develop the necessary interpersonal skills for accurate assessment of clients' concerns. Nurses can facilitate clients' cooperation with

treatment by developing interpersonal skills that improve the quality of therapeutic interaction. Active listening, appropriate non-verbal communication and empathy greatly enhance the interaction (Coringan, Leberman & Engel, 1990).

Trusting relationships allow the clients freedom to share their burdens and wishes with the nurses. It is through a good relationship that the nurses involve the clients, acknowledge and support the clients' goals (Byrne, Woodside, Landeen, Kirkpatrick, Bernardo & Pawlick, 1994). Good relationships that psychiatric nurses develop at the clinic with clients will contribute to valid assessment, planning and interventions because the nurses and clients are more involved with each other (Kidner, 1994). A good nurse- client relationship is one that manifests nurses' good attitude, commitment and client involvement.

(a) Nurses' attitudes

Studies have shown that nurses' attitudes towards clients are sometimes negative (Carling, 1999; Michener, 1998). Clients' complaints of negative nurses' attitudes were strictly linked to the way nurses value clients within the nurse- clients relationships. But the findings of this study have shown that nurses show a satisfactory attitude towards clients. Clients have reported that nurses respect them. Clients gave the example of being addressed by their names as an indication of nurses showing respect to clients. Sheppard (1993) who stated that clients' satisfaction and perceptions of the services they receive is related to nurses' interpersonal skills.

In the present study, clients reported that nurses are friendly and polite (table 1). This is contrary to findings of a study that revealed discriminatory attitudes towards clients come from health practitioners as much as from the general public (Carling, 1995; Michener, 1998).

Elame (2001) indicated that feeling valued as an individual and feeling comfortable are important indicators of client positive perceptions of their interaction with nurses. Nevertheless findings of the present study show that as much as nurses are friendly and polite, the majority of the participants indicated that nurses shout at them. A good nurse- clients

relationship shows nurse's understanding of the clients. There are times when the clients make mistakes. The nurse should at this time approach the clients with love and politeness to show that the nurse cares for them.

The Human Relations Counselling Model states that every time the clients come for follow up at the clinic, interaction starts with the initial contacts between the nurse and the clients. The nurse is supposed to develop an atmosphere that would make the clients comfortable, relaxed and free to air out their concerns. A climate should be provided that would enable the nurse to explore concerns and to begin to identify these concerns. But as the findings of this study indicate, clients feel frightened to approach the nurses for fear of being shouted at.

When the nurse communicates any message, it gives the clients an understanding of the feeling communicated to them by the nurse. Nurses should pay considerable attention to their non- verbal messages i.e. voice tone. The Human Relations Counselling Model states that understanding the real message is usually secondary to the feeling communicated. Within therapeutic interactions non- verbal messages are conveyed through body language, vocal tones, facial expressions and other cues accompanying verbal messages. The Human Relations Counselling Model (Okun, 2002) indicated that among the non- verbal cues that clients might identify from an interaction with the nurses are the nurse's ability be welcoming, to show empathy, hope and calmness.

Findings of this study also indicate that nurses do not involve clients in decision-making regarding their care (table 3). Client engagement in the care indicates nurses' attitudes on how the nurses value clients as important individuals in implementing the clients' care. Clients reported that they feel not being valued by the nurses during interactions if they are not involved. Coulter, Entwistle and Gibert (1999) also reported that clients active involvement in decision making about their treatment options increases their feeling of being valued resulting in effectiveness of therapeutic interactions.

(b) Nurses' Commitment

Commitment is defined as a complex affective response characterised by a convergence between one's desires and one's obligations and by a deliberate choice to act in accordance with them (Roach, 1992). Nurses need to show commitment if they are to win their clients' favour. The nurses' verbal and non- verbal messages communicate how committed they are to their clients.

Table 2 indicates that findings of the study show that the nurses' availability to clients was limited showing little nurses' commitment. This is only true when consideration is given to availability of nurses to clients as an indicator of nurses' commitment. Clients complained that nurses are mostly unavailable to them. Clients complained that when they arrive at the clinic, it takes too long before the nurses attend to them (Quint & Fergusson, 1997). Clients also stated that when nurses go for their tea break, clients are left unattended for long periods of time.

Findings show that when the clients meet the nurses, they are not given enough time to explain and talk about their problems. These findings are inconsistent with the Human Relations Counselling Model that states that nurses should give enough time to the clients to explain their problems. At the same time, nurses should also have enough time to explain important information for the clients' understanding of their illness and treatment (Kroenke, 1997).

Sibeko and Greeff (1995) found the same results about nurses' availability in a study of psychiatric nurses' communication with their clients in an acute psychiatric ward in Transvaal, Republic of South Africa. Sibeko and Greeff (1995) reported that most of the times when clients tried to approach a psychiatric nurse, the nurses turned the clients away. They also reported that psychiatric nurses tended to concentrate on the structured hospital routines that allow very short periods of nurse- client interaction.

Kroeke (1997) stated that short visit times are detrimental to the diagnosis and treatment of mental health disorders in community psychiatric clinics. Clients perceive such aspects like spending enough time with the nurse, and not feeling rushed during the visit as attributes of quality nurse- clients interaction (Byrne, 2001). It is thus very important that nurses show commitment to clients by being available to the clients.

Other findings of this study showed that clients reported positively on nurses' commitment to clients' well being. They reported that nurses did home visits to those that were unable to come to clinic. Clients perceived this as an indication of nurses' commitment. Through home visits nurses make themselves available to the clients. The Sherwood Therapeutic Model supported that clients' satisfaction with therapeutic interaction is dependent on the availability of the nurses to them. The nurse is required to be vigilant in surveillance of the clients' needs and to provide a supportive and protective environment for therapeutic interaction to occur (Sherwood, 1997). The Model also states that the nurses' therapeutic goal is manifested by the nurses' availability, receptivity and respect for the clients. The nurses show commitment by showing concern for the clients' well being and having time to sit, talk and listen. Clients experience the availability of the nurse as devotion or commitment to caring for them.

Findings of this study revealed that nurses show empathy and encouragement to the clients (table 6). As Sherwood (1997) indicated, empathy, providing support, hope and encouragement, comfort and preservation of the clients' dignity are also ways in which nurses show commitment to the care they render to their clients.

(c) Clients' Involvement/ Participation

In a good client- nurse relationship the opinions and contributions of the clients are valued. Community health nursing involves responsiveness to the need of service users, which advocate partnership and empowerment (Crowe, 1997). Community psychiatric care

promotes clients' autonomy and maximum clients' participation. Clients feel alienated and often identify themselves with the role of "passive recipients" when they are not involved in their care. Findings of the study show that clients reported that the nurses do not involve them in their care. Clients reported that they are not involved in the planning for their care i.e. date for next visit. They reported that they are just given the date as to when they can come again for the next appointment. Moira et al (2000) stated that clients perceive that their visit was client-centred when they are involved in the planning of their care.

Within therapeutic relationships, there is need that the clients be involved in the choice of the courses of action to be taken as interventions for their illness. The nurse and the clients should mutually decide clients' goals and objectives. As the interaction goes on, the clients should be able to know that they are part of the whole process. Findings of this study show that clients are not often encouraged to take part in decision making regarding their treatment. These findings are consistent with the results by Anthony (2000) that stated that for many years community psychiatric nurses and mental health services providers have had a belief that seriously ill people were too ill to participate, had poor judgement or were too unmotivated to participate in their own treatment. Cegala, McClure, Marinelli & Post (2000) stated that nurses thought that they had to make decisions for the clients, plan and carry out their treatment for them and view the clients as passive recipients of the services the nurses provided.

Waterworth and Luker (1990) recommended that clients should be regarded as being capable of decision making; this presupposes that clients need to be central to decisions which affect their health and well being. Batho Pele principles also emphasize the need for clients' right to exercise choice in health care and participation in decision making that affect their health (Department of Health, 2000). The findings of this study have shown that clients expectations of what should happening in regard to their participation in the care is contrary to what is happening at the clinics (table 13).

Clients feel unvalued in client- nurse relationships if they are not involved in decision making regarding their care. Coulter, Entwistle and Gilbert (1999) observed that clients active involvement in decision making regarding their treatment options increases their feeling of being valued and that this results in effectiveness of the treatment.

(2) Strategies

During therapeutic interaction, nurses develop strategies to help the clients. As stated earlier, nurses need to involve clients in developing these strategies so that clients are part of the whole process. Strategies that are mutually agreed upon are much more effective than strategies imposed on the clients. Nurses help clients to solve their problems. They monitor and evaluate clients' progress. For effective treatment approaches, nurses need to provide information to clients regarding their illness and how to manage their illness and problems.

(a) Problem Solving

Findings of this study indicate that nurses help clients to solve their problem. A number of clients reported that they were attached to income generating activities through the clinic. The majority of those attached are working at Sherwood Challenge Workshop. Successful treatment approaches that enhance wellness and reduce disability are best, facilitated within therapeutic partnership between the clients and their nurses. Wilson, Hobbs, Osborne and Archie (1996) stated that preventing relapse is dependent upon nurse- clients shared goals, shared agreements and a dynamic responsive treatment contact.

Nurses work together with clients so that they can understand the nature of their problems, conditions and illness. Clients' understanding of their illness or problems is the first step in solving their problems. Nurses need to work to ensure alleviation of clients' distress and suffering. Nurses should foster a sense of hope that is meaningful to the clients concerned by increasing their effectiveness.

Findings of the study indicated that 59.4% of the clients were unemployed. Under such circumstances, nurses and clients need to work together in order to develop easily accessible,

cost-effective alternatives that would offer effective mental health care as well as useful social rehabilitation programmes for clients.

(b) Progress Monitoring and Evaluation

Progress monitoring or evaluation figured more on the clients' expectations of therapeutic interaction. Clients reported that they expected nurses to monitor their progress. They also indicated that through progress monitoring, nurses are able to decide if a particular treatment or intervention is helping the client or not. So far studies have shown that in community psychiatric clinics, interviews are the main activity that enables the nurse to evaluate clients biopsychosocial progress (Staab & Hodges, 1996). A detailed interview of psychiatric clients has therapeutic benefits beyond the assigning of an appropriate diagnosis. Blaska (1990) indicated that many consumers of mental health care suffer needlessly as a result of being given wrong medication or the wrong dosage of right medication. Through therapeutic interactions nurses are able to discover such problems and intervene appropriately.

Findings of this study indicate that clients are not given enough time to explain their concerns or problems. This might eventually lead poor progress monitoring and evaluation. Studies show that progress monitoring in community psychiatric clinics usually differs from in- patient settings because of less frequent chances for evaluations (Strachan, 2000 (b)). Community psychiatric nurses have less opportunity to observe the clients behaviour directly and to implement interventions where necessary. Kroenke (1997) stated that short visit times are detrimental to the diagnosis and treatment of mental health disorders in community psychiatric clinics.

(c) Information Giving

Clients reported in the study that nurses occasionally give them information regarding their illness and management of their problems. Clients reported that nurses do not inform them about the purpose of their visit to the clinic. The majority of the clients only knew that they come to the clinic to collect medication. These findings are consistent with several

studies that were conducted elsewhere. Smith and Birchwood (1990) showed that clients were dissatisfied with not receiving general information related to their illness. Information giving provides adequate clinical knowledge to clients resulting in increased understanding of their conditions. Information giving encourages clients' health behaviour. Information is aimed at enhancing wellness and decreasing disability. Information giving attempts to actualise the health potentials of individual clients and their families.

Findings of this study have indicated that clients require information about their illness, management and prognosis. Kirkpatrick, Landeen, Byrne, Woodside, Pawlick and Bernado (1995) stated that the importance of education to the clients about illness should not be limited to symptoms and symptom control. Clients need information on how they can make their lives independent and productive. This is especially important as the results of the study show that only a few of the clients are employed. Most of them are not employed and have no steady sources of support and income.

As much as nurses accept that information giving is essential in nurse-client interactions, studies have shown that communication between nurses and clients is often inadequate (Oliver & Redfren, 1991). Holliger and Buschmann (1993) reported that most of nurse -client interactions seem to be superficial and task oriented and that the amount of social interaction and information given is limited. Beisecker & Beisecker (1990) reported that clients could benefit much if they were encouraged to ask questions. Cegala et al (2000) indicated that recent models of nurse-client communication emphasize information exchange in promoting partnership between a nurse and a client.

Findings of this study have shown that a good number of clients preferred not to be accompanied by their family members when coming to clinic. This is an indication of their lack of information about the impact of their family members on their recovery and well being. An important asset of recovery for the seriously mentally ill individuals is that the family is a great source of vital information. To open the door to a positive diagnosis,

medication and treatment, family involvement is essential. Studies have shown that family involvement in clients' care is essential and an integral part in the care of individuals with mental illness (Williams, 2002).

The positive role of families in mental health care programmes has been recognized relatively recently. The role of families now extends beyond day-to-day care to organized advocacy on behalf of the mentally ill. Such advocacy has been pivotal in changing mental health legislation in some countries, and improving services and developing support networks in others (WHO, 2001). Substantial evidence demonstrates the benefits of involving families in the treatment and management of schizophrenia, mental retardation, depression, alcohol dependence and childhood behaviour disorders. There are indications that the outcome for clients living with their families is better than for those in institutions (Leff & Gamble, 1995; Dixon, Adams & Lucksted, 2000). Clients need to be educated on the importance of family involvement in their care.

Findings of this study also showed that nurses do not often give information to clients' family members (table 5). Little or poor knowledge of mental illness among the community has a negative impact on the clients. The general public is coming into increasing contact with individuals with mental illness because of the shift of focus towards community-based psychiatric care. The community's attitudes towards individuals with mental illness would have a major influence on the acceptance of the mentally ill and their social integration. These attitudes would be at least partly determined by knowledge about mental illness (Wolff, Pathare, Craig & Leff, 1996). Clients reported that they expect nurses to provide information regarding their illness to their family members, but this is seldom done.

(3) Therapeutic outcomes

There is an outcome for each and every interaction that takes place between a nurse and clients. In most cases if an interaction is satisfactory, it yields positive outcomes. If an interaction is unsatisfactory there are always negative outcomes that follow.

(a) Service Utilization

Clients reported that poor relationship within therapeutic interactions might lead to treatment non- compliance. This is because clients do not get the adequate support they need to comply with treatment. Within a good relationship, clients feel encouraged and are given hope to comply with treatment. Zastowny, Roghmann and Cafferate (1989) also found that poor interaction results in treatment non- compliancy by the clients. Lack of knowledge of their illness also causes clients to be non- compliant to treatment. In the study by Kessler, Berglund, Bruce, Randy Koch, Laska, Leaf, Manderscheid, Rosenheck, Walters & Wang (2001), results indicated that clients were non compliant to treatment because they did not know that they had a problem that needed treatment. Furthermore, it was reported that the vast majority of the clients who were non- compliant, although they recognized that they needed treatment, preferred to deal with the problem on their own because they were not involved by the clinic in their care. This was consistent with the results that clients expected to be involved in their care. Failure to involve them leads into non- compliance in an attempt to try to solve their own problems.

Other studies have suggested that clients who stopped receiving treatment had no awareness of their illness (anosognosia) and thus they did not seek treatment (Goldman 1999; Rosenheck, 1999). It is clear from these studies and the finding of this study that clients need information regarding their illness so that they can utilize the services that are available to them at the clinics.

Bebbington (1995) suggested that a full understanding of non-compliance must take into account the relationship between clients and nurses in the context of the clients being sick. Several techniques for increasing compliance have been described, but they contain common elements i.e. the provision of information within the context of a warm and equitable therapeutic relationship, preferably maintained over some time, and the use of the relationship

to encourage and prompt compliance and to establish more productive views of the illness and medication (Bebbington, 1995).

Clients indicated in the study that if they were not satisfied with the way they interacted with the nurses it might result to a decrease in service utilization. Studies have shown that satisfaction in itself is an important outcome in its own right (Fitzpatrick, 1991). It has shown that satisfaction appears to be a predictor of whether clients would follow their recommended treatment or not. It also predicts whether clients would continue attending or not. Previous studies have shown that clients with mental health problems were more likely to maintain contact with nurses if they were satisfied with their interaction with the nurses.

(b) Clients' provision of Information/ Effective Assessment

Findings of the study showed that clients do not give adequate information to nurses because they are not given enough time to explain their problems. Kadner (1994) indicated that a client is more likely to be honest and forthcoming with caregiver who is trusted. A trusting relationship contributes to valid assessment, planning and interventions. Important details that may be of great positive impact might be left out in non- intimate relationship. Poor interactions that do not give clients an opportunity, freedom or comfort to talk within the therapeutic environment restrict the nurse in the quality of care rendered to clients. A considerable body of research indicates that primary care nurses often fail to recognize and treat mental illness in their clients (Barrett, Barrett, Oxman, & Gerber, 1988). This is caused by poor interaction between nurses and clients. Many consumers of mental health care suffer needlessly because nurses intervened wrongly. Clients suffer because of the nurses' failure to identify clients' problems or incorrect diagnosing of their conditions (Blaska, 1990). Incorrect diagnosis results either because clients did not give adequate information regarding effects of their present treatment or because nurses did not have adequate information about the clients' problem. Zastowny, Roghmann & Cafferata (1989) indicated that failure to elicit relevant information about symptoms and worries could result in inaccurate diagnoses, inappropriate

treatment advice and therefore poor outcome such as drop outs from treatment. Davis & Fallowfield (1991) also emphasized that as a result of poor communication the accurate exchange of information between the client and the community psychiatric nurse is likely to be severely limited, resulting in the probability that treating or advising the client appropriately diminishes.

(c) Client Empowerment

WHO (2001) indicated that the main objectives of community psychiatric treatment are consumers' empowerment, the reduction of discrimination and stigma, the improvement of individual social competence, and the creation of a long-term system of social support. Psychosocial rehabilitation is one of the components of comprehensive community-based mental health care in these community psychiatric clinics. Psychosocial rehabilitation enables many individuals to acquire or regain the practical skills needed to live and socialize in the community, and teaches them how to cope with their disabilities. It includes assistance in developing the social skills, interests and leisure activities that provide a sense of participation and personal worth. Clients get empowered within therapeutic interactions that value their existence. Community mental health care should not only be local and accessible, but should also be able to address the multiple needs of individuals. It should ultimately aim at empowerment and use efficient treatment techniques that enable people with mental disorders to enhance their self-help skills, incorporating the informal family social environment as well as formal support mechanisms. Community-based care (unlike hospital-based care) is able to identify resources and create healthy alliances that would otherwise remain hidden and inactivated (WHO, 2001).

Hostutler, Taft and Snyder (1999) indicated that nurses have a greater influence on clients' outcome and that they are in a position to change care that they render and promote more satisfying clients' experiences. Findings of this study have shown that therapeutic outcomes might be poor if clients feel that they are not part of the whole treatment process.

Meeting Clients' Expectations

Findings show that there are some aspects that nurses perform differently from what clients expect, but overall results show that clients' expectations in most cases are met. Findings also reflect that not all clients perceive the nurses equally. There is still a gap as to the way in which clients' expectations are met. Clients' perception show that there is still need for improvement that nurses should consider if the interaction that they have with clients is to be of maximum benefit to the clients. For example, clients perceived that nurses do not explain to them the purpose of their visit to the clinic. Findings have also showed that nurses do not involve clients in planning for the next visit. For both of the above examples, clients reported strong need for the nurses to explain the purpose of their visit and to involve them in planning for the next visit.

Phillips (2000) indicated that predicting the factors that affect therapeutic outcomes could aid providers to improve treatment approach. It is necessary that nurses should know what their clients' expectation are regarding clients' interaction with the nurses. Harrington (1999) revealed that failure to meet clients' expectations and needs to keep clients' illness in check results in poor outcomes, namely, relapse into psychosis, or decreased service utilization. Meeting clients' expectations ensures clients satisfaction, thereby improving treatment outcome (Elame, 2001).

Limitations of the Study

- The researcher could not manage to conduct two focus group interviews owing to time factor. The researcher identified that because only one focus group was conducted, that focus group was not truly representative of the population of the study. There was no presentation of other races in the focus group i.e. White and Indian.
- Filling in the questionnaire was done at the clinic. Although there were no nurses present in the room used for the study, the researcher feels that clients' feeling of being at the clinic might motivate bias for positive responses from the clients. The researcher feels that

this type of research could well be done using questionnaires that could be posted to clients' homes. This might help put the clients in a position where they were comfortable and very honest in their responses.

- The nature of the illness of the clients might have influenced their responses. Due to impairment in judgement and thought process clients might have not visualized the implication of false or incorrect responses. It might also be possible that some, due to the nature of the illness, did not understand what the researcher was looking for in the questions.

Conclusion

The findings of the study show that even though clients have reported on satisfactory mental health services delivery (Almeida, 2002) there are still gaps in the way the nurses interact with clients. Clients' perceptions of therapeutic interaction reveal that there is still more that the nurses need to improve in order to ensure high quality client care. Sharon, Dingman, Williams, Fosbinder and Warwick (1999) state that there is need for comprehensive, systematic psychiatric services that will meet clients' needs and expectations. Modrow (1996) indicated that continuity of mental health service utilization largely depends on consumers' perceptions and satisfaction with their interaction with service providers.

According to Boykin & Schoenhofer (1993) to respect and value the uniqueness of another truly is to respond to the wholeness of the other while valuing the heterogeneity of being. A person should not be viewed as a part but as a whole. A client should be assumed to be as complete and as true as the caregiver. This is why during therapeutic interaction with the clients, nurses need to respect, view and relate with clients as whole human beings.

Caring models have emphasised the importance of engendering an environment that values the uniqueness of the individual whilst caring for them from a holistic and therefore humanistic viewpoint (Peplau, 1997; Sherwood, 1997).

Sherwood (1997) anticipates that understanding caring will allow new predictions of therapeutic interventions for the well-being and health of individuals, families, and groups for movement along the continuum.

This present study has demonstrated that it is reasonable to ask clients in community psychiatric clinics about their perceptions of therapeutic interaction. These results suggest that the findings could prove helpful in identifying areas where improvements in the quality of clients- nurse interactions are most needed. Unmet need for treatment among those with the most serious and debilitating forms of mental illness is a growing concern for mental health services researchers, in part because of dramatic recent changes in social welfare policy and mental health care delivery systems (Rosenheck, Armstrong, Callahan, Dea, Del Vecchio, Flynn, Fox, Goldman, Horvath & Rodrigo Munoz, 1998).

This study was very important because direct feedback from care recipients reflects a justifiable and important perspective on the quality of health service delivery. It also helped to determine the unmet need of the clients i.e. clients' expectation not being fulfilled.

Whilst commitment and a duty to care are integral to the nurse -client relationship it must also be acknowledged that both nurse and client bring their own beliefs, anxieties, learning and preconceptions of each other into this interaction (Forchuk, 1997). Caring can be stressful and highly emotive for nurses. Although a nurse may develop a deep bond with a particular client this is not a usual scenario. The nurse cares for a number of clients simultaneously so must rationalise the care given to each client (Dyson, 1997).

Recommendations

Recommendations for Further Research

- Research on client's decision-making process and the reasons for those decisions need to be conducted.

- Research also needs to be conducted on the meaning of some variables like nurses' commitment, nurses' attitudes, and client involvement from the clients' perspective.
- Research should also be conducted on how nurses utilize results of research findings from studies conducted in their fields of practice.

Recommendations for Nursing Practice

- Clients can influence the improvement of care even more effectively if they are empowered to participate in quality evaluation and quality assurance. This can be done through maximum receptiveness to their suggestions, complaints and opinions. Monitoring and evaluation of the quality of service delivery to clients through their views of their interaction with the nurses is integral part of professional practice. For decades, mental health services have been accorded inadequate attention. It is thus the task of present nurses to ensure that they are paying much attention to mental health service.
- Understanding the factors that predict poor treatment outcomes can aid providers in improving treatment approach. Clients' perceptions towards services are aspect of service quality in determining treatment continuity. Provision of quality services may be impeded if clients are not satisfied with services. So it is the duty of nursing to ensure that nurses meet their clients' needs and expectations.
- If patient empowerment does in fact translate to better health outcomes, then understanding the dynamics that foster this may guide the formulation of a more successful health strategy. Ensuring that nurses are equipped with the appropriate skills to encourage mutual nurse-client interaction should provide a solid foundation from which patient empowerment can be nurtured and health outcomes improved.
- Nurses must endeavour to pursue trusting relationships with those for whom they care and their significant others, and also with the wider community. Society expects that they can place their trust in nursing professionals and deserves no less.

- To have continuous improvement of the mental health system there needs to be an evaluation of staff work performance by those people receiving the service and their family members/friends. People who have psychiatric disabilities have valuable knowledge and are excellent partners in such evaluations.

Recommendations for Policy Makers

- Nursing policy makers should ensure that clients participate fully in the quality assurance and evaluation regarding their care. Measures should be put in place that will ensure constant active participation on the part of clients to improve the quality evaluation and assessment.

Recommendations to Nurse Educators

- Within nursing education/ training, nurse -client relationship or environment should be emphasised. In nursing, a nurse client interaction is the most important medium in which nursing care can be delivered to the clients at all times.

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APPENDIX I

DATA COLLECTION INSTRUMENTS

INTERVIEW GUIDE

1. What do you think is supposed to take place at your monthly interaction with the community psychiatric nurses at the clinic?

2. How important is the monthly interaction with the nurses at the clinic?

3. How do community psychiatric nurses behave during this interaction?

4. What are the nurses' attitudes towards you during this interaction?

5. What impact does nurses' attitudes and behavior have on your service utilization?

6. How are nurses expected to behave during the interactions?

7. What do you wish could be done to improve this interaction?

QUESTIONNAIRE

SECTION A

For the following questions, circle the alphabet of the appropriate response, or fill in a response where required.

1. Sex

   A. Male

   B. Female

2. Age

   A. 11- 20

   B. 21- 30

   C. 31- 40

   D. 41- 50

   E. Above 51

3. Marital status

   A. Single

   B. Married

   C. Divorced

   D. Widowed

   E. Other _____

4. Educational background

   A. Primary

   B. Secondary

   C. Tertiary

   D. Other (specify)

Occupation _____

SECTION B

The following statements deal with your perception of interaction with the community psychiatric nurses at the clinic. Indicate how often the nurses use each of these statements.

For the responses 1- never; 2- occasionally; 3- sometimes; 4- always

		1	2	3	4
1	Nurses greet me before interaction				
2	They encourage me to feel free and comfortable				
3	Nurses introduce themselves to me.				
4	Nurses inform me the purpose of interaction				
5	Nurses address me by name				
6	Nurses encourages me to ask question				
7	Nurses asks if I understand whatever we are discussing				
8	Nurses give information about the illness				
9	They give enough time to talk about my problem				
10	Nurses listen to my problems.				
11	They give advice on my strengths and weaknesses				
12	They encourage me to take part in decision making about my treatment				
13	They involve me in planning for the next visit				
14	They show interest in helping me out of my illness and problems.				
15	Nurses encourage my family members always to accompany me to clinic				
16	Nurses involve my family members in decision making about my treatment				

		1	2	3	4
17	Nurses give my family members information about my illness				
18	Nurses treat me and family members with respect				
19	Nurses treat me with confidentiality.				
20	Nurses are receptive				
21	Nurses are supportive				
22	They acknowledge my contributions and opinions.				
23	They encourage discussion about solutions to my problems				
24	They always suggest alternative solutions to my problems.				
25	They encourage continuity in medication use.				
26	They encourage family involvement in my mental health promotion.				
27	Nurses are calm and polite				
28	Nurses use appropriate language				
29	Nurses show empathy				
30	Nurses give hope				

SECTION C

The following statements deal with your expectations of the interaction between you and the community psychiatric nurses at the clinic. Indicate how strong you agree to the following statements.

For the responses A= strongly agree; B= agree; C= not sure: D= disagree; E= strongly disagree.

	I expect nurses to	A	B	C	D	E
1	greet me before interaction					
2	encourage me to feel free and comfortable					
3	introduce themselves to me.					
4	inform me the purpose of interaction					
5	address me by name					
6	encourage me to ask question					
7	ask if I understand whatever we are discussing					
8	give information about the illness					
9	give enough time to talk about my problem					
10	listen to my problems.					
11	give advice on my strengths and weaknesses					
12	encourage me to take part in decision making about my treatment					
13	involve me in planning for the next visit					
14	show interest in helping me out of my illness and problems.					
15	encourage my family members always to accompany me to clinic					

	I expect nurses to	A	B	C	D	E
16	involve my family members in decision making about my treatment					
17	give my family members information about my illness					
18	treat me and family members with respect					
19	treat me with confidentiality.					
20	be receptive					
21	be supportive					
22	acknowledge my contributions and opinions.					
23	encourage discussion about solutions to my problems					
24	suggest alternative solutions to my problems.					
25	encourage continuity in medication use.					
26	encourage family involvement in my mental health promotion.					
27	be calm and polite					
28	use appropriate language					
29	show empathy					
30	give and foster hope					

APPENDIX II

PERMISSION LETTERS

UNIVERSITY OF NATAL
DURBAN CAMPUS

Faculty of Community & Development Disciplines

University of Natal Durban 4041 South Africa

Telephone: Faculty Officer +27 (0)31 260 3271
Student Records +27 (0)31 260 2685
Admissions Officer +27 (0)31 260 1201/2094
Facsimile: +27 (0)31 260 2458
e-mail khanyid@mtb.und.ac.za

RESEARCH ETHICS COMMITTEE

Student: MACKGHAM T. BVUMBWE

Research Title: CLIENTS' PERCEPTIONS OF THERAPEUTIC INTERACTION WITH NURSES AT ESCOVAL HOUSE COMMUNITY ~~P/C~~ PSYCHIATRIC CLINIC

A. The proposal meets the professional code of ethics of the Researcher:

(YES) NO

B. The proposal also meets the following ethical requirements:

	YES	NO
1. Provision has been made to obtain informed consent of the participants.	✓	
2. Potential psychological and physical risks have been considered and minimised.	✓	
3. Provision has been made to avoid undue intrusion with regard to participants and community.	✓	
4. Rights of participants will be safe-guarded in relation to:		
4.1 Measures for the protection of anonymity and the maintenance of confidentiality.	✓	
4.2 Access to research information and findings.	✓	
4.3 Termination of involvement without compromise.	✓	
4.4 Misleading promises regarding benefits of the research.	✓	

Signature of Student: _____ Date: 23rd October 2002

Signature of Supervisor: _____ Date: 04/11/2002

Signature of Head of School: _____ Date: 8/11/2002

Signature of Chairperson of the Committee: _____ Date: 11/11/2002

UNIVERSITY OF NATAL
DURBAN CAMPUS

School of Nursing
Faculty of Community and Development Disciplines
Durban 4041 South Africa
Telephone: +27 (0)31 260 2499
Facsimile: +27 (0)31 260 1543

29th October 2002

The Director,
Department of Health,
KwaZulu Natal Province,
Private Bag X9051,
Pitermaritzburg,
3200

Dear Sir/Madam,

APPLICATION TO CONDUCT A RESEARCH STUDY AT ESCOVAL HOUSE COMMUNITY PSYCHIATRY CLINIC

I hereby request permission to conduct a study at Escoval House Community Psychiatric Clinic, Durban.

I am registered as a student at University of Natal in the School of Nursing, undertaking a coursework Masters degree in Community Health Nursing.

The title of the study is clients' perceptions of therapeutic interaction with nurses at Escoval House Community Psychiatric Clinic.

The following documents are enclosed herein:

- A copy of my research proposal.
- The ethical clearance from the university's ethical committee.
- The research questionnaire.

Your consideration will be greatly appreciated.

Yours faithfully,

MACKSHAM BVUMBWE
(Student)

GUGU MCHUNU
(Research Supervisor)

PROVINCE OF
KWAZULU-NATAL
HEALTH SERVICES

SIFUNDAZWE
SAKWAZULU-NATALI
EZEMPILO

PROVINSIE
KWAZULU-NATAL
GESONDHEIDDIENSTE

NATALIA
330 LONGMARKETSTREET
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Private Bag :X9051
Isikhwama Seposi : Pietermaritzburg
Privaatsak 3200

REFERENCE : 9/2/3/R – Vol.6
ENQUIRIES : Miss N.N.M. Sithole
EXTENSION : 3123

24 DEC 2002

Macksham Bvumbwe
University of Natal
School of Nursing
Faculty of Community and Development Disciplines
DURBAN
4041

Dear Sir/Madam

APPLICATION TO CONDUCT A RESEARCH STUDY AT ESCOVAL HOUSE COMMUNITY PSYCHIATRY CLINIC

Your letter dated 29 October 2002 received on 17 December 2002 refers.

Please be advised that authority is granted for you to conduct a research at Escoval House Community Psychiatry Clinic provided that:-

(a) Prior approval is obtained from the Head of the Institution;

(b) Confidentiality is maintained;

(c) The Department is acknowledged; and

(d) The Department receives a copy of the report on completion.

Yours sincerely

SUPERINTENDENT-GENERAL
HEAD : DEPARTMENT OF HEALTH
NNM/bvumbwe-escoval house1

UNIVERSITY OF NATAL
DURBAN CAMPUS

School of Nursing
Faculty of Community and Development Disciplines
Durban 4041 South Africa
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29th October 2002

The Nursing Services Manager,
Escoval House Community Psychiatric Clinic,
Durban 4001.

Dear Sir/Madam,

APPLICATION TO CONDUCT A RESEARCH STUDY AT ESCOVAL HOUSE COMMUNITY PSYCHIATRY CLINIC

I hereby request permission to conduct a study at Escoval House Community Psychiatric Clinic, Durban.

I am registered as a student at University of Natal in the School of Nursing, undertaking a coursework Masters degree in Community Health Nursing.

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The following documents are enclosed herein:

- A copy of my research proposal.
- The ethical clearance from the university's ethical committee.
- The research questionnaire.

Your consideration will be greatly appreciated.

Yours faithfully,

MACKSHAM BVUMBWE
(Student)

GUGU MCHUNU
(Research Supervisor)

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Durban 4041 South Africa
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Dear Participant,

I am Macksham Bvumbwe a student undertaking a Masters Degree in Community Health Nursing at the University of Natal, School of Nursing. One of the requirements of the degree is to conduct a research study.

This letter serves to ask consent from you to take part in this research study after you have been selected randomly. The purpose of the study is to explore your perception and expectations of the way nurses interact with you at Escoval House Community Psychiatric Clinic. This will help to improve provision of psychiatric services at the clinic.

You are requested to answer questions on your perception and expectation of therapeutic interaction at the clinic. The researcher will be reading questions to you and you are asked to give your response to the questions. The researcher will then write down the responses on the questionnaire. No names will be used in this study. No nurse will have access to the responses that will be given. The researcher will keep all responses. The findings of this study will completely be used for academic purpose. Participation in the study is voluntary. If you decide not to participate, there will be no negative consequences.

It will take approximately 45 minutes for you to complete answering the questions.

Yours truly,

Macksham Bvumbwe.

_____ _____

Participant's signature Date

Thank you for your decision to take part in this study.

UNIVERSITY OF NATAL
DURBAN CAMPUS

School of Nursing
Faculty of Community and Development Disciplines
Durban 4041 South Africa
Telephone: +27 (0)31 260 2499
Facsimile: +27 (0)31 260 1543

Dear Participant,

I am Macksham Bvumbwe a student undertaking a Masters Degree in Community Health Nursing at the University of Natal, School of Nursing. One of the requirements of the degree is to conduct a research study.

This letter serves to ask consent from you to take part in this research study after you have been selected randomly. The purpose of the study is to explore your perception and expectations of the way nurses interact with you at Escoval House Community Psychiatric Clinic. This will help to improve provision of psychiatric services at the clinic.

You are requested to take part in a discussion on your perception and expectation of therapeutic interaction at the clinic. The researcher will be introducing a question to the group and you are asked to actively discuss your response to the questions. The discussion will be tape recorded in order to capture the responses No names will be mentioned in this study. No nurse will be present during the discussion.

The findings of this study will completely be used for academic purpose. Participation in the study is voluntary. If you decide not to participate, there will be no negative consequences.

The discussion will take approximately one.

Yours truly,

Macksham Bvumbwe.

_____ _____

Participant's signature Date

Thank you for your decision to take part in this study.