

**AN EVALUATION OF A REORIENTATION TRAINING PROGRAMME IN  
CHANGING NURSES ATTITUDES TOWARDS THE PROVISION OF MENTAL  
HEALTH CARE**

**BY**

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## Declaration

I Nompumelelo Madi do hereby declare that this dissertation is a result of my own investigation and research and that it has not been submitted in part or full for any other degree or to any other university

A handwritten signature in black ink, appearing to be 'N. Madi', written over a horizontal line.

Signature

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Date

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### **DEDICATION**

This thesis is dedicated to my daughters, Nomaswazi, Mpho and Basetsana thank you for your patience and the positive effect you have on me, putting a smile on my face when I am down. To the father of my children Bassie Maduwane. I would not be here if it was not for your encouragement and support. Khwazi this is for you, you always remind me that anything is possible in life.

## Abstract

The transition from the apartheid rule to a new democracy in South Africa has been accompanied by a vision of a national health care system that is based on the principles of universal primary health care. This vision opens up access to provision of mental health to everyone. This means that nurses, as gate-keepers of primary health care, have had to be trained in identification and management of minor mental health problems that are presented in their community clinics as well as health centres.

For the current study, the need for such training was identified by an intern psychologist placed in one of the clinics in the area of KwaDedangendlale (Valley of a Thousand Hills). His work in the area alerted him to the shortcomings of the nurses in both identification and management of what was perceived to be mental health problems. These shortcomings included the nurses' inability to identify and hence properly refer patients who needed the intervention of a professional mental health specialist. From this, a training programme which also included a reorientation process to deal with negative attitudes that are usually levied against the mentally ill was undertaken.

Reorientation in this context was based on the assumption that prior to training nurses had a particular world view or position towards the provision of health care, which was identified to be biomedical and this training sought to re-orientate them towards the provision of a more holistic care which is inclusive of psycho social aspect of functioning

The follow up to that training and reorientation programme was an evaluation component. This sought to ascertain whether after training, nurses were better equipped to identify and manage mental health problems. Further to that, the researcher sought to identify whether their attitudes had improved, such that they would be willing to deal with patients who presented with minor psychiatric problems.

The objective of the current study is to present results of the evaluation component that was undertaken after training. This evaluation took into consideration both the process undertaken during training and the outcome of the reorientation process itself. Process evaluation focused on what makes a programme successful or unsuccessful. This included *how* the training was undertaken, i.e. manner of instruction etc. Outcome evaluation focused on establishing *how good* the programme was and whether it managed to provide desired outcomes i.e. change in nurses' attitudes. The Physician's Belief Scale (Ashworth, Williamson & Montano, 1984) was used for both the pre and post evaluation of the nurses' attitudes.

The results revealed that before training, nurses had limited knowledge of mental health problems and as a consequence of this limited knowledge they developed negative attitudes towards provision of mental health care. One of the unexpected results of the study was the response of one of the groups of the nurses trained to the integrative manner of instruction. Their response highlighted the importance of understanding the influence of the pedagogy on knowledge transmission and acquisition. Nurses reported to be accustomed to harsh pedagogical methods, used during formal nursing training. This kind of pedagogy was viewed as disempowering, as well as somewhat disrespectful, and hence, the much as the friendly and warm atmosphere presented by the facilitators in the current study was viewed as a welcomed change and an empowering process. Most importantly, one was also alerted to the importance of providing ongoing support to health care professionals after being trained. As Petersen (2000) has cautioned that should there be no additional mentoring or support, nurses would be likely to revert to their usual/old styles of dealing with their patients' problems, given that the training does not necessarily change their environments. They would still be pressured to see large numbers of patients within a limited time period. And because of this, it becomes easier to just prescribing medication than to explore issues that are psychological in nature.

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## CHAPTER 1

### *1.1 INTRODUCTION*

In South Africa the cost of mental disorders, particularly when they are diagnosed late is at least as high as those of substance abuse. In addition to this, there are human costs, for example individual suffering, marital and family disruptions, as well as family breakdown (Science in Africa, 2002)

A report by the Mental Health Information Centre (Science in Africa, 2002) indicates that one in five South Africans suffer from mental disorders severe enough to negatively affect his/her life. The report stated that roughly 25% of all patients presenting at general practitioners' consulting rooms as well as clinics are ill mostly due to psychiatric rather than medical conditions. Unfortunately, these are often misdiagnosed and treated as medical conditions. A number of factors can be attributed to this, and these include an inability, by some practitioners, to properly diagnose psychiatric disorders as well as the fact that most South African people do not necessarily conceptualize their problems as being psychiatric in nature (South African health information, 2004). In addition, a large number of people still attach a great deal of fear and shame towards the mentally ill, possibly because of religious and cultural myths and beliefs. What is unfortunate is that health care professionals are also reportedly not immune to feeling negatively disposed towards mentally ill patients (Brinn, 2000).

Because of this and other problems in the mental health sector, there has been a growing need to provide practitioners with additional training to help them provide a more holistic care that will also address problems which are psychological in nature. A number of researchers (Mavundla, 1993; Uys, 2002) and other institutions of higher learning such as the Community Mental Health Programme (CMHP) heed the call and designed programmes that were for the purposes of training nurses, doctors and community health workers in mental health care. However, one of the biggest problems with programmes that are conceptualised in response to a pressing need is that they rarely include an evaluative component. The current study is thus an attempt to bridge that gap, and will present results from an evaluation of a nurses training

programme that was undertaken to reorientate nurses into providing mental health care. Included in this training were skills in identifying minor psychiatric problems such as depression and anxiety, as well as basic counselling skills, which also included referral to proper services.

## ***1.2 BACKGROUND***

The aforementioned training was provided by the School of Psychology from the University of KwaZulu –Natal (Westville), formerly known as University of Durban Westville. The Community Mental Health Programme (CMHP) a community outreach project, initiated by the school of Psychology, facilitated the process. The overall aim of CMHP was stated as the development of a model for the integration of mental health within the framework of a district health care system.

Intern psychologists who conducted weekly consultations at the Valley of a Thousand Hills clinic identified the need for this training. On their weekly visits to the clinic, they found that there was a general lack of adequate referrals from the nurses, with cases involving assessment for disability grants being the only cases forwarded to them. This lack of referrals was attributed to the nurses' limited skills in identifying mental health problems. An attempt was thus made to provide these professionals with integrated and comprehensive mental health training, involving identification, management and referral of patients with mental health problems.

During the period spanning between 2001 and 2002, sixteen nurses from different clinics in the Valley of a Thousand Hills area participated in the training. This limited number was influenced by a shortage of nursing staff in most clinics. In order to ensure that the training did not interrupt services, the number of participants from each clinic was determined by the number of staff each clinic had. Two groups were trained at different times, each consisting of eight nurses. Only nurses without previous training in psychiatry were considered for the training.

### **1.3 AIMS**

The present study seeks to provide the results of an evaluation conducted to assess the effectiveness of the aforementioned training programme. This was a twelve- week training programme, which sought to re-orientate nurses towards dealing with acute mental health problems. These problems were those identified as most common among the patients who presented at the nurses' respective clinics and health centres. The aim of this evaluation was two-fold.

Firstly, it sought to provide an ongoing monitoring and evaluation of the process followed in the implementation of the training programme on offer.

Secondly, the aim was to assess whether there were any changes in the nurses' attitudes towards the provision of mental health care following the acquisition of new information and skills.

### **1.4 OBJECTIVES**

The objective of the study was to evaluate whether, following training, was there any significant changes in the nurses' beliefs, attitudes and perception towards the provision of mental health care.

### **1.5 HYPOTHESES**

The researcher hypothesized that following the training, the nurses' attitudes would change for the better and that they would be reoriented to positively view mental health patients and feel more confident in providing mental health services.

## **CHAPTER 2**

### ***2.1 INTRODUCTION***

Rossi and Freeman (1993) believe that it is essential to start any evaluation that deals with process issues with a description of the programme being assessed. A full description of the programme assists the reader in understanding the study, and most importantly the results emanating from it. They further stated that it is necessary to give a detailed account of the training programme as it assists in monitoring the programme, and keep track of the subsequent implementation. Without adequate programme monitoring it is impossible to estimate if resultant treatments are efficacious. This chapter will therefore begin by providing a detailed description of the nurses training programme that was subsequently evaluated.

Before the training began, an analysis of needs was conducted to ascertain what the nurses thought were important areas and skills to be focused on during their training. This is where they identified mental disorders that they usually encountered in their respective clinics, which they felt they were less equipped in dealing with. Thus, training had to be tailor- made to focus on such weaknesses.

### ***2.2 TRAINING PROGRAMME***

According to Freeman (1992) mental health has always been marginalized and often separated from physical health. Because of this, the need for training nurses in rendering holistic care is always advocated.

The training programme included four phases.

#### *Phase One*

The first phase focused on needs analysis and an exploration of the nurses' expectations. This phase was important because the facilitators needed to identify problems, which the nurses were faced with in their respective clinics. The needs analysis was going to assist in designing a relevant and practical programme

concerning what the nurses reported, as they were regarded as highly knowledgeable in relation to their working environment.

#### *Phase Two*

The second phase involved a pre evaluation using a Physician Belief Scale (Ashworth, Williamson and Montano, 1984) and vignettes that were developed specifically for the programme. To ascertain what the nurses knew i.e. their knowledge base, they were also shown a video clip with different disorders, which they were asked to identify. They were further required to give reasons for their chosen diagnosis (symptoms) and then provide a recommendation for proper management. The Physician Belief Scale (Ashworth, Williamson and Montano, 1984) was used as an initial assessment tool so as to track any identifiable changes after the training was complete.

#### *Phase Three*

The third phase constituted the beginning of the actual training. One of the outcomes of the pre- evaluation component was the identification of the fact that nurses tended to use the bio-medical approach incessantly. This was as a result of their medically oriented training. This then propelled the facilitators to attempt and re-orientate them towards the bio-psycho-social framework of understanding illness and disease. Further to this orientation process, nurses also needed training in basic counselling skills. These were deemed necessary, as they would help facilitate proper identification and subsequent management of the case, even if this entailed referral to a specialist.

#### *Phase Four*

The fourth phase was the post evaluation. After the last session nurses were asked to again complete the Physician Belief Scale (Ashworth, Williamson and Montano, 1984). This was to be used as an index for comparison i.e. the scores from the post evaluation were to be compared with those prior to training. In addition to this, they were also asked to complete an evaluation form that sought to assess their general perception of the training as a whole.

### **2.3 COMPONENTS OF THE PROGRAMME: CONTENT**

During the needs analysis nurses reported that they lacked skills and knowledge in identifying and managing mental health problems. They listed the following disorders as areas of concern and wanted the training programme to provide focus in these areas. Of interest is the fact that similar disorders were identified by a different group of nurses from the same area when Petersen (2000) provided her reorientation training programme.

- Depression
- Anxiety Disorders
- Post Traumatic Stress Disorder
- Rape
- Substance Abuse
- Delirium
- Dementia
- Intellectual Impairments e.g. Mental Retardation
- Epilepsy

The training included (i) firstly exploring problems with a biomedical approach which was currently used; (ii) using a meaning – centred approach to understanding patients' explanatory model of illness, (iii) skills for holistic care; relationship between the nurse and the patient and process of holistic care (Petersen, 2000) (iv) Providing a critical link between the biomedical framework and the meaning –centred approach.

### **2.4 DEFINITION OF THE IDENTIFIED PSYCHOLOGICAL PROBLEMS**

Below is a list and concise definitions of some of the disorders that were identified by the nurses. The definitions provided are based on the American Psychiatric Association (APA, 1994) and not those provided by nurses. The reason for this is that the focus of the study is on the evaluation component of the training process, and it is not the intention of the researcher to defocus from that.

It is also important to report that the nurses admitted being aware that some of the problems they encountered were psychological in nature, but because of their lack of proper skills, they opted to use a bio -medical approach in dealing with them i.e. prescribing medication.

#### **2.4.1 Depression**

Depression may be defined as a persistent disturbance of mood that is characterized by sadness or irritability, hopelessness or aggressiveness, loss of interest in previously enjoyed activities, poor appetite, weight loss, sleep disturbance, loss of confidence and self-esteem (APA,1994). Satorious (1978), Swartz (1998) have indicated that in developing countries depression is usually presented as somatic complaints. The training with the nurses highlighted this fact, and some of them were able to identify, albeit in retrospect, some of their repeat patients, who seemed not to be responding to medication, as possibly having depressive symptoms.

#### **2.4.2 Anxiety Disorders**

Anxiety can be defined as “a state of feeling worried, apprehensive, or nervous that is much more intense than the external situation warrants”. Anxiety acts as a safeguard to keep us from ignoring danger and have an adaptive functioning. It is only called anxiety disorder, when overwhelming anxiety disrupts social functioning or produces significant distress (APA, 1994). Although not many cases had been previously seen by nurses in their clinics, they believed that since there is reported comorbidity between depression and anxiety, it was important to at least have information so as to know when and how to refer.

#### **2.4.3 Post Traumatic Stress Disorder**

According to APA, (1994), Post Traumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event. The event might involve actual or threatened death or serious injury or other threat to the physical integrity or witnessing an event that involves death injury, or threat to the physical integrity of

another person, or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by family member or close associate. The person's response to the event involves intense fear, helplessness or horror. With the history of violence, poverty and abuse (physical or sexual) in the community, nurses felt that they might be more equipped to help if they had basic information on any issues related to trauma, and not just the DSM-IV (APA, 1994) classification.

#### **2.4.4 Rape**

Rape is defined as sexual intercourse with a woman or girl-child without her consent. The law limits the definition of rape to penetration of the vagina by the penis. When a woman is forced into sex that does not include sexual intercourse, the law describes this as indecent assault (APA, 1994). South African Law defines rape as a forcible act: this means that the act is "accomplished by force or threats of force against the victim or a third person, such threats being express or implied and must place the victim in reasonable fear that he, she or a third person will be subjected to violence, detention, duress or psychological oppression". This act is the penetration of the vagina, the anus or mouth by the penis, or of the vagina or anus by other object. In this context, it includes penetration, however slight, of the vulva, anus or oral cavity, by the penis and sexual penetration of the vulva or anus is not limited to the penis (South African Human Rights Commission, 2003). This definition is discriminatory because it does regard rape only if there is penetration; it also does not cater for man on man rape or female on female rape.

Again with rape, nurses felt that they needed more information of how to deal with the patient when presented in their clinics, particularly the legal aspects, so as not to "mess up" important evidence.

#### **2.4.5 Substance Abuse**

Substance abuse is a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substance. There may be repeated failure to fulfil major role obligations, repeated use in situations in which it is physically hazardous, multiple legal problems and recurrent social and

interpersonal problems (APA, 1994). Like any community with high levels of poverty, alcoholism and/ abuse of substances was reported to be quite high. Nurses reported to always finding themselves at odds with how to help their patients, especially those who were secondary victims of substance abuse.

#### **2.4.6 Delirium**

Delirium disorder is characterized by a disturbance in consciousness (awareness of immediate environment) and in thought processes that develops over a short period of time (APA, 1994). Nurses reported not seeing many patients who presented with such symptoms. However, they felt the need to include this condition as it was perceived to present similarly as other cultural conditions that had been reported in the community. A cited example of this was *ukuhayiza*, which is a condition characterized by hysterics, falling down and subsequent loss of consciousness. The discussion was to therefore focus on identifying similarities between these two conditions, if any, and also on the emphasis on incorporating the patient's explanatory models in understanding illness and disease.

#### **2.4.7 Dementia**

Dementia forms part of degenerative disorders. These disorders are characterized by several deficits in cognitive processes without disturbance in consciousness. A diagnosis of dementia also requires that one presents with deficits in memory (APA, 1994). The nurses felt that because their clinics cater for a number of elderly people, it would be important for them to be able to distinguish between the normal aging process and dementia induced memory losses. Over and above that, there were ongoing concerns about younger patients who were presenting with symptoms, which mimicked early dementing processes that one would identify in the elderly. These were reported to be symptoms of HIV/AIDS related opportunistic diseases that affected the cortex. The objective was to identify these conditions as early as possible and provide appropriate interventions.

#### **2.4.8 Intellectual Impairments, e.g. mental retardation**

Mental retardation is a developmental disability that first appears in children under the age of 18. It is defined as an intellectual functioning level (as measured by standard tests for intelligence quotient) that is well below average and significant limitations in daily living skills (adaptive functioning) (Batshaw and Shapiro, 1997). As it was reported in the section highlighting the background of this study, most patients, especially children who were initially referred to the intern psychologist were those presenting with cognitive impairment that was associated with mental retardation. As parents were mostly interested on how to apply for disability grants, nurses felt that the onus was on them to gain more information in order to be able to educate caregivers and perhaps assist with rehabilitation.

#### **2.4.9 Epilepsy**

Epilepsy is a condition characterized by recurrent seizures that may include repetitive muscle jerking called convulsions. A seizure is a sudden disruption of the brain's normal electrical activity accompanied by altered consciousness and/or other neurological and behavioral manifestations (Tran, 2004). Nurses reported seeing quite a number of epileptic cases and some of them have been to training programmes focusing on identification and management of epilepsy. The nurses wanted more information about epilepsy, especially on how to differentiate epilepsy from mental retardation. The nurses reported that most parents who came to the clinic had children with severe cases of epilepsy, which was comorbid with mental retardation. They found that the parents' interests were solely on applying for disability grants. The biggest problem experienced by nurses is the lack of proper resources in the area, where they could refer these children for some form of intellectual or cognitive stimulation.

### **2.5 TRAINING METHOD**

Prior to the first session, which focused on counselling skills, nurses were asked to do a role-play where they would pretend to be counselling their colleagues. This was done in order to assess their basic skills before any input from the facilitators. It was

here that it was identified that for nurses, counselling meant giving advice to their clients/ patients rather than exploring available options with them, which was more of the style adopted by facilitators. This helped the facilitators in identifying how they were to attempt to re-orientate the nurses into adopting a more client-centred approach.

The structure of the training was designed in such a way that all participants were encouraged to take active part in the session. This was achieved through small groups' discussions and or pairing nurses with each other. Vignettes of cases were often used to facilitate discussions. Participants were introduced to the topic of that particular session and asked to define the disorder to be discussed. Issues relating to identified causes of the disorder and possible intervention strategies also formed part of the discussion. Following this, facilitator would then address any myths and misconceptions that emanated from the overall discussion, while providing an accepted definition and symptoms of the disorder, i.e. using the American Psychological Association's manual as a guide (APA, 1994). Possible management strategies were also discussed and these included appropriate referral facilities. In addition to this, Cultural Explanatory Models of disease and illness (Katon & Kleinman, 1980) as reported by patients were also explored.

The method adopted for this particular training session was the problem - based method. This method encourages students to be responsible for their own learning, the teacher or tutor functions as a facilitator of learning rather than an expert dispensing knowledge (Gordon, Rogers, & Comfort, 2001; Maxwell, Bellissimo, & Mergendoller, 2001; Stepien & Gallagher, 1993; Torp & Sage, 1998). Accordingly, the method encourages creativity, helps develop problem-solving skills, and promotes critical thinking.

Hlongwa (2003) states that choosing an appropriate method of teaching when providing training is very important. He postulates that teaching methods play an important role in the provision of holistic care. This is supported by Bailey & Smith (1999). They argue that problem -based learning is an appropriate method of education to prepare nurses in providing comprehensive health care. They further state that problem based learning aims to develop critical thoughts, analytical abilities

and self – directed learning and synthesis of knowledge and skills within the context of professional practice.

### **3 CHAPTER**

#### ***3.1 THEORETICAL FRAMEWORK***

##### **3.1.1 EVALUATION RESEARCH**

Evaluation research theory will be used as the basis for understanding the process undertaken in this study. According to Bowling (1997), evaluation research is a rigorous and systematic collection of research data that is usually utilised to assess the effectiveness of organizations, services and programmes in achieving their predefined objectives. This not only tracks the effectiveness of the programme financially, but also in terms of human and social development. Its main goal is to answer questions regarding social programmes and their development. In this study, the question to be answered is whether the reorientation training programme provided for nurses was effective in improving their skills and subsequently changing their attitudes towards the provision of mental health in primary health care.

The goal of evaluation research is to contribute to the improvement of social conditions by providing scientifically credible information and balanced judgments to legitimate social agents regarding the effectiveness of interventions intended to provide social benefits. It is believed that the skills obtained by the nurses from the training will not only positively affect their attitudes towards providing care where mental health problems are indicated, but the success of the training will provide credibility for recommending similar training programme in other areas. Providing a continual evaluation of the implementation process also becomes vital in furthering the ends of the specified aims.

Recommending similar training programmes to other areas will be challenging as it will need results that will not only indicate positive outcome but also indicate the positive impact the training had on the nurse's attitudes towards provision of mental health care. Meaning that the evaluation results should go beyond the training programme and look at how results fit into National Strategic Plan (NSP). The results should be linked to the broader Primary health care's NSP and linked to the strategic plan indicators mainly Outcome level and impact level. An outcome indicator will then show to what extent the project has achieve its planned outcomes in regards to

NSP and an Impact indicator will show to what extent the project has contributed towards its goals of improving access to mental health for everyone and how that links to NSP. This could have buy-in from the Department of Health and thus strength recommendation for the training.

This poses a challenge of identifying the “real” outcome of the study as the study will only identify the immediate outcome. Another study could have been conducted after 6 months or year to evaluate long term effects of the training programme. Other challenges in assessing outcome and impact with regard to the health sector is that the outcome indicators in the health sector tend to move slowly and the surveys that produce them are conducted only after a few years, which poses a challenge in identify the outcome of the training programme but mainly identifying the impact of the programme in the health sector.

Evaluation research draws on many different theories of social change, including attitudinal theories such as the Expectancy-Value Model (Lipsey, 2000). A theory for social change arises from a conceptualisation of the way in which the intended social improvements will come about because of the actions implicit in a programme's activities, or those that may be sometimes explicitly articulated. Such theories depend on assumptions related to the aetiology of the problems that the programme attempts to address, and the mechanisms by which change can be induced. In the current study, the researcher postulated that negative attitudes in nurses are the result of lack of knowledge regarding mental illness. For this reason providing knowledge and orientating them in holistic care might lead to a change in their attitudes and positively influence their contribution to the provision of mental health care.

Explanation of the effects of the programme, or lack thereof, requires a theoretical basis of the way that such an intervention is presumed to bring about the intended effects/ change. It is such a theory that can serve as a framework for organizing and interpreting information emanating from both the descriptive and experimental components of the research (Bowling, 1997).

The theory chosen by the evaluators gives them a road map that directs attention to what stakeholders view as the critical programme activities, the intended outcomes,

and the presumed relationships between those activities and the intended outcomes. Its purpose is to identify the important variables and relationships that should be studied, and furnish a conceptual framework for organizing and interpreting the results emanating from it.

A central concept to be borne in mind in the discussion regarding the theory to be used in the current study is that of change. The key issue is explaining how problematic social change conditions are transformed by the interaction of the programme with those conditions. The concept of change seems especially promising for further development of the explanatory aspects of outcome evaluation and warrants additional attention.

Assessing effects of any intervention is inherently an investigation of change, in particular the changes in social conditions brought about by the intervention, which itself represents a deliberate change in the social environment. From this perspective, one of the more interesting trends in outcome evaluation is increased attention to change as an important concept for understanding intervention and its effects. Two domains of change that correspond to the common distinction between programme action and the mechanisms through which that action produces social changes are important.

The first domain focuses on considering the matter of organisational change. Evaluators investigating whether a programme has been adequately implemented, or attempting to assist programme managers improve its functioning, must inevitably theorize about organizational change and the factors that inhibit or facilitate it (Chen, 1990; Lipsey, 1997; Weiss, 1997).

The second domain of application of change theories relates to the casual process through which desired change in social condition comes about as a result of programme action. Thus, some set of cause and- effect links is presumed to connect the intervention to its intended effects.

According to Lipsey (2000), programme change involves a sequential assessment in which the first step is to determine whether the programme implementation has

reached some criterion level. The first stage of the analysis focuses on ascertaining whether the intervention has been applied or delivered as intended at programme or organizational level. In the current study, analysis will first be based on the process of implementation of the programme, which will be discussed in detail later in the study. Once this is established, the analysis then turns to the observed change among those receiving the service. In this study, the change, which was monitored, was a change in attitudes towards the provision of mental health. The linkage between programme implementation, programme theory, and outcomes is chiefly a logical one. This therefore leads to an assumption that if the programme in the current study was implemented as intended and effects were observed, then the programme theory is presumably supported.

## **3.2 DEFINITIONS OF TERMS**

### **3.2.1 Rereorientation**

This concept needs to be understood as emanating from the word orientation or to orientate which means a cognitive process/ specific position / a conceptual point of view that yields a characteristic disposition to react to events. The Penguin Dictionary of Psychology (Reber, 1985) defines orientation as a particular world-view or perspective on life, philosophy, science etc. In this context, this means that prior to training nurses had a particular world view or position towards the provision of health care, which was largely biomedical and this training sought to re-orientate them towards the provision of a more holistic care which is inclusive of psycho social aspect of functioning.

### **3.2.2 Attitudes**

Research has recognised that attitudes are relevant in understanding and predicting social behaviour (Ajzen, 2001). Among social psychologists, there are three Mainstreams, or dominant school of thought

The one approach views an attitude as a combination of affective, behavioural and cognitive reactions to an object. According to this view, attitudes have three

components. Firstly, attitudes are in part, an affective reaction. To have an attitude about something is to evaluate it favourably, unfavourably, or with mixed emotions.

Secondly, attitudes have a behavioural component, in that they predispose people to behave in a particular manner towards an object.

Thirdly, attitudes have a cognitive component, how one feels about an object depends in part on beliefs about that object. This is in keeping with Allport's (1935) original view of attitudes. He stated that an attitude comprises three parts, the affective behavioural and the cognitive components. According to him, the affective component is largely emotional (like/ dislike), the behavioural component is the overt behaviour arising from internal attitudes, and the cognitive component is the storage component where information about the attitude object is organised. De Vries & Mudde (1998) on the other hand believe that attitudes refer to beliefs an individual holds about the pros and cons of behaviour.

Attitudes as a construct continue to be a major area of focus in theory and research among social and behavioural scientists. Research has revealed that an attitude represents a summary of a psychological object that is captured in attribute dimensions that are in binary opposition such as good /bad, harmful/ beneficial, pleasant /unpleasant, likable /dislikeable (Eagly & Chaiken, 1993).

As early as 1935, Allport defined an attitude as a mental and neural state of readiness, organised through experience, exerting a directive or dynamic influence upon the individual's responses to all objects and situations with which it is related. This idea that attitudes are 'organised through experience', in itself implies that an attitude is never neutral or biologically determined, but rather it is socially constructed through various socio-cultural structures, such as parental teachings, media, cultural customs and rituals. This assumes that people are not born with their attitudes, but acquire them through the socialization process

Fishbein and Ajzen (1975) suggested that it is useful to use the term "attitudes" to refer only to a person's overall evaluation of an entity (in our case mental illness), and reserve the term "belief" for the cognitive component. This view helps in

understanding change in attitudes. If the term belief is associated with the cognitive component, it might suggest that people can change their beliefs when they gain more knowledge. This will be reserved in the cognitive component and a change of belief might influence the way people evaluate situations or entities. This suggests that nurses' attitudes towards the provision of mental health are influenced by their beliefs. As mentioned earlier, beliefs are associated with a cognitive component and if nurses are provided with information that they can store in their cognitive component, such a process can change their beliefs regarding the process of providing mental health care and therefore their attitudes.

### **3.2.3 Measuring attitudes**

One of the major problems researchers have in trying to measure someone's attitude is that they can only infer its existence. It is very difficult to infer a person's attitude from watching their behaviour. One way in which researchers have used to determine people's attitude is to ask them. This they did by placing their responses on a bipolar evaluative continuum. This means that it is assumed that people's attitudes can be located on an evaluative continuum at any position from extremely negative to extremely positive, including a neutral point. It is also assumed that people who evaluate an attitude object favourably are likely to associate it with positive attributes and unlikely to associate it with negative ones. Similarly, it is assumed that people who evaluate an object negatively are likely to associate it with negative attributes (Eagly & Chaiken, 1993). This line of reasoning would then lead to assumptions that nurses have negative attitudes towards provision of mental health care because their evaluation of it was negative, and it is hoped that after training nurses would evaluate mental health positively. This would in turn lead to a positive change.

## CHAPTER 4

### 4.1 LITERATURE REVIEW

#### 4.1.1 INTRODUCTION

This chapter presents a review of relevant literature on training programmes that attempted to change nurses' attitudes towards provision of mental health. It examines the influence of training on attitudes towards mental illness, the importance of integrating mental health into primary health care, which will include training nurses in mental health care.

Petersen, Parekh, Makhale and Ngwenya (1996) conducted a study in the Halley Stott Primary Health Care Clinic (PHC), in the Valley of a Thousand Hills area in KwaZulu Natal, which is where the current study was also based. Their study was focused on the prevalence and nature of psychological disorders. They discovered that half of the patients attending the Health Centre potentially suffered from psychological disorders. These symptoms were however presented as body aches and pains. They, therefore, concluded that these presenting symptoms created difficulties for nurses who were not trained in identifying psychological disorders. This difficulty is assumed to be the reason why these disorders were treated as medical conditions.

Besides the lack of skills, researchers such as Mavundla (1993) have mentioned that there are other factors that influence nurses' inability to identify psychological disorders. These include general negative attitudes towards provision of mental health, which in turn is influenced by their lack of confidence, as they are aware that they have insufficient knowledge/ training in this particular area.

In 1993, Mavundla conducted a study to assess nurses' attitudes towards mental illness in a general hospital. The results obtained in Mavundla's study suggested that very few nurses had positive attitudes towards mentally ill people. They were also found not to be inclined to providing care for such patients. She also found that most negative attitudes towards mentally ill people were not due to demographic factors

like age, rank and marital status of respondents but were a result of insufficient knowledge that nurses generally have towards mental illness. This led this researcher to believe that there is a relationship between knowledge that people have about mental illness and their attitudes towards it.

In her study, Mavundla also made reference to comprehensive psychiatric training programme that was introduced in South Africa in 1986. The aim of this training was not only to impart knowledge but also to try and improve nurses' attitudes towards mental illness. Unfortunately, this was a specialised programme for only those nurses who wished to study psychiatry as an additional module, which means that in practice most nurses did not have the opportunity to try to reap from its benefits. Unfortunately Mavundla did not provide any information on whether there was any evaluation component to this study as this would have been of use for comparative purposes.

Previous studies have shown that providing health workers with training in mental health can significantly improve their knowledge of and attitudes towards the provision of such care. One such study conducted by Lee, Thom, Zwi, Clews, Sibeko, Mahlo & Masondo (1997) for the World Health Organization (WHO) Collaborative Mental Health Group found that when the health workers who had been previously trained were assessed after 18 months in Mental Health Care, they showed significant improvement in their knowledge and attitudes towards mental health problems and management.

Hugo (2001) suggests that mental health workers need to be aware of their attitudes towards their clients, as it is believed that if nurses did not have negative attitudes towards mental health problems, they would not overlook them or see them as a burden, but rather as part of their job. This would at least make the social environment amenable to recovery.

The importance of the patients' social context was endorsed in a study conducted by Canter & Shoemaker (1960) which showed that the well-being of mental patients is, to some extent, influenced by the social contexts. These researchers argued that mental patients are sensitive to and are influenced by the attitudinal atmosphere

created by health workers. They believe that a favourable attitude of health professionals towards mental illness is likely to help reduce the stigma attached to mental illness thereby encouraging the successful reintegration of former mental patients into society. This leads to the conclusion that in order to make sure that the WHO's definition of health is promoted, training should also include attitudinal changes.

#### ***4.2 Integrating Mental Health into Primary Health Care***

The Primary health care system places equal emphasis on the physical, mental and social well being of all human beings. Its underlying philosophy is the provision of health care based on the Alma Ata Declaration of the World Health Organization (1978), which entails comprehensive care including preventative, curative, promotive and rehabilitative care within the context of, amongst others, community participation and intersectoral collaboration.

According to Goldberg & Huxley (1992), primary health care services have the potential to make a significant contribution to the care of people with mental health problems, as the bulk of mental health morbidity is dealt with at a primary level of care. It has been observed that in South Africa, nurses in community or Primary health care clinics generally provide this service. As much as these service providers provide direct care for many people, they also act as the point of entry for referral to specialist services. To this end, it is important that nurses are equipped with the skills to identify and manage mental health problems and to be able to deal with minor mental health problems, which might not need specialist attention.

According to Kriegler (1992), psychological services are inadequate or non-existent for the majority of South Africans. What does exist is almost exclusively aimed at the custodial care of the mentally ill. Freeman (1992) states that approximately only 20% of the population can afford private care, while 80% of the population is dependent on the public and welfare sectors. However, only 10% of registered psychologists are employed in hospital or state posts in order to serve the latter 80% of the population. This means that there is a greater need to train nurses in identifying and managing

minor mental health problems so that everyone has access to mental health intervention.

Political change in South Africa has also led to change in the health system. According to Petersen (2000), the transition from the apartheid rule to a new democracy in South Africa has been accompanied by the vision of a national health care system based on the principle of universal primary health care. This vision is now firmly in place in the form of a White Paper for the Transformation of Health Systems in South Africa. This opens up access to provision of mental health to everyone, which therefore encourages such studies as the current one to try and equip nurses with skills to maintain the vision of the principles of universal primary health care.

The World Health Organisation (WHO) also promotes the integration of mental health into primary health care. This involves the orientation of primary health care personnel into promoting holistic care, the aim of which is to promote the WHO's definition of health as a "state of physical, mental and social well-being, and not merely the absence of disease or infirmity" (World Health Organization, 1990)

For the past two decades, researchers such as Harding, Busnello, Cliement, Diop, El-Hakim, Giel, Ibrahim, Ladridro-Ignacio, & Wig, (1983), Murthy (1992), Petersen (2000), and Pillay (1999) have been advocating the integration of mental health into Primary health care. This broader policy shift to Primary health care led to a change in the health care system in that Primary health care which encompasses a holistic view of health, now acknowledges the social and emotional aspects of ill health as well as embracing prevention, health promotion and community participation (Petersen, 2000). Within this philosophy, mental health is thus understood to refer not only to psychiatric problems, but is conceptualised more broadly as to include non-psychiatric mental health problems and the promotion of mental health (WHO, 1990).

The adoption of a holistic approach at the primary level of care by primary health care workers would ensure that the majority of South Africans, both in rural and urban settings have access to comprehensive health care services. As most South African citizens cannot afford specialist services, the inclusion of mental health within

Primary health care would ensure easier access to mental health care for the less fortunate, and assist the majority of citizens to attain healthy lives both physically and mentally.

According to Uys (2002), there are two major health care movements that exert an influence on mental health nursing. The first is a move towards Primary health care and the second is the focus on psychosocial rehabilitation in community psychiatric care. She further states five advantages of including psychiatric mental care in Primary health care:

(i) Nurses and other health professionals in a community setting would learn to understand mental health better, enabling them to be positive role-models in their communities, thereby combating the stigma attached to psychiatric patients and their families.

(ii) Early detection and treatment in Primary health care settings would be possible, so that treatment would cause the least possible disruption in the functioning role of the patient.

(iii) Should hospitalisation sometimes be necessary, there would be a local professional involved in the admission procedure. This would increase the involvement of the family and local social networks in the treatment of the patient. It would also provide the hospital team with information regarding the patient and his /her situation and in this way improve treatment.

(iv) Rehabilitation would also be possible within the community in which the patient lives. At the moment, many patients, particularly in black rural areas or informal settlement areas, have no address to which families can be traced. They can therefore not be discharged, and consequently spend many years in hospital while they could have been living with their families.

(v) The availability of staff trained in psychiatry in community clinics has the potential to improve the community's understanding of mental illness and to combat the stigma attached to sufferers.

### *4.3 The need for Training Nurses in Mental Health Care*

In view of the shortage of trained mental health workers in South Africa, some researchers such as Armstrong (1987), Petersen (2000) and Uys, Sokhela & Mkize (1996) believe that training of Primary health care workers in diagnosis and management of minor psychological disorders is essential. It has also been suggested that mental health specialists might be more effectively deployed in a training and support capacity. In addition, they can also provide a back-up referral service. They suggested that the first step towards developing primary mental health care and comprehensive care for all is the “decentralization of responsibility for mental health care to front-line personnel”(p.341).

These researchers believe that, in theory, nurses should be able to provide a degree of mental health care. The minimum requirements for registration as a nurse include “orientation” to diagnostic and therapeutic communication skills, group skills, crisis intervention skills and stress management skills. As these requirements have only been recently introduced, most nurses do not have them.

Petersen (2000) found that, although nurses understood the need for holistic care, they only provided biomedical care. She reported that when these nurses were faced with patients with psychosocial problems, they either avoided discussing the problem or coerced the patient into adopting a biomedical explanatory model of disease. She explained this as resulting from the nurses’ limited skills in identification and management of psychosocial problems.

These conclusions have been supported by Littlewood (1989), May (1995) and Strasser (1999). These researchers identified similar difficulties in their research with nurses. They argued that although primary nursing practice is based on holism underpinned by the bio- psychosocial model, in practice it is characterized by a biomedical approach to patient care. The causes of mental health problems likely to require intervention are often identified as having an anatomical or physiological manifestation. This refers to what Katon and Kleinman (1980) described as dealing with the disease and not with the illness problem.

This is problematic since studies have shown that 50% of patients who visit primary care providers have psychological complaints (Ashworth, Williamson & Montano, 1984). Ashworth et al. further stated that, in spite of a documented need and additional training, many Primary health care providers have been found to have difficulty with psychosocial diagnoses and treatment.

The problem with the biomedical view is twofold.

Firstly, it does not take into account how the patient perceives and understands his/her illness, which Katon & Kleinman (1980) defined as a “patient’s explanatory model”. Secondly, understanding the problem as only a biological malfunction of the body does not take into consideration the social and psychological aspects of the illness, in relation to their aetiological effects.

Understanding the patient’s explanatory model is important as it reveals the patient’s understanding of the cause of his/her illness; its pathophysiology, the expected course and prognosis, and the treatment that s/he believes will or should be administered. In this regard, the biomedical view does not incorporate an understanding of the meaning the illness has for the patient (Katon and Kleinman, 1980).

Rajendral, Bhana and Pillay (1996) provided a variety of reasons for the poor detection of mental illness by most health practitioners:

(a) Patients mostly report somatic complaints.

(b) Biomedical training of Primary health care workers in which psychological factors are not adequately recognised for the role they play in the development of poor health; and

(c) Heavy case load and limited consultation time.

These are legitimate concerns, which will need to be addressed if the system is to be improved.

Petersen (2000) mentions that it is easy to treat serious mental illnesses such as schizophrenia from a biomedical perspective, as medication are one of the most common treatment strategies. However, in Primary health care, common mental health conditions such as anxiety, depression and behavioural problems have been found to be ignored and mistreated because of the lack of resources and proper training in the identification and management of these disorders. These disorders present at Primary health care level as physiological complaints, which, because of lack of skills to identify and treat them, are often treated with analgesics. This is in keeping with the Nolan, Murray & Daddlender (1999) findings. They discovered that many nurses felt unprepared for this type of work and were reluctant to become seriously involved with the clients in case they uncover problems they were unable to cope with. Lack of access to appropriate educational support is identified as the main problem currently faced by nurses, alongside poor inter-professional relationships with other mental health personnel.

In line with Rajendral, Bhana & Pillay (1996), Petersen (2000) has also argued that short visit times are one of the important constraints on the diagnosis and treatment of health problems in Primary health care. Goldeberg, Jenkins, Millar and Faragher (1993), however, dismisses this argument and contends that the identification of psychiatric problems depends mainly on the first few minutes of consultation and that longer visits do not ensure a better diagnosis. This leads to the assumption that skills to identify psychiatric disorders are more crucial than the time allocated for each client.

Although other researchers such as Littlewood, May and Strasser (in Petersen, 2000) argue against the utilisation of nurses in the provision of holistic care, Nolan et al.(1999) and Armstrong (1987) found that nurses would be a great asset in providing a mental health service in Primary health care, as they are the ones who are most accessible to patients. Uys (2002) expresses the same sentiment. She believes that the training nurses have in mental health will result in specialized knowledge and skills becoming widely available. This would ensure that adequately trained people are available to provide psychiatric care.

Bradshaw, Ewers, Ewers and McGovern (2003) believe that training nurses in mental health and providing more knowledge regarding mental illness leads to more understanding about the nature of mental illness. They further argue that this makes it possible for nurses to deal with mental illness in a holistic way.

These problems, which have been highlighted by South African researchers, are not endemic to our country. As Nolan et al. (1999) have indicated over a third of people presenting in primary care in the UK have mental health problems associated with some degree of disruption in their lives. They further argued that by far the largest professional groups currently involved in mental health care in Primary health care are nurses.

These researchers discovered that although nurses were willing to assume responsibility for people with mental health problems, many of them admitted that they were not fully prepared for this new dimension of their work. They recognised that they were learning on the job how to cope with such patients, and felt that they needed to improve their counselling skills in order to help patients with mental problems. It is now becoming obvious that training programmes are needed to help Primary health care workers to manage the complexities of caring for patients with mental health or combined medical and psychiatric problems. Most of the studies conducted in the UK indicated that this is a global problem, and not only prevalent in South Africa.

Atkin, Lunt, Parker & Hirst (1993), Dyer (1997), and Golderberg et al (1996) (in Nolan et al., 1999) also discovered that nurses were aware that, as the frequency of their contact with mental health patients increased, so did the urgent need for further education. Nearly three quarters of the nurses in this study were concerned about their lack of confidence in caring for mentally ill patients. More than a quarter of nurses acknowledged uncertainty about the management of less severe or minor mental health problems such as depression and anxiety.

According to Glied (1998), finding reasons for the success or failure of primary practitioners to diagnose mental health problems, with therapists and other gatekeepers, is important in helping to address the problem of untreated mentally ill

patients. She advocates further education for nurses in order to enable more effective delivery of care for people with mental health problems, as well as improving nurses' job satisfaction. Spending some resources on training nurses would cost little and yet greatly improve the present situation of unidentified and untreated patients.

In order to achieve the WHO standard of health by providing holistic care for everyone, a nursing review recommended that mental health skills should be made available to all Primary health care nurses (Cutcliffe, Gourary, and Ward, 2000). If nurses were provided with the necessary skills to identify and manage mental health problems there would be an increase in the number of 'hands' available. This is important in that nurses can become more involved in secondary prevention of mental health problems.

The need for nurses' involvement in the care of emotional disorders is increasingly recognized, but there is a growing gap between the demands made on them and the competencies and skills they possess in order to cope with those demands (Mead, Bower and Gask, 1996).

Murthy and Narendra (1983), argued that training in the health care system should be determined locally, based on the needs of each clinic or primary health care service. They maintained that emphasis should be placed on the development of interpersonal skills, which include basic counselling techniques and empathetic listening. Appropriate training should also include simple methods of identification, management and referral.

A number of training programmes have been conducted in low-income countries, for example, the integration process in Guinea Bissau included training of Primary health care personnel in the recognition and management of common mental disorders. According to Petersen (2000), evaluation of this programme showed improvement in the identification and treatment of these disorders. Likewise, the decentralization and integration process of mental health into Primary health care in Botswana involved training of Primary health care personnel in dealing with both serious and common mental disorders such as depression and anxiety. Evaluation of this intervention

indicated a reduction in admission rates for serious mental disorders to institutional care (Ben-Tovim, 1987).

In 1975 the WHO directed a collaborative study for extended mental health care in low-income countries. This study was in response to the commitment by WHO and its member state to comprehensive mental health care, which culminated in the Alma Ata declaration. It was centrally concerned with establishing the feasibility of community-based mental health care through decentralizing and integrating mental health services into primary health care in low-income countries (Sartorius, 1978). Key findings that emerged from the evaluation of the collaborative study indicated that primary health care personnel could acquire and apply mental health skills throughout training (Climent et al., 1980). Sartorius & Harding (1983) noted that although there is an initial resistance to change, with training and support there is a gradual shift to acceptance of dealing with mental health problems. This is accompanied with a resultant change in attitudes as well as an increased awareness of the importance of wider psychological issues in the production of ill health.

Another study worth mentioning is the one conducted in Zimbabwe (Abas, Broadhead, Mbape, Khumalo –Sakatukwa, 1994). This was associated with a training course for Primary health care nurses in the identification and management of depression. In this project, Primary health care nurses were trained using an algorithm known as Multiple Symptom Cards. This was to help with diagnosing of probable depression and was followed by a seven-step management plan (Abas, Broadhead, Mbape, Khumalo –Sakatukwa, 1994). Following this, an improvement in identification and care of mental disorders was noticed.

Solutions to mental health problems should not be confined to the realm of medicine, but should lie primarily in intersectoral collaborative programmes within a Primary health care framework. There needs to be a movement away from purely medical models and a concerted effort to focus more on groups and consultative community interventions.

The literature reviewed in this chapter highlights the importance of training nurses in mental health care. The training of nurses will not only uphold the implementation of

WHO's definition of health, but will also ensure that the majority of South Africans have access to mental health, as most of them use Primary health care services.

The literature also showed that training nurses improves their knowledge, which in turn impacts positively on their attitudes towards the provision of mental health. Lack of confidence was also found to be a factor that negatively affected the ability to provide necessary care. Most studies reviewed indicated that nurses gained more confidence after training.

## CHAPTER 5

### 5.1 *DESIGN AND METHODOLOGY*

#### 5.1.1 Introduction

This chapter will provide a brief discussion of the design and methodology utilized in the collection of data. Included in this will be information on how the design also informed how the data was analysed.

#### 5.2 *Participants*

Sixteen nurses from different clinics around the Valley of a Thousand Hills participated in the training. In view of the need to ensure that the training did not interrupt the provision of health services, the number of participants from each clinic was determined by the number of staff available. Two groups were run at different times, and both groups consisted of eight nurses. Only nurses who had never received any previous training on psychiatry were considered for the training programme.

#### 5.3 *Methodology*

For the purpose of this study, a quasi-experimental time-series design was employed. In a quasi-experimental research design, the researcher studies the effects of the treatment on a particular group, rather than using randomly assigned experimental and control groups (Mertens, 1998). Quasi-experimental designs are most commonly used for estimating the impact of a partial coverage programme when random assignment cannot be undertaken (Rossi & Freeman, 1993). In this study it was not possible to have a randomly assigned sample because of the shortage of staff in the clinics as indicated in the preceding paragraph, hence the adoption of this methodology.

In order to achieve the objective of the study, which is evaluating the nurses' training programme, evaluation research was necessary. According to Richard and Cook (1979) cited in Petersen (2000), a comprehensive evaluation of the training should be concerned with an analysis of both process and outcome. Process analysis involves

two aspects; in the first instance there is programme monitoring, which is concerned with assessing whether the ongoing intervention is adequate to meet the intended goals of the programme. To this effect, each training session needs to be followed by a meeting, which assesses whether that particular session has met its intended goals. The second aspect involves providing a causal explanation for the results of the intervention.

In meeting the goals of the training, the evaluation process was informed by both process and outcome. Process evaluation seeks to elucidate what makes a programme successful or unsuccessful, and is thus mainly concerned with knowledge building or developing an understanding of what makes the programme work or not work (Rossi &Freeman, 1993).

Outcome measures provide a measure of the effect or outcome of a programme. In outcome evaluation, the evaluator's task is to evaluate the merits of the intervention. Outcome evaluation is thus concerned with establishing how good a programme is and whether it was worth doing (Rossi &Freeman, 1993).

#### **5.4 Instruments**

The Physician Belief Scale adopted from Ashworth, Williamson and Montano (1984) was used to assess nurses' attitudes. The physician belief scale is a 32 item self-reporting questionnaire. The scale was used to compare responses prior to and after learning. The intention was to evaluate whether training was effective and learning had had an effect on the nurses' beliefs and attitudes towards mental health problems. A five-point Likert -type response scale ranging from "strongly disagree" to "strongly agree, follows each item on the scale. The scale was scored from 1 to 5. The scores represented the following meaning: 1 -strongly disagree, 2 -disagree, 3 - unsure, 4 - agree, 5 - strongly agree. The instruments were administered in English. An agreement was reached with nurses that English be used as a medium of instruction as some of the participant did not understand African languages mainly Isizulu.

The scale was originally designed to measure beliefs regarding psycho – social aspects of patient care held by Primary health care workers. According to Ashworth et

al. (1984), this instrument may be used to describe objectively where a physician, or in this case a nurse, falls on a dimension of acceptance versus rejection of psychological tenets in medical care. In order to assess if the programme had a positive effect on the participants' attitudes and perceptions about mental health, this scale was also used in the post evaluation. For the purpose of this study, two extra items were included. These sought to assess whether nurses consider or incorporate the clients' understanding of their illness in their management plan.

According to Ashworth et al. (1984) "... the Physician Belief Scale appears to be able to measure tacit belief held by primary care providers about psycho social aspects of patient care. Psychometric qualities of the scale are excellent and demonstrate an ability to distinguish among provider specialties in meaningful ways. Psychometric characteristics for a rotational scale include high internal consistency, test-retest reliability, mean score that do not deviate substantially from midpoint of the possible range of scores, a dispersion of scores narrow enough to avoid 'basement' or 'ceiling' effects, and reliable relationship with related variables" (p.1237).

### **5.5 Process**

Petersen (2000) suggests that for every training programme to have a degree of success it is important to have an ongoing evaluation of the training process using programme monitoring. For the purpose of the current study, it was important to elicit the help of the nurses in providing this ongoing evaluation. This was done in order to make them take ownership of the project. One of the requirements of the training was that nurses not only practice their skills in the simulated role-plays performed during their training but they needed to apply their skills with the patients in their respective clinics. Such a process required a conscious effort on their part not only to apply the skills but also to monitor themselves while doing so.

The evaluation process therefore involved discussions and reflections after each session, these discussions and reflections were recorded using a portable tape recorder and later transcribed and analysed. This process included highlighting problems with the material itself, manner of instruction, but over and above that, the problems encountered when attempting to follow the process of implementation itself.

What this means is that, at the end of all sessions, the nurses provided an overall evaluation of the process that had been undertaken in implementing the programme. Facilitators also held weekly meetings to find out if the outline of the programme was followed as initially conceived. .

### ***5.6 Analysis of the process***

The results of the process evaluation were analysed using thematic analysis (Terre Blanch & Durrheim, 1999). The nurses' responses were analysed and common themes were identified and discussed amongst the facilitators and participants.

After each session the nurses were given opportunity to comment on the session highlighting problems with the material itself, manner of instruction and the problems encountered during session. These discussions were recorded on tape and later transcribed. Facilitators would then hold weekly meetings to analyse the discussions identify common themes and discuss them with the nurses on the before the beginning of the next session.

### ***5.7 Analysis of the outcome***

The results obtained from the Physician belief Scale were analysed by using a computerized Wilcoxon Signed Rank Test. According to Searle (1999) this test is used " when you have two data at the ordinal level and you are testing to see if there is a difference between two sets of scores obtained from the same participants in a repeated measure design or from matched pairs"(p. 167).

The Wilcoxon Signed Rank Test can be used to test the hypothesis that the response level of one treatment differs from another when both treatments are applied in the same block. The test is also applied to paired differences, and is appropriate when the data is from a continuous and from a 2-tailed test symmetric distribution. It is not necessary to assume symmetry for a 1-tailed test.

The Wilcoxon Signed Rank Test was used for comparing the pre- and post-training scores. Scale scores were obtained by summing up item scores for each individual thus obtaining a total score. The scale had 34 items, each scored from 1-5. A valid overall score can range from 34 (maximum degree of psychosocial orientation) to 170 (minimum psychosocial orientation).

The Wilcoxon test is generally a more powerful test than the sign test. Studies have shown that the relative efficiency of the sign test compared to Wilcoxon, is  $2/3$  when the differences are normally distributed, and  $1/3$  when they are uniformly distributed. This test presumes an “interval” level of measurement of performance on subtests; i.e., equal differences in the performance measure between two systems mean the same, whatever the absolute level of performance. (Wilcoxon signed rank, 2002)

Under the null hypothesis, providing the distribution is symmetric, if the values are ranked according to the size of their deviation from zero (ignoring their sign), the sum of the positive treatment differences should be equal the sum of the negative ones.

## **CHAPTER 6**

### ***6.1 RESULTS AND DISCUSSION***

This chapter presents and discusses the results of the study. These results will be discussed within the context of the methodology as outlined in the previous chapter. This means that the researcher will firstly present the outcomes of the monitoring and evaluation of the process that was followed in implementing the training programme. Secondly, focus will be on the results obtained from the Physician Belief Scale. This will indicate whether there were any observable changes in the nurses' attitudes towards the provision of mental health care following the acquisition of new information and skills. Lastly, the results will also be discussed with reference to the current literature and theoretical context of the topic, as was presented in chapter three.

### ***6.2 PROCESS***

The evaluation of the process entailed an ongoing monitoring of the method of instruction. This was done on a weekly basis. Following each session, nurses were requested to evaluate the process, content of the session as well as the manner in which it was delivered.

The responses obtained from the assessment undertaken with each of the two groups suggested that the nurses were pleased with the content and were gaining valuable information, which made them feel more confident in dealing with mental health problems.

As part of monitoring and evaluation, facilitators held meetings before and after training sessions. The meetings before training focused on the structure and content of the training material. As mentioned before, the training programme in the current study was part of internship programme, this meant that the facilitators met with the supervisor to ascertain whether the programme's plans were in order and that the structure and content of the training programme were standardised.

The general structure of the programme was approved by the supervisor, however there were some further suggestions made, for example more time was given to disorders such as Mental retardation and epilepsy as these were conditions that nurses had been most concerned about. This concern was emphasized by the number of clients referred to the interns placed at the Halley Stott clinic at the Valley of the Thousand Hills. Most of the cases referred were people suspected to be mentally retarded and the intention was to apply for disability grants.

On the part of facilitators, one of the objectives for having meetings after every training session was to identify and deal with problems that would adversely affect the training. Sometimes these were things that were not directly related to the training itself. Included in these were technical problems such as transport, which proved to have a significant impact on the time factor. The availability of transport and time of arrival of the nurses influenced the amount of contact time. After a number of nurses had arrived late citing problems related to transport, there was a need to intervene and alternative means of transport were arranged.

As part of the process of ongoing monitoring, facilitators noted that the nurses were reluctant to discuss cultural factors that influenced mental illness. The interpretation was that perhaps the nurses felt that their legitimacy as health professionals would be if they adhered to the bio-medical approach. Understanding presented complaints in a bio – medical approach has been found by Petersen (2000) to be essential to the nurses' power and status in the health care system and, at a macro level, they were seen to need to hold on to the power and status that providing biomedical care gives them.

In order to address the above facilitators devised a strategy that would force them to move beyond biomedicine in understanding problems. This included using vignettes which had a cultural content. This gave nurses latitude to have more input when discussing influences to mental health that were cultural in nature, including focusing on the patients' cultural explanatory models of illness and disease. A good example of this was when the process of 'ukuthwalwa', and its relation to rape was highlighted. Ukuthwalwa is when a woman is taken against her will or abducted by her admirer. She is reportedly kept in the suitor's home until she gives in to his demands. During

this abduction period she is also forced /expected to perform sexual acts with the abductee who is seen as a future spouse. The ensuing debate centred on whether this situation could be identified as rape and could it be perceived as traumatic as one would say of a rape victim. The cultural dimension and the dynamics involved in this experience highlighted the difficulty in marrying what is perceived as traditional and that which can be characterized as purely bio-medical in nature, and thus needing a purely bio-medical intervention.

### **6.2.1 Manner of instruction**

As indicated on chapter two, the manner of instruction adopted in this training involved group discussion, vignettes and role- plays. In their evaluation nurses reported the training to be quite different from what they were used to. They argued that during their formal training to become nurses, as well as when they attended workshops, they were used to having the sister tutor or facilitator stand in front of the class and instruct them on the intricacies of the subject matter without exploring issues from their perspectives or allow them to provide their own conceptualisation of the matter under discussion. This was a didactic manner of approach. Because of this, the participatory and interactive manner employed in this particular training was found to be both empowering and at the same time unsettling.

Nurses reported to be used to harsh pedagogical methods, which tend to be disempowering, as well as somewhat disrespectful, and hence, as much as the friendly and warm atmosphere presented by the facilitators was viewed as a welcomed change, it was at times disconcerting, leading them to not taking the training as seriously as they should have. It is important to report that this behaviour was mostly observed from the second group of nurses. This might have been influenced by the fact that, at the time of the training, this group was also attending another workshop, which was reported to adopt a different approach. This could then have led to these contradictory and conflicting reactions to the training. Their evaluation was thus influenced by their response to what was familiar (harsh pedagogical methods), which seemed to take precedence over the new and, at that time, untested methods. It is also important to indicate that the training under evaluation coincided with them preparing for their

exams. To this effect, their anxieties over their coming exams could have coloured their responses to the evaluation questions.

### **6.2.2 Content**

In chapter two, it was mentioned that an analysis of needs was conducted before the start of the training in order to identify the topics that the nurses considered to be of relevance. The content of the training programme and the process of delivery was done in such a way that nurses became part of the training by providing whatever knowledge they had on the topic and also sharing their experiences. This ensured that the content included issues that nurses were mostly concerned with. It is mostly in this area that the influence of the bio-medical approach was identified, with nurses finding it difficult to talk freely about other influences to mental illness, particularly those that were cultural in nature. This behaviour was again mostly noted in the second group.

As indicated before, this difference between the two groups of nurses can be explained in terms of the facts reported above, i.e. the different and bio-medically inclined workshop they were attending at the same time as the training under discussion. This was further complicated by their examinations which dictated that their focus be on bio-medical issues which were part of their training.

### **6.3 OUTCOME**

As part of the training programme, a pre-evaluation of nurses' counselling skills was undertaken. This revealed that nurses were sometimes lacking in empathy and warmth. They were also prone to using leading questions while telling the client what to do, rather than helping them come to a solution. Some of their interjections were very harsh. An example of this was depicted when on one of the role-plays presented a problem with a working female who was also studying and had a difficulty in coping with work and her studies. The participant who served as a counsellor in the role-play asked the client "*What were you thinking taking so many courses at once? You know that studying is difficult. You are going to fail. It would be better if you deregister*". These pre-evaluation role plays helped identify the focus of the training with regards to counselling skills.

After nurses had been exposed to new ways of providing counselling, they were asked to share incidences when they had used their newly learned counselling skills in their respective clinics. Indications were that there was an improvement in the way that participants were managing clients who needed counselling. They were however concerned that the process took too much time, which was something, they could not afford as they usually had other patients waiting to be attended to. In a study conducted by Petersen 2000, highlights that the nurses complained of the increase number of patients they see since the introduction of free health serviced. Petersen also mentioned that the evaluation of nurses performance was based ob daily records which measured quantity as to quality; this therefore supports the nurses concern about time spent with one patient who has mental health problems.

To achieve the second aim, which was to assess whether there were any changes in the nurses' attitudes towards the provision of mental health care, following them learning new information and gaining new skills from the training, a self-administered questionnaire, the Physician Belief Scale was administered to a sample of 16 nurses, i.e. two groups consisting of 8 nurses each.

The descriptive statistics will be presented first. Table 1 shows the comparison of pre- and post-test scores for both groups. The results of pre-evaluation indicate a high score (322), which suggest that both groups were initially bio-medically oriented. Post-evaluation scores are (87). This low score suggests that there was a change from a biomedical orientation to a bio-psychosocial framework.

For the purpose of this study, the following terms will be used; PRETRAIN, PRECOM, POSTTRAIN AND POSTCOM. These mean/ indicate the following:

PRETRAIN – results obtained before the training (pre training)

POSTTRAIN – results obtained after the training or post training

PRECOM – results of combined groups before training or pre training

POSTCOM – results of combined groups after or post training

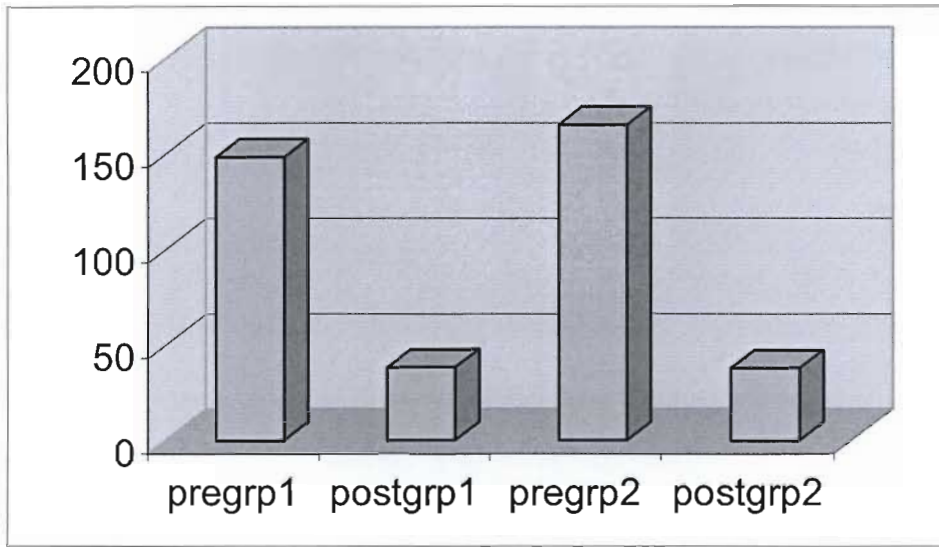
**Numbers 1 and 2 refer to the groups' i.e. first and second group of eight nurses that were trained.**

6.4 Table 1

**Pre- and Post-evaluation Groups**

	N	Mean	Std. Deviation
PRETRAIN1	8	148.50	4.309
POSTTRAIN1	8	38.25	5.726
PRETRAIN2	8	165.50	2.878
POSTTRAIN2	8	38.00	2.070

The results show significant differences between pre and post test scores. The results of this study suggest that after the nurses went through the training on mental health issues, there was a significant improvement in their knowledge and attitudes towards mental health problems and their management. This is in keeping with other training programmes, such as the WHO collaborative study, which was conducted in other developing countries (Sartorius, 1978).



6.5 *Figure 1*

Figure 1 is a graphic description of Table 1. The graph shows the different scores in both groups on pre- and post-evaluation. The score for group 1 before training is 148.50 and the score for group 2 before training is 165.5. An interesting observation is that collectively group two scored higher on pre evaluation than group one. In other words, group two seemed more inclined to draw on bio-medical theoretical model than group one. The possible reason for this difference has been sufficiently explored in the preceding section.

6.6 TABLE 2: Test Statistics

	POSTTRAIN1 - PRETRAIN1	POSTTRAIN2 – PRETRAIN2
T	2.521	2.527
Asymp. Sig. (2-tailed)	.012	.012

The difference between the two groups is statistically significant. Usually, statistical significance is determined by calculating the probability of error (p value) by the t ratio. The difference between the two groups is judged to be statistically significant when  $p = 0.05$  or less. At  $p = 0.01$ , the difference between two groups have only 1% of occurring by chance alone.

Table 2 shows the significance for the results obtained from each group. Each group had a p value of .012. This suggests that results are significant at 1% level and that the training had a significant impact on the nurses' attitudes towards the provision of mental health care.

The problem with the  $p$  value approach is that two groups could differ significantly (with  $p = 0.05$  or less), yet the actual difference between the two groups could be so small that it is not clinically significant. This problem usually occurs when: (i) the group size is very large or very small. In this particular study, the group size is small, (ii) score within the group are very similar, (iii) the experimental design uses repeated measure as in the current study. The small group size might lead to the results to be insignificant. In the next table, clinical significance will be calculated using the percent improvement.

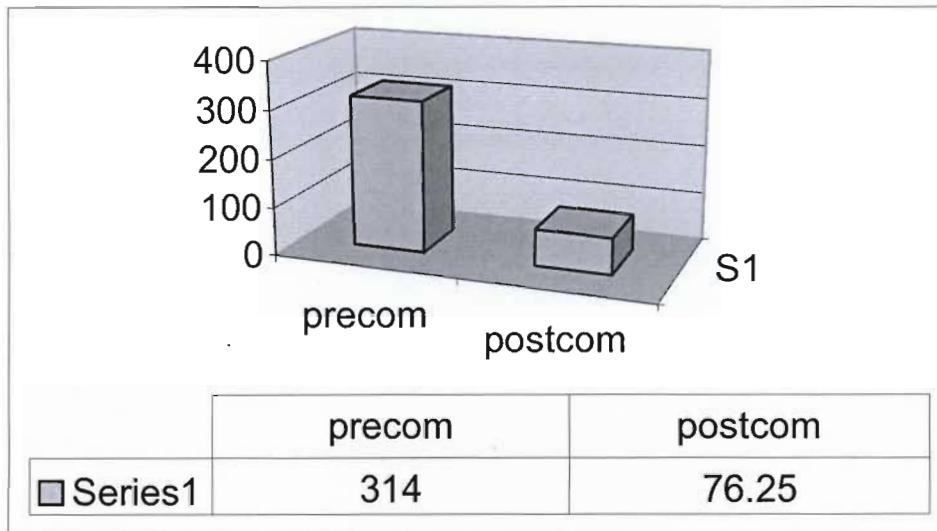
6.7 TABLE 3: *Descriptive Data - Pre and Post-evaluation Combined Groups*

	N	Mean	Std. Deviation	Minimum	Maximum	Percentiles		
						25th	50th(Median)	75th
PRECOM	16	314.00	6.118	305	322	307.50	315.00	319.25
POSTCOM	16	76.25	6.628	69	87	72.50	73.50	83.50

To assess clinical significance, a percentage of improvement needs to be calculated. The convention is that a 25% improvement or greater represent a clinically significant difference. For “before vs. after” experiments, percentage improvement = [(post-test group mean – pre-test group mean) divided by (pre-test group mean)] x 100.  $[76.25 - 314.0] / 314.0 \times 100 = -75.71$ -(ignoring the minus sign, which means that there was a 75% improvement in the nurses’ attitudes (statistical difference, 2003). In order for the results to be considered significant, the improvement should be 25%. The improvement in the current study is 75%. This suggests that although the group size was small the results can be considered as significant.

Table 3 presents the results for both groups combined on pre- and post-evaluation. The findings indicate that both groups have a significant statistical difference in the post-evaluation when combined. Both groups had a mean of 314.00 for pre-evaluation and a mean of 76.25 for post-evaluation, which is about four times less than pre-evaluation. This suggests that the training had a positive impact on both groups. As the aim of the study intended, these results suggest that the training was able to change the nurses’ beliefs and attitude about the provision of mental health care. This is in keeping with the results from a study conducted by Lee et al. (1997) for WHO collaborative Mental Health Group. The WHO study found that providing health

workers with training in mental health could improve their knowledge and attitudes towards provision of mental health care.



6.8 Figure 2

Figure 2 is a graphic description of the scores of both groups combined and clearly shows the difference in the scores. The pre-test result for both groups combined is 314 and the post-test result is 76.25. As mentioned earlier a higher score suggests that the nurses were more bio-medically oriented and low scores suggest that the nurses became bio- psychosocially oriented after training. This graph shows the difference of the scores before and after training, which suggests a significant improvement in the nurses' attitude towards mental health.

**6.9 TABLE 4 : Test Statistics**

	PRECOM – POSTCOM
	2.524
Asymp. Sig. (2 – tailed)	.012

Table 4 shows the significance of the results from the combined scores.

The p value is .012, which suggests that there was a significant change in the nurses' attitudes after going through the training programme.

This is in keeping with the suggestion made by Mavundla (1993). Mavundla conducted a study, which aimed at imparting knowledge as well as try to improve nurses' attitudes towards mental illness. This training assessed nurses' attitudes towards mental illness in a general hospital. The results obtained in Mavundla's study led her to believe that there is a relationship between knowledge that people have about mental illness and their attitudes towards it. This is supported by the results of the current study, which suggest that before training, nurses did have negative attitudes. One can therefore deduce that the results obtained before training might be influenced by the limited knowledge and the results show a shift in attitudes after training.

**6.10 Limitations of the study**

The first limitation is that the evaluation was undertaken shortly after training. There were no follow up interviews conducted after some time had elapsed following the training. A possibility exists that nurses would have reverted back to their usual/old styles of dealing with their patients' problems, given that their environments would not have changed. They would still be pressured to see large numbers of patients within a limited time period. One would expect that in the long run it would become easier to continue just prescribing medication than to explore issues that are psychological in nature. Petersen (2000) does caution against relying on nurses as the

key provider of mental health care without appropriate support and change in the health care system.

Another area of concern which may have an impact on the results is the social desirability effect. Crowne & Marlowe (1960) defines social desirability as the need to obtain approval by responding in a culturally appropriate and acceptable manner. According to Pauhus (1991), individuals will always try to give answers that make them seem well adjusted, open minded and democratic. This suggests that nurses could have given answers that were positive in order to indicate their changed attitudes as well as to present as amenable to the idea of providing mental health care. In her study, Petersen mentioned that nurses were more concerned with obtaining certificates for the training rather than focusing on the experience of learning, which suggests that responding in a desired manner was just means towards an end. A further limitation of the training process itself was that there was not enough practical exposure during training. This means that the nurses were never observed using their skills and knowledge in a true-life situation (as was the case with Petersen's study) they were only observed in a simulated setting during training.

### ***6.11 RECOMMENDATIONS***

As a follow up from the highlighted limitations, it is recommended that another study be conducted in order to evaluate the long term effects of the training programme

As mentioned in literature review nurses act as a gateway for provision of mental health care. Training nurses would therefore assist in identifying mental health cases and manage them regardless the limited professional services in our health system. It will make sure that everyone has access to holistic care. It is therefore recommended that nurses be trained in mental health

It is also recommended that a professional provide the nurses with support after training, to make sure that they do not lose the acquired skills and revert to their old ways of doing things.

## **6.12 CONCLUSION**

According to Bundler (1994), solutions to mental illness are not confined to the realm of medicine, but lie primarily in intersectoral collaborating integrated programmes within a primary health care framework. One of the greatest obstacles in provision of mental health in primary health care is limited knowledge and negative attitudes towards provision of such care.

Literature reviewed in the current study has highlighted the importance of training nurses in mental health care. It also pointed out the significant impact that the training had on the nurses' perceptions towards provision of mental health in primary health care.

CMHP headed a call for including mental health care into PHC so that every individual could have easy access to mental health care. This was done by introducing reorientation training programme which was intended in equipping nurses with skills to identify and manage mental health problems. The evaluation aimed at identifying any significant change in the nurse's perceptions towards provision of mental health in primary health care. The results of the study are in keeping with the literature review as well as the intended outcome.

Bradshaw (2001) points out that training nurses in mental health and providing more knowledge about mental illness leads to better understanding of the nature of mental illness, and therefore a change in negative attitudes towards the provision of mental health and 'better performance' in managing mental health issues, which was observed in the current study.

The findings in the current study suggests and enforces the importance of providing nurses with better and broader understanding of mental illness and training them in broader range of interventions. Literature reviewed as well as the results of this study suggests that the factors mentioned above help nurses to be more positive in providing mental health care.

Petersen (2000) mentions that caution should be taken towards the possibility of nurses reverting back to the biomedical approach of managing mental illnesses, it is therefore very crucial that the nurses are not only trained in managing mental illness but also provided with support from their management and from a professional. This might reduce the chances of the nurses reverting to their old ways, as they will not feel pressured to produce the numbers, as it is the way in which the nurses performance is evaluated. They will also know that there is a professional available to assist them when ever they need help.

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## APPENDIX A

Please answer the following questions as accurately and sincerely as possible rating yourself from 1-5

**1 - Strongly disagree**

**2 - Disagree**

**3 - Unsure**

**4 - Agree**

**5 - Strongly agree**

ITEMS	1	2	3	4	5
1. I cannot treat psychological problems	1	2	3	4	5
2. my patients do not want me to investigate psychosocial problems	1	2	3	4	5
3. I cannot help patients with problems I do not have experienced myself	1	2	3	4	5
4. I do not focus on psychosocial problems until I have ruled out organic problems	1	2	3	4	5
5. If I address psychosocial issues, patients will reject them and never return	1	2	3	4	5
6. Mind and brain influence physical diseases and body perceptions	1	2	3	4	5
7. Exploring psychosocial issues with patients often causes pain	1	2	3	4	5
8. The biological model of disease is most appropriate model for health care	1	2	3	4	5
9. I am intruding when I ask psychosocial questions	1	2	3	4	5
10. I must consider organic and psychosocial problems concurrently	5	4	3	2	1
11. It is difficult to deal with psychosocial problems when I have many of the same problems as my patients	1	2	3	4	5
12. Evaluating and treating psychosocial problems will cause me to overburdened than I already am	1	2	3	4	5
13. I feel guilty probing the psychosocial concerns of my patients	1	2	3	4	5
14. I am too pressed for time to routinely investigate psychosocial issues	1	2	3	4	5
15. My patients feel questions about the psychosocial aspects of their lives are irrelevant	1	2	3	4	5
16. The stresses we all experience do not significantly influence the onset or cause of disease	1	2	3	4	5
17. one reason I do not consider psychosocial information is the limited time I have available	1	2	3	4	5

18. patients will become more dependent on me if I open up psychosocial concerns	1	2	3	4	5
19. If I deal with psychosocial concerns, I will lose my patients	1	2	3	4	5
20. there are many issues to be investigated when seeing a patient that I do not always consider psychosocial factors	1	2	3	4	5
21. my own psychosocial problems do not interfere with my ability to treat patients	5	4	3	2	1
22. consideration of psychosocial problems will require more effort than I have to give	1	2	3	4	5
23. patients blame for psychosocial problems	1	2	3	4	5
24. talking about psychosocial issues causes more trouble than it is worth	1	2	3	4	5
25. Investigating psychosocial issues decreases my efficiency	1	2	3	4	5
26. Patients will reject the idea of my dealing with psychosocial issues	1	2	3	4	5
27. Investigating psychosocial causes me to loose time and money	1	2	3	4	5
28. I cannot help patients with psychosocial problems I have not resolved myself	1	2	3	4	5
29. I can investigate psychosocial issues without decreasing my efficiency	5	4	3	2	1
30. I focus on organic diseases because I cannot treat the psychosocial	1	2	3	4	5
31. Depressed patients frequently present with vegetative somatic complaints	5	4	3	2	1
32. patients with psychosocial concerns tend to become dependent on me	1	2	3	4	5
33. I ask patients about their understanding of illness	5	4	3	2	1
34. I incorporate their understanding in negotiating their treatment	5	4	3	2	1

## APPENDIX B

### RAPE

#### INTRODUCTION

This section deals with rape. Firstly, we will look at what the term rape means, as well as explore belief system or myths around rape. Secondly, we will focus on psycho-education to highlight how rape victims are usually affected by being raped, thirdly, we will look at ways in which one can assist rape victims deal with effects of rape.

Task: brainstorms the term rape
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#### Vignettes

V.1. Lindiwe a 17 year old girl went to fetch water. When she reached the fountain three men were waiting for her. They grabbed her put her on their shoulders; they beat her up because she was resisting. They dragged her kicking and screaming into their home and made her their elder brother's wife. Lindiwe is very unhappy about what happened.

V.2. Thandi broke up with the father of her three year old son a year ago. Last Friday he invited her into his house to collect their son's maintenance. He then forced himself on her, arguing that if she needed the money she had to earn it.

V.3. Mrs. Zama does not enjoy making love to her husband when he is drunk because she experiences him as aggressive. Mrs Zama has expressed her feelings to her husband several times and he views this as absurd as she is his wife. Two nights ago Mr. Zama was drunk and he forced himself on her threatening to beat her if she refused to have sex with him.

V.4. Mzamo is a 6 years old boy who stays with him mother's family. His 25 year old uncle has anal sex with him.

V.5. Sibusiso is doing his 2<sup>nd</sup> year at University. His parents are struggling to pay his fees. Due to his excellent academic performance, a wealthy local business man offered to pay for his tuition fees. A day before he is due to leave for university this man asked him to come and collect the money from his house. He showed him the money but then forces him to watch him naked and touch his private parts, and then gives him the money warning him not tell anyone and that if he does tell no one will believe him anyway.