The experiences and feelings of general nurses working at a Maltese psychiatric hospital

A Heideggerian interpretive phenomenological study

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ABSTRACT.

The purpose of this study was to gain an understanding of the feelings and experiences of general nurses working at a Maltese psychiatric hospital, which had not been addressed in published literature to date.

A Heideggerian interpretive approach was adopted for this study. A purposive sample of six nurses was chosen and data was collected through semi-structured interviews. The data was analysed in accordance to Colaizzi’s (1978 cited in Knaack, 1984 and quoted by Smith, 1996: 77).

Three broad interrelated themes emerged from the data. These were related to psychiatric nursing practice, hospital culture and the meaning of nursing to nurses. Findings were discussed in relation to them and their related concepts.

The study’s findings suggested how general nurses providing care to patients at this hospital, viewed their world. They are considered to contribute to a greater understanding of feelings and experiences of general nurses working at this hospital. Recommendations were made to ensure that the needs of these nurses are addressed, thus enhancing their ability to care for their patients and influence the latter’s health outcomes favourably.
DECLARATION.

This dissertation is submitted to the RCN Institute in part fulfilment of the M.Sc. in Nursing and has been conducted and presented solely by myself. I have not made use of other people's work (published or otherwise) and presented it here without acknowledging the source of all such work.

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# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>i</td>
</tr>
<tr>
<td>Declaration.</td>
<td>ii</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>iii</td>
</tr>
<tr>
<td>Dedication.</td>
<td>iv</td>
</tr>
<tr>
<td>Chapter 1 Introduction</td>
<td>1</td>
</tr>
<tr>
<td>1.1 Research question</td>
<td>1</td>
</tr>
<tr>
<td>1.2 Rationale of the study</td>
<td>1</td>
</tr>
<tr>
<td>1.3 The social and historical context of this research project</td>
<td>2</td>
</tr>
<tr>
<td>1.4 Importance of the study</td>
<td>4</td>
</tr>
<tr>
<td>Chapter 2 Literature Review</td>
<td>5</td>
</tr>
<tr>
<td>2.1 Introduction</td>
<td>5</td>
</tr>
<tr>
<td>2.2 How mentally ill people experience their illness</td>
<td>6</td>
</tr>
<tr>
<td>2.3 Mentally ill patients' experience of hospitalisation and nursing care</td>
<td>9</td>
</tr>
<tr>
<td>2.4 Feelings and experiences of caregiver relatives of mentally ill people</td>
<td>14</td>
</tr>
<tr>
<td>2.5 The experience of general hospital nurses caring for mentally ill people in general hospital settings</td>
<td>18</td>
</tr>
<tr>
<td>Chapter 3 Research Design: Methodology and Methods</td>
<td>21</td>
</tr>
<tr>
<td>3.1 Introduction</td>
<td>21</td>
</tr>
<tr>
<td>3.2 Philosophical underpinnings</td>
<td>21</td>
</tr>
</tbody>
</table>
3.3 Phenomenology

3.3.1 Husserlian transcendental phenomenology

3.3.2 Heideggerian interpretive phenomenology

3.3.2.1 Clarifying terminology

3.3.2.2 Principles of Heideggerian Interpretive Phenomenology

3.4 Choice of Heideggerian Interpretive Phenomenology for the study

3.5 Data collection

3.6 Pilot/Rehearsal interviews

3.6.1 Learning points from pilot / rehearsal interviews

3.7 Ethical Implications

3.7.1 Voluntary participation, Informed consent and Participant Autonomy

3.7.2 No harm to the participants

3.7.2.1 Participant protection from psychological harm

3.7.2.2 Anonymity and confidentiality

3.8 Rigour of the study

3.8.1 Relationship with participants

3.8.2 Participants' validation of data

Chapter 4 Data Collection and Analysis

4.1 Introduction

4.2 Ethical clearance

4.3 Selection of participants

4.4 Permission from participants

4.5 Characteristics of sample
Chapter 5  Presentation of Findings  

5.1 Introduction  

5.2 Psychiatric nursing practice  

5.2.1 Career choice  

5.2.2 Feelings at the beginning of the career  

5.2.3 Nurses' lack of knowledge about mental health and psychiatry  

5.2.4 Difference between general and psychiatric nursing  

5.2.5 How nursing is carried out  

5.2.6 Dilemmas in psychiatric nursing  

5.3 Hospital Culture  

5.3.1 Relationships of nurses  

5.3.2 Multiprofessional lack of co-operation  

5.3.3 Lack of job description  

5.3.4 Lack of discipline  

5.3.5 Ignorance about the role of nurses at psychiatric hospitals  

vii
Chapter 5 The meaning of nursing to nurses

5.4 The meaning of nursing to nurses
5.4.1 Nurses' perception of themselves
5.4.2 Attitudes of nurses towards their work
5.4.3 Stress and Burnout
5.4.4 Job satisfaction

5.5 Conclusion

Chapter 6 Recommendations

6.1 Introduction
6.2 Recommendations for the improvement of nursing care delivery and nurses' working conditions
6.3 Recommendations for further research
6.4 Conclusion

References

Appendices

Appendix A Research Information Form - Maltese version
Appendix B Research Information Form - English Version
Appendix C Background information questionnaire
Appendix D Interview Guide
Appendix E Colaizzi's (1978) seven steps for data analysis
Appendix F E-mail to Students' Advisory Section of the University of Malta and its reply
Appendix G(i) Letter to secretary of Bioethics Consultative Committee
Appendix G(ii) Reply from secretary of Bioethics Consultative Committee
Appendix H  Letter from M.Sc Programme Director . . . 114
Appendix I(i)  Letter to the Ethics Committee of the University of Malta 115
Appendix I(ii) Reminder letter to the Ethics Committee of the University of Malta . . . . .
116
Appendix J  Letter to Director of the Malta Institute of Health Care . 117
Appendix K  Letter to Manager of the local Psychiatric In-patient Services . . . . . . . . . 118
Appendix L  Reply from Manager of the local Psychiatric In-patient Services . . . . . . . . . 119
Chapter 1

Introduction
CHAPTER 1. INTRODUCTION.

1.1 Research question.
The purpose of this study was to explore the feelings and experiences of general nurses who work at a Maltese psychiatric hospital. Since the aim of the study was to understand the complex phenomena surrounding the provision of care in this particular psychiatric hospital, the research study was conducted within the interpretive paradigm. This perspective is concerned with holism and rejects reductionism, thus it allows the researcher to understand human experience within the historical and social context in which it occurs (Masterson, 1996). A detailed discussion of the research methodology and design which were used in this study to answer this research question, may be found in chapter 3, whilst in chapter 4, I discussed issues pertaining to data collection and its analysis. In the latter chapter, I also outlined the limitations of this study.

1.2 Rationale of the study.
My ongoing interest in how people feel and experience their way of being, prompted me to select a research topic which brings to the foreground the tacit feelings and experiences of nurses. The three years working experience which I had at a Maltese psychiatric hospital, my mixed feelings aroused by them and the subjective and documented knowledge about the hospital itself and the nurses providing care in it, guided me to focus my interest and address their often forgotten experiences and feelings with the current study. My initial hunches and motivation to carry out this study were strengthened by the literature which is discussed in chapter 2.
1.3 The social and historical context of this research project.

The psychiatric hospital in which I used to work has been subject of longstanding controversies. It has been described by several sources. An example is Inglott (1867 quoted by Sammut, 1998: 4), who stated that:

"The inheritance of an antiquated hospital building which was already recognised as being out of date before it was put into use in 1861."

Documents which discuss the conditions of this hospital include the ombudsman’s report on the “Treatment of Mental Patients” and the CPT’s (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment) “Report to the Maltese Government on the visit to Malta carried out by the CPT” in 1990, 1995 and 2001. In all reports, it has been pointed out that the acute wards of this hospital, house a number of chronic patients, and the mentally ill are mixed with mentally subnormal persons and others with special needs (CPT, 1992; CPT, 1996; Sammut, 1998).

According to Sammut (1998) refurbishment, improvements and developments at this hospital have been continuously in progress. Nonetheless, nothing has ever been done to improve the image of its nurses in the public eye. So much so, my work experience at this psychiatric hospital helped me realize that nurses working at a psychiatric hospital are often stigmatised and labelled by their peers as unknowledgeable people, good for nothing who spend their time at work guarding patients.

Furthermore, it has been reported in a prominent Maltese newspaper – The Malta Independent on Sunday – that a substantial number of nursing personnel
at this psychiatric hospital are on psychotropic medication (Alosio, 1998). The same reporter, quoted the Maltese director of psychiatry, as saying that “this phenomenon is found also in institutions such as prisons and hospitals where staff members are under constant stress and pressure” (Saliba, 1998 as quoted by Aloisio, 1998: 1). He also stated that members of the nursing staff have been working in this psychiatric hospital for decades (Aloisio, 1998).

This latter fact was also substantiated by the ombudsman in his report. He stressed that most nurses have been working at the hospital for more than thirty years or longer (Sammut, 1998).

Considering that the first diploma in psychiatric nursing course started only in 1992 (Incorvaja, 1999), the nurses were trained only as general nurses with hardly any emphasis on mental illness, its consequences and management. This problem is well summarised in the following extract from the National Policy on Mental Health Service (1995 as cited in CPT – 1996 report: 21)

“Although by international standards the complement of nurses is sufficient to cope with the nursing demands, their level of training is inadequate to proffer effective psychiatric nursing care notwithstanding that a good number of nurses are motivated and make an effort.”

It has been asserted in this same policy that the subject of mental health and its reform in Malta has long been a subject of frustration, hopelessness and anomalies (Incorvaja, 1999). The psychiatric hospital referred to in this study, was also said to have, for many years, ignored and left to decay the human qualities and potentials of many people (MHASD, 1995). In fact it has been
used over the years by people in governments for “punishing” nurses whose political affiliation differed from theirs (Sammut, 1998).

1.4 Importance of the study.

This study is the first one of its kind in my country. Though it is on a small scale and the results of which cannot be generalised, it brings to the foreground the complex feelings and experiences of general nurses working at the above mentioned psychiatric hospital.

The proposed Mental Health Reform in Malta is to increase the range, quantity and quality of the mental health services offered in this country (MHASD, 1995). Thus, in an era when the mental health sector in this island is going through great changes, I consider the findings of this study (which may be found in chapter 5), to be of great relevance to the nursing profession in Malta. They may instruct and guide the directorate of nursing on the measures to be taken so that the needs of these nurses would be fulfilled, whilst utilising them to their full capacity as accessible, cost-effective, full service providers. Thus in my final chapter, I shall be making recommendations for practice, education and research as a consequence of themes which emerge from the data.
Chapter 2

Literature Review
CHAPTER 2. LITERATURE REVIEW.

2.1 Introduction.

In this literature review chapter, I intend to discuss the four distinct subjects which formed the basis of my research question about the experiences and feelings of general nurses working at a Maltese psychiatric hospital. These four topics are:

- How mentally ill people experience their illness,
- Mentally ill patients’ experience of nursing care and hospitalisation,
- Feelings and experiences of caregivers’ relatives of mentally ill people,
- Feelings and experiences of general nurses caring for mentally ill people in general hospitals.

On enhancing my knowledge and information about these four topics, I was directed towards formulating my research question. The reason for this was that I felt that the feelings and experiences of nurses working at psychiatric hospitals have direct influence on the patients’ perceptions of their illness, their experience of nursing care and hospitalisation and the outcome of the latter. This is because nurses are the patients’ primary caregivers of mentally ill people when these are hospitalised for their illness.

Prior to focusing on the literature discussing each of the above topics, I would like to point out that I am aware that within the phenomenological approach – the approach used in this study – the literature review is usually delayed until after data collection. The rationale behind this is bracketing, or the notion that
the researcher should collect and examine data with an uncluttered mind. As discussed in chapter 3 (section 3.2.1), bracketing is the basis of Husserlian transcendental phenomenology. The approach of this study is based within the Heideggerian interpretive phenomenology. As described in section 3.2.2, within this methodology the researcher is allowed to maintain her preconceived ideas about the subject. Thus, I did not see any contraindication not to review the literature in the beginning of my study. This action allowed me to identify whether my research question has already been adequately answered, thus avoiding the replication of other studies.

2.2 How mentally ill people experience their illness.

Narratives of individuals with mental illness are quite rare in the literature (Johnson, 1998) though not completely absent. For example, in their book “Wounded healers: Mental health workers experience of depression”, Rippere and Williams (1985) provided graphic case studies taken from professionals' personal experiences of mental illness. However, very few research studies have endeavoured to discern the world of persons who are mentally ill from the perspective of the mentally ill persons themselves. Yet, insight into the lifeworld of people suffering form mental illness gives nurses the opportunity to venture into the lives of their patients, which may enlighten them to a more empathic (Johnson, 1998) and benevolent direction for nursing care (Hayne and Yonge, 1997).

The three research studies, which specifically addressed the question of what it means to be mentally ill, that were identified in this review are all in agreement...
about the intense suffering of these people (Chafetz, 1996; Hayne and Yonge, 1997; Johnson, 1998), as they constantly battle against their symptoms to maintain control over themselves (Chafetz, 1996). The participants in Hayne and Yonge’s (1997) study described this suffering as one which causes psychic pain which is tangible, soundless, screaming pain entombed somewhere deep inside the body. This struggle and pain often led mentally ill to ask existential questions like “Why me?”, “Why am I the way I am?” and “Why am I mentally ill?” – questions for which they do not find an answer and with which they cope with anger (Johnson, 1998).

This finding may be challenged when one takes into consideration that not all patients consider themselves mentally ill. Here, one might argue that these patients lack insight into their illness (Stuart and Sundeen, 1991; Thompson and Mathias, 1994), however there is an issue of who decides that someone is mentally ill and on what criteria. In Szasz’s (2000 quoted by Sullum, 2000) opinion, a psychiatrist could, if he were so inclined, diagnose as mentally ill someone with whose worldview he disagreed – “which is essentially what it means to say that a person is ‘suffering from delusion’”.

Though not intending to be as radical as Thomas Szasz, Peplau (1995 cited in Reynolds, 2001) further developed the notion on delusions in her extensive work on the interpersonal relationship model. She defined a “delusion” differently from the usual medical definition (Reynolds, 2002 – personal communication) of it being a false and fixed idea that is unaccepted by others of the same culture and beliefs (Stuart and Sundeen, 1991). So much so, Peplau
(1995 quoted by Reynolds, 2001) reconceptualized a delusion as an erroneous conclusion that was made by a person from an actual and real experience.

With these theories in mind, Kay et al's (1988 quoted in Johnson, 1998) questioning about the credibility of stories and experiences when these are narrated by psychiatric patients, may be disputed. This team of authors argued that a reader cannot trust these narrations to be true because of their being unintentionally contaminated due to the effects of the narrator's mood or memory deficits (Kay et al, 1988 cited by Johnson, 1998). On quoting this, Johnson (1998) could not help but wonder whether these beliefs have contributed to the paucity of research about how psychiatric patients experience their lives and illness. Nevertheless, she asserted that the issue with such studies is not whether the events happened exactly as the participants reported them, but how they experience their lives and illness.

The literature about this theme highlighted that through understanding the experiences of patients who are diagnosed as mentally ill, nurses are in a better position to offer therapeutic care and support to their mentally ill clients (Johnson, 1998; Hayne and Yonge, 1997). The findings from this literature review about how mentally ill people experience their illness, stimulated me to question whether nurses working at a Maltese psychiatric hospital, possessed the necessary attitudes and clinical skills to empathise with the patients' experiences and offer them therapeutic intervention that could result in favourable outcomes of the patients' illness as desired by them. This issue is
further examined in the literature discussed within the following section (see section 2.3).

2.3 Mentally ill patients' experience of hospitalisation and nursing care.

Two themes emerged from Armstrong's (1996) research study about the psychiatric patients' experience of a planned admission programme. These were the viewing of the hospital as a "sanctuary" and the feeling of belonging at the hospital. Depending on their life situations outside the hospital, patients often felt threatened or frightened and experienced a sense of relief and / or respite when being in hospital (Armstrong, 1996). This sense of belonging and physical and psychological safety, often leads to the revolving door admission patterns – for which a variety of admission programmes are being devised to curtail them (Armstrong, 1996). These include partial day hospitalisation, day treatment programs, respite programs, residential treatment and planned admission programmes (Armstrong, 1996). The latter, which was studied by Armstrong (1996), involved admitting patients every four, six or eight weeks during which admissions they met with members of the health care team including their treating physician. These planned admissions took place over a period of nine months, at the end of which, a summary team conference was held to evaluate patient achievement and stabilise outpatients treatment.

Contrary to Armstrong's findings, Cohen (1994) described psychiatric hospitalisation as an "experience of trauma". In her article, which examined this phenomenon she used a scenario to give several examples to justify her assertion. Cohen (1994) associated the core experiences of emotional trauma
mentioned by Herman (1992 quoted by Cohen, 1994) – terror, disempowerment and isolation, with the heart of a stay in a locked psychiatric unit. In corroboration with this are Joseph-Kinzelman et al’s (1994) findings of a research carried out to study the patients’ perceptions of their involuntary admission to a psychiatric hospital. Using an open-ended interview schedule, this team of researchers uncovered feelings of psychological pain, fear, vulnerability, anger, sadness and “being trapped” which were experienced by their research participants (Joseph-Kinzelman et al, 1994).

In the above study, all participants wanted the staff to offer emotional support by being flexible, conducting timely admission procedures, taking time to listen and exploring situations at the participants’ pace. They also suggested that the staff should be attentive to their physical and emotional needs, answer questions, offer explanations and reevaluate their medication (Joseph-Kinzelman et al, 1994).

Although they addressed different issues, Müller and Poggenpoel (1996), Ricketts (1996), Breeze and Repper (1998), McLaughlin (1999) and Talseth et al (1999) are in concordance with Joseph-Kinzelman et al (1994) findings which highlighted the clients’ need to communicate with staff members as a crucial aspect throughout their hospitalisation. On a similar vein, Reynolds et al (1999) argued that clients could inform nurses about what is effective, or ineffective about the nurse-client relationship.

McLaughlin’s research participants were in agreement that any genuine attempt
by nurses to communicate with them was useful and very much appreciated. However, they were adamant that they require more time in one-to-one psychotherapy and their responses suggest that this would improve care for them.

Talseth et al’s (1999) results of their research about the meaning of suicidal psychiatric in-patients’ experiences of being cared for by mental health nurses clearly highlighted this. In talking about good or bad nursing care, these suicidal patients emphasized their need for confirmation during their interaction with nurses when in hospital after suicide attempts or because of severe mental health problems with suicidal thoughts. Such confirmation must be recognition of the patient as a person whose ideas and expressions deserve to be met with respect and interest.

In their paper which examined what goes on between clients and nurses during interpersonal relationships, from the perspective of the clients, Forchuk and Reynolds’ (2001) findings substantiated the findings of the above mentioned authors. To answer their question “How do clients perceive the evolving therapeutic relationship with nurses?” these two authors compared the results of two qualitative studies carried out in two different countries – Scotland and Canada. Forchuk and Reynolds’ (2001) participants described a positive nurse-patient relationship as the cornerstone of their in-patient care. They pointed out respect, closeness, genuine likeness and trust with the nurse, when the relationship went well, whilst describing a painful experience when it did not work well. In addition, listening, availability, and a friendly approach were
identified as critical in the nurse-client interaction by the Canadian participants. Consistently the Scottish ones wanted nurses to listen, be sensitive to feelings, seek clarification of confused messages, help them to anchor accounts of problems in the personal time and setting of the problem, help them focus on solutions to problems, and to sound warm and genuine (Forchuk and Reynolds, 2001).

In a very negative tone, Warner (2001) pointed out, recently there has been no shortage of negative feedback on the care provided on in-patient psychiatric wards, much of it coming directly from service users. In a study conducted by the Sainsbury Centre for Mental Health (1998), users reported concerns about basic amenities as well as more serious problems such as feeling unsafe on the ward and thinking the nurses did not spend much time with them. This correlates with Rose's (2000) account of her lengthy stays in both acute and secure wards which were characterised by a lack of communication with nurses that prolonged rather than alleviated her distress.

Further research which concur with this issue are those of Müller and Poggenpoel (1996) and Ricketts (1996). In both studies, the participants delineated a lack of satisfaction with their interactions with nurses. The former study showed significant findings within the psychological dimension of psychiatric patients' internal environment with specific reference to their perception of the interaction with nurses. These included the negative aspects of stereotyping, custodialism, rule enforcement, lack of intimacy and lack of empathy (Müller and Poggenpoel, 1996).
All Breeze and Repper's (1998) research participants without exception, recounted experiences of having no control over their care. This is congruent with Ricketts' (1996) results. The latter corroborated this result with the ward manager of the ward where he conducted his study. The reason given for this lack of patients' involvement in their care was the unorthodox view that some clients may be unable to communicate with nurses effectively because of their mental state, especially during the early stages of their in-patient stay (Ricketts, 1996).

A consequence of this lack of patient empowerment is patients' tendency to develop "difficult" behaviour - one which threatens the nurses control and competence (Breeze and Repper, 1998). The patient participants in Breeze and Repper's (1998) research all carried the label of "difficult patients". They recounted their experiences of being controlled and their need and struggles to retain some element of control. On the other hand, in the same study, Breeze and Repper (1998) demonstrated that an empowering nurse-patient relationship, time and skilled interventions appeared to have a positive influence upon the care experience and subsequent patients' behaviours. This latter comment concurs with Forchuk and Reynolds' (2001) conclusions in which they argued that nurses ought to allow clients to have a more active role in problem-solving, especially in relation to their need for emotional support. This is also relevant to the suggestion in the Patients' Charter (1992 that clients should share in the responsibility for their own health, tell professionals what they want and be entitled to be treated as a person and not a case (Reynolds and Scott, 1999).
In the light of the above literature findings, where psychiatric patients (often referred to as clients) relate what they expect of the nurse-patient relationship and the nursing care they receive, I was prompted to ask how the developmental experiences of nurses – their education, clinical support, ward culture – impacts on the patients’ experience of the mental health service.

2.4 Feelings and experiences of caregiver relatives of mentally ill people.


I acknowledge that other research about the experience of relatives caring for mentally ill people have been carried out. Thus the above mentioned studies represent only a sample of those carried out between 1981 and 1999, which
turned up in a computer search done at the Malta Institute of Health Care’s Library.

In a critical review of the literature, Maurin and Boyd (1990) concluded that regardless of the population studied, mental illness creates a significant burden for family members. The phenomenon of caregiving was labelled as a “burden” because the person with mental illness requires that the caretaker places the needs and wishes of him/herself after those of the client (Jones, 1996; Tuck et al, 1997; Ricard et al, 1999).

In a recent research study about the experiences of family carers in Hong Kong, Ip and Mackenzie (1998) identified five main categories which emerged from the analysis of their interview transcripts. These were: emotional impact, coping and adaptation, psychosocial effects, social support needs and perception of mental illness and mental health services.

These categories concur with findings of other studies carried out in different countries. Family carers described a range of emotional reactions in living with mental illness and in coping with their relatives’ deviant behaviours and mood swings (Jones, 1996; Doornbos, 1997).

A myriad of emotional reactions and feelings were described by Eakes’ (1995) sample of parents of chronically mentally ill individuals when they got their child’s diagnosis. These included shock, disbelief, grief, anger, frustration, sadness, confusion and despair. These feelings of chronic sorrow are congruent
with Tuck et al’s (1997) research results which revealed that the diagnosis of mental illness in a child is experienced by the parents as a destructive force that interrupts and rapidly transforms the normative family life trajectory. This grief-filled experience involves both the loss of an imagined, idealised child and a transformation of the physically present child into a needy stranger (Tuck et al, 1997).

Siblings of mentally ill people go through tough times as well. Marsh et al (1994) listed the ten most salient themes which emerged from their study of this population, which are caregivers concerns, family disruption, trouble balancing needs, own needs not met, grew up too fast, guilt, helplessness and hopelessness, need to be perfect, poor self-esteem and chronic sorrow. Whilst supporting these themes, Kristoffersen (1998) highlighted that being a sibling of a mentally ill person is difficult since the experience is deeply rooted in the feeling that the psychological integrity of that sibling is weakened or at breaking point. Concordant with Marsh et al’s (1994) findings Kristoffersen’s (1998) study revealed that emotions of sorrow and loss stand central in the lives of all his participants experiences. He explained that these emotions are central because they feel that the mentally ill sibling is dead socially, that they have lost a brother or sister with whom they could associate and with whom they could share the important events in their lives, that they have lost the person as he or she was before the illness and at the same time the person who might have been if he/she were normal (Kristoffersen, 1998).
Mays' (1999) study involving ten male research participants identified that the degree of caregiver burden was found to vary according to the level of understanding and acceptance of the relative's illness, the period of caregiving and the caregivers' attempts to continue with their own lives. The respondents in this study talked about feeling overwhelmed with the problem of caring for a mentally ill relative, however they all expressed resiliency and willingness to adjust to the situation (Mays, 1999).

Family members who provide care to mentally ill relatives often feel helpless in dealing with problems associated with severe and persistent mental illness (Reinhard, 1994; Ip and Mackenzie, 1998). Because of this, many families seek support and information about illness from mental health professionals to help them cope with the burdens of their role (Reinhard, 1994). Although it was demonstrated that professional and social support can reduce family members sense of burden and feelings of helplessness (Norbeck et al, 1991; Reinhard, 1994; Horwitz et al, 1996), the caregivers respondents from Norbeck et al's (1991) study showed a consistent pattern reflecting extreme lack of support.

All the above caregiver studies reviewed, consider family caregiving a burden. Less is known about the benefits of caring for individuals with mental illness. Horwitz et al (1996) and Rhoades and McFarland (1999) studied this aspect of caregiving. Whilst acknowledging difficulties of caring for mentally ill relatives, the participants in both studies reported feelings of satisfaction arising from altruism, self-actualisation and gaining a purpose in life. Nonetheless,
Horwitz et al (1996) demonstrated that the satisfaction of caregivers is strongly associated with how much support they gained from mental health services.

The insight gained about the experiences and feelings of relatives caring for mentally ill persons, motivated me to inquire whether nurses’ attributes (both therapeutic and untherapeutic) identified by the patients’ themselves (see section 2.3), were also viewed by caregivers as unsupportive to their efforts to care for their mentally ill relative.

2.5 The experience of general hospital nurses caring for mentally ill people in general hospital settings.

Only two research studies were identified about this subject – one dealing with registered nurses’ perception of caring for adolescent females with anorexia nervosa (King and Turner, 2000) and the other studying the professional nurses’ experience of nursing mentally ill people in a general hospital setting (Mavundla, 2000).

In Mavundla’s (2000) study, the general nurses’ perception of nursing mentally ill people in general hospital settings was persistently negative with predominant feelings of frustration and fear. On the other hand, King and Turner (2000) results delineated the experiences of their nurse participants caring for young girls with anorexia nervosa as a bumpy and emotional journey filled with many lows but also with some highs.
In both studies, King and Turner (2000) and Mavundla (2000) conferred results which revealed the lack of confidence experienced by general nurses in dealing with their mentally ill patients, due to not being equipped with appropriate knowledge and skills. Thus in the conclusion of both studies, educational programmes which address interpersonal and assertiveness skills and skills for dealing with psychiatric patients were highly recommended. Furthermore, emotional support for general nurses who deal with mentally ill patients were also strongly suggested (King and Turner, 2000; Mavundla, 2000).

This literature revealed an insight into how people who are mentally ill perceive their experience. Nurses may not have sensitive awareness of the patients' world, unless they possess certain attitudes and skills that are said to be necessary to investigate the experience of the patient in a relationship that is said to be therapeutic. So much so, patients have pointed out that not only are nurses sometimes not therapeutic but they sometimes view the illness experience differently from them. This is particularly so if mental illness is viewed from a unitary paradigm, such as the medical neurobiological model (Barker et al, 1998; Reynolds, 2001). Attitudes and behaviours perceived by patients to be untherapeutic are possibly viewed by family caregivers to be unsupportive to their efforts to come to terms with and support their mentally ill relative.

The development of a clinician who is highly empathic, has investigative counselling skills, and an extensive knowledge of the therapeutic relationship and family systems, presents a considerable challenge to nurse educators (Egan,
Moreover, patients themselves have identified what sort of relationship they like to have with their nurse (Forchuk and Reynolds, 2001). Consequently, I felt the need to investigate the experiences of Maltese nurses working with the psychiatric inpatient context, since these were not provided with adequate education in mental health nursing.
Chapter 3

Research Design: Methodology and Methods
CHAPTER 3. RESEARCH DESIGN: METHODOLOGY AND METHODS.

3.1 Introduction.

In this chapter, I shall be discussing the perspective, methodology and methods, which I used to collect and analyse data in my study. I shall also be explaining why I opted to use them, whilst demonstrating the “fit” between the chosen methods and methodology by describing other methods that could have been utilised. Ethical issues and rigour of the study will also be outlined in the light of the methodology used.

This research, which aims to explore the feelings and experiences of general nurses working at a Maltese psychiatric hospital, followed a Heideggerian interpretive phenomenological approach. The philosophical underpinnings of this methodology are rooted within the interpretive paradigm (Masterson, 1996).

3.2 Philosophical underpinnings.

Within the interpretive paradigm, reality is seen as essentially relative and subjective. There is a belief that the world should be studied from an individual’s personal point of view “as different things take on different meanings to people in different circumstances” (Masterson, 1996: 19).

Munhall (1989 cited in Masterson, 1996) asserted that there are several key philosophical assumptions within this paradigm. These are:
- Individuals are seen as active agents who interpret their own experiences and create themselves by their inner existential choices.

- Individuals and groups have varying histories, varying "here and nows" and varying perceptions of the future.

- The world and its people are constantly changing and evolving, with the consequence that reality is dynamic.

- "Truth" is the interpretation of phenomena; the more shared that interpretation is, the more factual it seems to be; yet it remains temporal and cultural.

- The subjective experience of the individuals and groups is valued and described. Meanings come from the source and are not presumes, assumed or prescribed.


These assumptions contrast dramatically with those of the positivist paradigm, the focus of which is manipulation and control (Masterson, 1996). Although the positivist paradigm has informed the professional body of nursing for many years (Omery, 1983), its view of the human being is not comprehensive (Roberts, 1998).

Thus the use of positivism, with its underlying philosophy of quantifiability and reductionism (Masterson, 1996) was deemed inappropriate to answer my study's research question about complex nurses' experiences and feelings. This is because, human individuals exist and experience their lives in an environment which constantly bombards them with stimuli that colour and
influence their emotional feelings, thoughts, perceptions and behaviours (Thomson and Mathias, 1994).

3.3 Phenomenology.

A historical reaction to the inadequacies of the positivist paradigm when brought to bear on human experience is phenomenology (Anderson, 1991). It examines the lived experiences of humans, provides understanding of a person’s reality, values individuals and their relationships and embraces a holistic approach to the person (Holmes, 1990).

Hopkinson (1999) pointed out that the term phenomenology incorporates within it several methodologies, whereas Taylor (1993) mentioned not less than six types of phenomenologies. Nonetheless, all of them share certain characteristics including the concern with interpreting human experiences and the use of inductive research methodology to explore and describe subjective experiences (Hopkinson, 1999). Thus phenomenology is used to increase understanding where previously there was little information and awareness (Ryan, 1996).

In concordance with Masterson (1996), Hopkinson (1999) stated that there are two main schools of thought within phenomenology, namely: “Husserlian transcendental phenomenology” and “Heideggerian interpretive phenomenology”. Koch (1995) suggested that between these two are definite distinctions, which have implications for the methodology, employed.
A description of these two schools of thought follows. This is considered to be important since it would guide the reader to understand the reason why I chose Heideggerian interpretive phenomenology as the methodology for my study.

3.3.1 Husserlian transcendental phenomenology.

Husserl (1859 – 1938), the father of transcendental phenomenology, attempted to restore and capture the reality of humans, in their life-world in the belief that ideas do not occur in a vacuum but feed on and develop in response to pre-existing ways (Masterson, 1996). With transcendental phenomenology, Husserl wanted to bring to light the life experiences that shape our self-view.

There are three dominant notions that are essential to Husserlian phenomenology, namely intentionality, essences and phenomenological reduction or bracketing (Koch, 1995).

**Intentionality:** This idea was based on the assumption that our own conscious awareness is one thing of which we could be certain. The building of our knowledge of reality should therefore start with this conscious awareness (Koch, 1995).

**Essences:** These life and interpersonal experiences are assumed to be held in suspension (Masterson, 1996) and can therefore be isolated and studied (Thompson et al, 1989).

**Bracketing or Phenomenological reduction:** Schutz (1970 in Koch, 1995) highlighted that the first step in Husserl’s phenomenology is the “elimination of all preconceived notions”. The ultimate level of transcendental phenomenology...
is the bracketing of both the outer world and the individual’s consciousness (Koch, 1995; Masterson, 1996; Hopkinson, 1999).

Hopkinson (1999) criticised Husserlian phenomenology on the basis that a person’s understanding of life events cannot be isolated from their contextual world. Quoting Heidegger (1967), she sustained that bracketing is impossible as individuals always see the world in the light of their past experiences and understandings (Hopkins, 1999).

3.3.2 Heideggerian interpretive phenomenology.

3.3.2.1 Clarifying terminology.

Some of the literature concerning Heideggerian interpretive phenomenology referred to this approach as “Heideggerian hermeneutic phenomenology” (Koch, 1995; Annells, 1996; Masterson, 1996; van der Zalm and Bergum, 2000). However, as I furthered my knowledge about interpretive phenomenology and on in-depth discussions with my research supervisor and another expert on the topic, I realized that Heideggerian interpretive phenomenology and hermeneutics are two distinct methodologies, the philosophical beliefs of which are different.

In congruence to my conclusion, Byrne (2001b) pointed out that the terms “Hermeneutics” and “Phenomenology” are used interchangeably. However, she continued by highlighting that philosophical beliefs differ among phenomenologists and hermeneutic philosophers, because whilst phenomenology focuses on a person’s lived experience and elicits
commonalities and shared meanings, hermeneutics refers to textual interpretation and finding meaning in the written word (Byrne, 2001b).

Following my new insight “that in the context of nursing science where nurse researchers are exploring the meanings of research participants’ experiences, there is no such thing as Heideggerian hermeneutic phenomenology” (Hallila, L., 2002 – personal communication), I do not intend to refer to this school of phenomenology as “hermeneutic phenomenology” anywhere in this project, but I opt to use the term Heideggerian Interpretive Phenomenology.

Having said this, I shall now elucidate the principles of Heideggerian interpretive phenomenology, prior to discuss the reasons for choosing this approach in my study.

3.3.2.2 Principles of Heideggerian Interpretive phenomenology.

Heidegger (1889 – 1976) who was Husserl’s pupil argued to resist cartesian dualism on the grounds that individuals cannot relate to the world around them without being influenced by their background experiences (Koch, 1995). His beliefs liberate us from believing that mathematical physics and related social and natural sciences are the central clues to grasping the more complete human phenomena (Blitz, 2001).

In fact, the Heideggerian phenomenological view of the person arises from the ontological question: “What does it mean to be a person?” (Leonard, 1989). This phenomenological stance reacts against the cartesian tradition and sees a
person’s background – or past history – and perceptions as influencing his/her understanding of what is real (Koch, 1995; Masterson, 1996). As Blitz (2001) argued, what is distinctive about human beings is not that they are rational animals or a “mysterious compound of particles and consciousness”, but their ability to disclose their Being.

As its name denotes, interpretive phenomenology aims for a deeper and more interpretive understanding of the nature and meaning which individuals attach to their everyday experiences (Hopkinsons, 1999). Byrne (2001a) asserted that interpretive phenomenologists believe that meaning can only be understood by those who experience it, because people are whole and create their own particular meanings (Taylor, 1993; Blitz, 2001).

These “meanings” can be understood by engaging the person in dialogue which can occur by means of conversation or an interview, the resulting narrative of which becomes the text to interpret (Ilorrocks, 2000). Thus an understanding of their issues and concerns in everyday life are sought (Hopkinsons, 1999).

In the interpretive phenomenological approach, the researcher assumes a different role from the one in the Husserlian phenomenological approach. Masterson (1996) explained that in Husserlian phenomenology the researcher brackets him/herself from the interpretive process. On the other hand, Heideggerian interpretive phenomenology allows the researcher to bring his/her background, pre-understandings and frames of meanings to dialogue or interview with the research participant.
3.4 Choice of Heideggerian interpretive phenomenology for the study.

The study, which I carried out, concerns the lived experiences of nurses providing care at a Maltese psychiatric hospital. It focuses on the subjectivity of their experiences, feelings and perceptions as they carry out their duties day in day out. Since the real world of nurses in practice is one of human actions having human consequences (Taylor, 1993), I needed to choose a methodology with an orientation to concrete experiences, to persons' experiences of relationships with others, to beliefs and practices and to the intent to understand the meaning of the person's experience (van der Zalm and Bergum, 2000).

Heideggerian interpretive phenomenology satisfies all the above criteria, whilst it values the stance and background which the researcher brings to the study. Considering that I worked at the psychiatric hospital in question for about three years, I simply could not put my experiences, feelings and knowledge about the subject being studied, aside. Thus I feel that Heideggerian interpretive phenomenology is the ideal methodology to answer my research question.

3.5 Data collection.

A variety of research methods can be used across paradigms and methodologies (Smith, 1996). In order to explore the experiences and feelings of general nurses working at a Maltese psychiatric hospital, semi-structured interviews were used as the tool for data collection. A clear description of how this tool was used may be found in section 4.6. (See appendix D for interview guide).
I made this choice of data collection method rather naively. When I was still in the phase of research proposal, the idea of gathering qualitative data seemed the most daring and alluring. However, as I enriched my knowledge of interviews which were often described as "a multiple process of actively listening, guiding without leading, and simultaneous data collection, inquiry and analysis in order to share the meaning of the participants" (Perry, 1998: 18), the idea became more and more daunting.

Thus I opted to use a semi-structured interview. I thought that an interview guide, as delineated by Rubin and Babbie (2001), would be very useful and would make me feel more comfortable in my role as an interviewer. Nevertheless, I intended to ask the questions of the interview guide in a flexible manner and as directed by the flow of information gained from the respondent. This method of data collection was also used by Thompson et al (1995) in their study of "The experiences of patients and their partners one month after a heart attack".

On enhancing my comprehension of the central role which storytelling plays in interpretive phenomenology, I realized that my data collection tool should have been as inductive as possible (Hallila, L., 2002 – personal communication) allowing the participants to tap into their more immediate experiences (Benner, 1994). Thus interpretive phenomenologists favour the use of unstructured interviews (Reynolds, W., 2002 – personal communication) which fit well with both the interpretive phenomenological methodology and the interpretive paradigm, since both attempt to understand a person's individual viewpoint in a
particular context, without elements of control (Roberts, 1998). However, as Benner (1994) asserted, novice interpretive researchers, like myself, need to learn to listen to the story with as little interruption as possible, whilst participants must be instructed that narrative accounts of events, situations, feelings and actions are wanted.

Highly structured interviews which attempt to ensure that all respondents are asked the same questions in the same sequence to maximize the comparability of responses (Rubin and Babbie, 2001), were not considered as an option for the data collection method. This was because these kind of interviews reduce the natural conversational nature of the interview and the interviewer's flexibility to follow up on important unanticipated circumstances or responses (Rubin and Babbie, 2001).

Besides interviews, a questionnaire with open-ended questions could have been used to ask nurses about their experiences and feelings. This research method would still have elicited qualitative data in the form of words. However, this data is just descriptive and cannot be exploratory, because unlike in an interview, the researcher is not present to investigate in greater depth the experiences mentioned by participants. Consequently, questionnaire data should be treated at face value and there is no opportunity to unravel the real meaning of each individual response, since what people say and what they mean is different (Parahoo, 1997). Hence, this method was not deemed to fit within the interpretive phenomenological methodology.
3.6 Pilot / Rehearsal interviews.

Piloting my interviews was vital. As the role of researcher / interviewer is new to me, not only did I need to develop my interview skills, but also I needed to discover the likelihood of nurses’ understanding and responding to my questions.

I conducted two pilot interviews with two colleagues of mine who are general nurses at another hospital but who have spent some time working at a psychiatric hospital. I am aware that pilot interviews should be conducted with interviewees who are representative of the population from which the participants are drawn, as suggested by Lucock (1997), however, since I did not find any volunteers from the population in question, this was the closest I could get.

I carried out these interviews on the date and at the time and venue chosen by the interviewees themselves. Nonetheless, the first pilot interview was not quite what I call successful! Though the interviewee did not express it specifically, it was evident that she had fitted me in her busy schedule and wanted to get the interview over and done with. I tried not to be influenced by this attitude but it was practically impossible. She asked me to see my interview guide, which I showed her voluntarily. She then started talking about each and every point in the guide without leaving me space to ask her to elaborate. This interview did not take more than twenty minutes!
It is quite understandable, then, that I approached the second pilot interview with considerable misgivings. However, by acting on my research supervisor’s suggestions, I managed to conduct this interview better.

3.6.1 Learning points from pilot / rehearsal interviews.

- I realized that some interviewees will present a greater challenge than others. Thus it was indispensable for me to work at establishing a rapport with the interviewee.

- There could be unforeseen impediments during the conduction of interviews such as lack of privacy and interruptions, which may distract both interviewer and interviewee. In such instances I could negotiate a fresh time and place for the interview.

- Since in the first interview the interviewee spoke fast and without breathing space, field notes written after the interview proved to be useful. I also realized that the noting down of points during the interview so that the interviewee could be asked to elaborate later could have been indispensable.

- The interview guide seemed to be appropriate since it appeared to cover the aims of my study.

- Though I was using an interview guide, I still intended to engage in conversation with my interviewees. Thus my major anxiety was caused by
the fact that I did not know when, how and whether to intervene when interviewees were answering my questions. I am conscious of my own contribution to a dialogue but I did not want to lead my interviewees to give me answers which I wanted to hear, rather than what they felt and thought. In my second pilot interview I successfully attempted to practice my communication skills, which resulted invaluable in later interviews.

- I attempted to practice transcription of these interviews, which made me appreciate how much of non-verbal communication was lost in the process. I was always aware that spoken Maltese was quite different from grammatically correct written Maltese. Thus to transcribe the interviews word for word did not prove to be without difficulty.

- Translation to the English language – considered important for the reporting of this study – was the most arduous task, since I did not want to lose any of the meaning of the interview content during the translation phase. Thus for later interviews I sought the assistance of a friend with a better mastery of the English language than myself so that she would help me capture as much content essence of these interviews as possible. I was mindful of the fact that this conflicted with what I promised the study’s participants in the research information form that “nobody except myself will have access to this information”. This was therefore discussed with the participants prior to the interviews and their verbal consent was sought.
3.7 **Ethical Implications.**

Throughout the following chapter I shall be discussing some ethical issues, namely anonymity (section 4.5) and imposed participation (section 4.4). Thus, I am dedicating this section to elucidate in detail the ethical issues, which were addressed in this research study.

3.7.1 **Voluntary participation, Informed consent and Participant Autonomy.**

In view of the ethical demand of participant autonomy, the researcher is obligated to ensure that potential participants are given as much information as possible in order to voluntarily decided whether to consent to participate in the study (Rubin and Babbie, 2001). I addressed this need by formulating a thorough research information form followed by a consent form at the bottom which had to be signed by potential participants had they conceived to participate in my study (see section 4.4 and appendix A).

After much deliberation with myself about the pros and cons of approaching the nurses and giving them the letter by hand as opposed to mailing it to them, I settled for the latter since I felt that in this way they would have more freedom to decide whether to participate. My presence when handing them the letters and the fact that they knew me personally, would have interfered with their decision as they could have felt obliged to participate in my study out of friendship's sake.

To further enhance informed consent, I verbally explained to each participant what the study was all about and waited for their response prior to starting the
interviews. They were also allowed to ask any questions regarding the study and their part in it, which I answered promptly and willingly.

3.7.2 No harm to the participants.

The subject of "non-maleficence" or "no harm to participants" involves protecting the participant from possible psychological and / or physical harm when intimate details are disclosed and painful experiences discussed, requiring confidentiality and anonymity and a weighing up of risks and benefits (Rubin and Dabbic, 2001).

3.7.2.1 Participant protection from psychological harm.

Since the conceptualization of the idea to study the feelings and experiences of general nurses providing care at a Maltese psychiatric hospital, I was aware that the data, which I shall be collecting, would be sensitive in nature. Thus I was aware that situations may arise that necessitate abandoning further investigation of any area that is too painful for the participant to discuss despite its potential usefulness to the research. This decision was made in view that it would be unacceptable for the researcher "to advance a research agenda at the psychological expense of the participant" (Kavanaugh and Ayres, 1998: 95).

As elucidated by Heywood-Jones (1999), I made it clear to each and every participant prior to the interview that they were free to share with me those ideas, feelings and experiences only which they feel comfortable about disclosing.
I was prepared to allow any participant, who seemed to be distressed during the interview, to withdraw from the study. The opportunity of withdrawal from the study at any time, even if this involved not giving a reason, was also highlighted in bold capitals in the research information letter, which I sent to my potential participants.

Before the beginning of the interviews, I also ensured the services of a qualified psychiatric nurse who was willing to act as a counselor to those participants who could have become distressed by the re-awakening of unpleasant memories during the interviews.

### 3.7.2.2 Anonymity and confidentiality

The protection of participants' identities is a major concern in the protection of their interests and well-being. If revealing their responses would injure them in any way, adherence to this norm becomes all the more crucial (Rubin and Babbie, 2001).

From earlier on in my research I had foreseen that the information provided to me by participants during the interviews could be very delicate. I could predict that they would have to disclose, amongst others, their political opinion – either directly or indirectly, thus I made sure that the issues of anonymity and confidentiality were completely covered.

Although it was clearly mentioned in the research information letter and they had signed the consent form, verbal permission to audiotape the interview was
sought. Following the interview I gave the participants’ the choice to either keep the audiotape themselves or have it erased by myself after transcription and data analysis. All the participants agreed that the data should be destroyed by myself.

Since it was not mentioned in the research information letter, I verbally highlighted to them that a trustworthy person who will help me with translations, was going to have access to the provided information, beside myself. None of the participants had any problem with this. They were also assured that the raw data will be stored in a secure place with no access to anybody else.

Regarding anonymity, I made sure that code numbers and pseudonyms would be used instead of participants’ names and any references to the name of the hospital they work in or wards in which they provide care would either be altered or omitted from the transcripts to protect participants’ identification.

Confidentiality in phenomenology was elucidated by Rubin and Babbie (2001) to involve non-identification of the individual participants to third parties. Sandelowski (1994b) warns about the use of quotes in reporting studies’ results which may be too revealing especially when the sample is small and when participants in the study are likely to recognise each other in the quotes selected. Thus I requested the permission from participants for using their quotes and explained to them that they could withdraw any information provided by themselves at any point in the study.
3.8 Rigour of the study.

Considering the nature of methodology used to answer my research question, it could be claimed that applying objective criteria to establish validity and reliability of the study would be inane. This is because, qualitative research emphasizes the uniqueness of human situations and the importance of experiences that are not necessarily accessible to validation through the senses (Sandelowski, 1986). Because of this, Koch (1996) maintained that there is lack of agreement on the criteria of rigour in qualitative research. Besides, Aroni et al (1999) argued that the concern with rigour is rooted in the positivist, reductionist modes of thought. However, they continued that if rigour has to be demonstrated, the responsibility lied solely in the researcher's hands as he/she attempts to manifest to integrity, credibility and competence of the study (Aroni et al, 1999).

Points regarding the rigour of the study, raised by Hallila, L. (2002 – personal communication) were:

- correspondence between the chosen method and the phenomenon being studied (section 3.5)
- accurate selection and description of participants (sections 4.3 and 4.5)
- whether the researcher has influenced the participants' accounts (section 3.5 and 4.6)
- participants' own narratives are quoted in the study (chapter 5)
- as an outcome of the analysis, phenomenological construction is carried out by the researcher (chapter 5)
- relationship between researcher and research participants
• validation of analysis by participants.

As denoted in the brackets, the first five points are discussed elsewhere within this dissertation. Thus, I am going to discuss the last two points which show rigour within a study.

3.8.1 Relationship with participants.
Lucock (1996) asserted that rigour from the qualitative perspective is dependent on the relationship built up between interviewer and participant. In relation to this, when discussing the researcher-interviewee relationship, Sandelowski (1986) warned that the consequences of closeness between the two is two-fold—both positive and negative. On the one hand, the researcher in a close relationship with his/her interviewee is more likely to have direct access to the latter’s experiences, however he/she may also be unable to maintain distance from those experiences required to be described or interpreted in a meaningful way (Sandelowski, 1986).

As I point out in section 4.3, I was more or less acquainted with my interview participants. This enhanced our relationship and I felt that it helped the participants to give a detailed account of their experiences. To support this there is Rapoport and Rapoport’s (1976) comment, which assert that the formulation of a relationship between the interviewer and interviewee is an important element in achieving the quality of information.
A useful way to view researchers in qualitative inquiry is "as subjects" in their own studies (Sandelowski, 1986). This is particularly true in my case since my three years working experience at the particular mental hospital influenced me and informed me about the subject under investigation. However, with coaching and support from my research supervisor, I resisted the threat of entangling my own experiences with those of my participants.

3.8.2 Participants' validation of data.

As Sandelowski (1993) pointed out there are both pros and cons in allowing participants to check the interpretation of the data they provided. The advantages include the fact that this process validates the researcher's interpretations and enables the participants to have access to what has been made of their experiences (Sandelowski, 1993). Nevertheless, the stories that participants tell in interviews are constantly changing—they only represent a particular moment in their lives (Sandelowski, 1993). Thus, participants' access to the researcher's interpretation of these narratives may undermine the trustworthiness of a project since stories previously told may elicit feelings the participants' no longer have, thus they may want to alter such stories or completely removed from the data. (Sandelowski, 1993). However, one might argue that on returning to the participants after a period of time might elicit other data which they remembered or did not think about during the interview (Reynolds, W., 2007—personal communication).

For the data analysis process (see section 4.9) I used Colaizzi's method. Adherence to this method obligates the researcher to go back to the research
participants and ask them whether the analysis describes their experiences (Colaizzi, 1978 in Knaack, 1994 quoted by Smith, 1996: 77). Thus I returned to my participants and asked them whether I understood their experiences correctly and whether my conclusions about what they said were right. On doing so, I reminded them of confidentiality and anonymity and encouraged them by telling them that the information they provided was very useful.
Chapter 4
Data collection and Analysis
CHAPTER 4: DATA COLLECTION AND ANALYSIS.

4.1 Introduction.
In this chapter, I shall be discussing how I collected and analysed the data. However, prior to these sections I shall include and discuss issues, which led to these two events. As instructed by Lucock (1997: 71) in the dissertation guide, I would be “telling it ‘warts and all’”!

These issues include:

- Ethical clearance (section 4.2),
- Selection of participants (section 4.3),
- Permission of participants (section 4.4),
- Characteristics of sample (section 4.5).

At the end of the chapter, I shall be discussing the limitations of this study.

Although I shall be presenting the content of this chapter thematically, I do not intend to imply any linear chronology. The sub-titles which I shall be using are there only to provide signposts throughout this dissertation which will help the reader to move confidently back and forth, thus making this project more reader-friendly.

4.2 Ethical clearance
Ethical clearance proved very difficult to acquire, not because of the topic, which I proposed to study, but mainly due to the lack of information about ethical research
committees in Malta and also because of the lack of support and cooperation from the people contacted.

My unfamiliarity with such ethical committees triggered me to e-mail the students’ advisory service of the University of Malta. My e-mail was directed to the Communications Officer at the Institute of Health Care, who advised me to contact the Bioethics Consultative Committee. On doing so, I was informed by the committee’s secretary that I should write to the Ethics Committee of the University of Malta, a committee about which the people at the students’ advisory service did not know anything! Though I wrote to the head of this committee twice, I never received any answer (See appendices I(i) and I(ii)).

At this point, I discussed my difficulties with my research supervisor and the programme director of the M.Sc in Nursing Course. The latter suggested:

1. That I should contact any Maltese nursing authority to enquire about the availability of any research ethics committees and their remit.

2. To approach the hospital where I plan to conduct my study to see whether there is any research policy or forum.

3. That in the absence of the above committees, I should write to the hospitals nursing director, offer a clear account of the planned research and ask for permission to proceed. (Price, B., 2001 – personal communication). (See appendix H).
I acted upon the first suggestion and wrote to the Institute of Health Care’s director, to whom I explained my research and my query. Nonetheless, I received no reply for my letter (See appendix J).

As for the second suggestion, there was no need for me to inquire about any research forum or policy at the hospital in question, since from my working experience there, I knew there was none. Therefore, I wrote to the manager of the local psychiatric inpatient services, explained my research proposal to him and asked for his kind permission to approach nurses at this hospital (see appendix K). This action proved successful, for I received a positive and quick written response stating that this research would be very useful both for my personal advancement and for the mental health services in Malta (See appendix L). Following this enthusiastic response, I could embark on my research project.

4.3 Selection of participants

A purposive sample of general nurses was chosen for their ability to describe their experiences and feelings. All the general nurses working at this particular psychiatric hospital were eligible to participate in this study. Since “ability” to participate includes requisite time and experience of the phenomenon under consideration, the choice was narrowed to exclude those nurses who were employed in the past two years, the reason being that these would still be orienting themselves to the place and had not yet experienced most ups and downs of their work.
In the remaining population, there were those nurses whose potential I knew well and others with whom I was less acquainted. Out of these, the former seemed most likely to provide rich information about the phenomenon under study.

At this stage, however, I had no guarantee as to the nurses’ willingness to participate in this study and to discuss their experiences and feelings with me. Therefore, I decided to send a consent form to twenty nurses and act according to the response I get. These were chosen on the grounds of my subjective opinion about them and their ability to articulate their feelings and experiences. Due to time constraints, I did not intend to conduct more than twelve interviews.

On the contrary to my expectations the response was quite poor. In fact I received back eight positive responses, out of whom two decided to drop out of the study prior to the interview date. Hence, the sample of this study consisted of six general nurses who provided care at the psychiatric hospital in question. Nonetheless, considering that I selected a purposive sample for a phenomenological study, this was considered to be adequate (Sandelowski, 1995).

4.4 Permission from participants.

The ability to express feelings and describe experiences entails reflection on these experiences in specific situations. This is unlikely to be achieved in the face of constraints and coercion, since such reflections on possibly challenging and painful experiences requires both motivation and participation. In view that imposed participation is ethically unacceptable, I wrote to the twenty chosen nurses individually.
In my letter (see appendix A), which was written in Maltese (for translation, see appendix B), I explained to each and every one of them about my research and the purpose why I am undertaking it. The length of the interview and its focus was disclosed to them, as well as the fact that I intended to audiotape it. Ethical considerations of confidentiality and freedom to withdraw from the study at any time, were also elucidated in the letter.

At the bottom of the letter, I included a consent form, which they had to sign if they agreed to participate in the study. I gave them fifteen-day chance to send this back to me in the self-addressed envelope provided.

As mentioned in section 4.3, I received eight signed consent forms. I contacted each of the nurses who were willing to participate in the study, by telephone and agreed with them on the date, time and venue for the interview. The dates were set in about a week after the first contact with them was made, to give them time to reflect on their decision to participate. One nurse dropped out of the study when I contacted her first, whilst the other withdrew his participation during this week’s "reflection period" – just the day before the interview.
4.5 Characteristics of sample.

Table 1: Table to summarise characteristics of sample.

<table>
<thead>
<tr>
<th>Case</th>
<th>Pseudonym</th>
<th>Age</th>
<th>Grade</th>
<th>Experience at psychiatric hospital</th>
<th>Previous experience elsewhere</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Esther</td>
<td>28y</td>
<td>SN</td>
<td>7 years</td>
<td>Haematology ward - UK Medical ward - UK</td>
</tr>
<tr>
<td>2</td>
<td>Martha</td>
<td>50y</td>
<td>SN</td>
<td>20 years</td>
<td>Medical ward - UK Medical ward - Malta Surgical ward - Malta Elderly care - Malta ITU - Malta</td>
</tr>
<tr>
<td>3</td>
<td>Kathrina</td>
<td>30y</td>
<td>SN</td>
<td>10 years</td>
<td>None</td>
</tr>
<tr>
<td>4</td>
<td>Lucia</td>
<td>38y</td>
<td>SN</td>
<td>18 years</td>
<td>None</td>
</tr>
<tr>
<td>5</td>
<td>Sandro</td>
<td>51y</td>
<td>SN</td>
<td>22 years</td>
<td>Surgical ward - Malta</td>
</tr>
<tr>
<td>6</td>
<td>Francesca</td>
<td>41y</td>
<td>SN</td>
<td>20 years</td>
<td>None</td>
</tr>
</tbody>
</table>

Out of the six nurses who participated in the interviews, five were females and one was male. All of them are Maltese staff nurses whose age ranges from 28 years to 51 years. Their years of experience at this psychiatric hospital range from 7 to 22 years. Three of them had no working experience in other hospitals prior to their recruitment in this hospital, whilst the other three had nursing experience elsewhere. Two of the latter provided care in hospitals in the United Kingdom.

All participants agreed voluntarily to supply data in order to describe the overall characteristics of the sample (for questionnaire see appendix C). Nonetheless, I decided not to reveal the name of the hospital nor the wards in which they work. As the Maltese saying goes: “Malta zghira u n-nies maghrufa’” - “Being a small island, Maltese people know each other”, thus providing such specific data would easily give away the participants’ identity, especially as the sample is small (Sandelowski, 1994a). This would conflict with the promise of anonymity outlined in the informed consent. My decision not to reveal the above mentioned is also based on the assumption that the participants’ are less likely to be identified by
their quotations. I am aware that this would make reader analysis and comparative studies problematic but I would rather protect the participants’ anonymity.

4.6 Data collection.

Data was collected over a three-month period at a time and venue chosen by the participants. Prior to each interview I worked hard to establish a trusting relationship with the participants which I learned from the pilot interviews was necessary to sharing understandings. To enable myself to build such a relationship, I engaged myself in general discussion with them as we made ourselves comfortable in the chosen setting. In fact I found that success of the interviews depended on the atmosphere of reciprocal trust and agreement that was established from this initial interaction.

As the trusting relationship developed I moved on to explain to each individual participant what the study was all about and why I chose this particular subject. With them I went through the research information form and verbally explained to them what they have consented for. Since it was not written on this form, I explained to them by word of mouth that another person was going to help me with the translations of transcripts and that parts of the interviews may be reproduced verbatim in the report. Thus prior to the interview, I obtained their verbal permission for these two. Then, I allowed they time to ask me any questions that they felt were important to clear any doubts, which they might have.

With the interview guide at hand, I then commenced the interview with the following broad question: “Can you tell me about your experience at the
psychiatric hospital? You can start by telling me about your first days when you started working there .......” The interview continued with myself engaging in a conversation with the participants especially when they included comments like Kathrina’s:

“This may sound unbelievable, but you should know. You worked there for some time. You must know that what I’m saying is true!”

In such instances I allowed myself to give my own view about the subject discussed. I view this action appropriate within the chosen methodology, as in Heideggerian interpretive phenomenology the stance which the researchers bring with them to their studies is particularly valued, because “they are inseparable from their worlds; they are constructed by and construct their world as the people whom they are studying” (Masterson, 1996: 22).

Every now and then I prompted the participants with an open question from my interview guide. Nonetheless, I asked the questions flexibly, directed by the flow of the participants’ story-telling. At times, clarification of some points was essential but not always immediately possible. Thus, I took notes of these elements and re-introduced them into the interview at an appropriate time. Examples of prompts used to enable the participants to elaborate more about some incidents were: “Can you tell me more about that incident?” and “Give me an example of ...”. In some interviews, there was no need for me to ask all the questions in my interview guide, since the participants discussed these points without the need for prompting them in doing so. Therefore, as pointed out in section 3.5, though unstructured interviews are favoured within my chosen methodology, the degree of
structure in my interview guide did not interrupt the respondents’ flow of ideas and did not inhibit them from digging deep into their experiences.

After each interview, I noted in my field notes points about the interview itself. For example, on one occasion I wrote:

"Sandro appeared really moved when he described his first day at the hospital. He clenched his fists .... He looked scared – as if he was reliving the experience."

Whereas, after I conducted the interview with Lucia, I wrote:

"This participant did not seem comfortable at the start – as if she had plenty to say but did not know from where to begin."

Since in transcripts most of the observed features of speech such as changes in pitch and rate and non-verbal communication are virtually impossible to be represented (Sandelowski, 1994), these field notes became an indispensable tool for interpretation of data.

Therefore, interpretation began during the interviews as both myself and the participants engaged ourselves in the conversations and interacted with the story being told. Each interview was concluded with time to unwind in which the participants gave me feedback about the interview itself. Two of them expressed enthusiasm about how they thought the study was of value, whilst another participant was grateful that she was given the opportunity to open up and “get it off her chest!”.

4.7 Language used in interviews.

The main native language in Malta is the Maltese language (Brincat, 2000). However, since the English language has some influence on the Maltese population
and culture, there is a section of the Maltese population who tend to speak the English language even socially and informally, whilst others tend to mix the Maltese and English languages when they speak (Brincat, 2000).

Conversations during the interviews were necessarily conducted in the Maltese language. However, a couple of participants had a tendency to use some English expressions here and there in their conversations whilst switching to the English language to explain certain issues especially those pertaining to their psychological feelings and subjects which had to do with nursing. This phenomenon may be due to the reasons highlighted by Brincat (2000), one of which is that because post-secondary school text-books are written in the English language, people tend to use the same terminology when speaking.

As pointed out by Brincat (2000), there is, then, another section of the Maltese population who feel more comfortable to use the English language in their everyday life. A particular case in point is that of my interview with Martha, after which I noted in my reflective research diary:

"This participant seemed to be more confident to use the English language when expressing herself and describing her experiences."

4.8 Translation of verbatim transcripts.

Following the interviews, I transcribed the conversations verbatim. Afterwards, with the assistance of a colleague – as mentioned previously - I translated these verbatim transcriptions entirely into English.
These translations, however, though important for the reporting of this study, proved problematic. As Perry (1998) pointed out, translations of transcripts from one language to another, betrays the context from which the language is derived. Hence, though the translations carried out aimed to remain faithful to the text the quotations from transcripts presented in this thesis are only approximations in the English language rather than equivalents.

In order to analyse and interpret the conversations without separating them from the culture and the world in which they were created (Sandelowski, 1994), I used the Maltese text throughout the entire process. Therefore the translated scripts were used solely for the purpose of reporting quotes in this study.

Later I realised, however, that I could have done without translating the Maltese transcriptions into the English language. I could have translated only those parts of the text, which I wanted to quote. This procedure was carried out by Perry (1998) in her attempt not to lose any of the essence of the conversations, because as she put it: “If the words are part of a conversation which is a manifestation of a context, then by trying to fit the words into an alternative (English) expression, I am in effect divorcing them from the world that created them” (Perry, 1998: 48).

4.9 Data analysis and interpretation.

Because Heideggerian phenomenological methodology is based on the assumption that we are interpretive beings, with the participants relating their interpretation of events, thoughts, feelings and experiences, interpretation by the research starts at the interview stage (Lucock, 1996). Therefore, interpretation is made by the person
telling the story and by the one hearing it, since both of them bring to the situation their pre-understandings and prejudices (Masterson, 1996), which in my case, I found that these facilitated the disclosure of information from the participants. In this process, data is generated rather than collected and further construction of new understandings takes place during the interaction between the researcher and the recording or transcribed narrative (Perry, 1998).

Prior to transcribing each interview, I listened to the recordings a number of times to gain a sense of the whole story. Later, followed the translations into the English language, as described in section 4.10.


Despite having used an interview guide, I looked at the text as a whole. I read the transcripts several times as a whole and made note of the topics, issues and significant statements that directly pertain to the topic under investigation. These, together with notes from my reflective research diary formed the basis for further interpretation.

Next I attempted to extract meanings as they came forth from the “significant statements”, whilst looking for similarities and contrasts between participants’ accounts. Throughout this process I did my best to remain faithful to the original
texts by constantly re-reading the transcripts and comparing them to my interpretations.

Following my interpretation of the data, I approached my research participants to see whether my conclusions and interpretations were correct. This is described in section 3.8.2.

4.10 Limitations of the study.

4.10.1 Research tool.

As pointed out in sections 3.5 and 4.6, I used a semi-structured interview as a means to collect my data. Notwithstanding that I was very flexible in the way I used the interview guide, the fact remains that the research method has deviated from the purist view of that within a phenomenological study.

Throughout the process of this research, I continuously furthered my awareness about the interpretive phenomenological methodology. The insight which I developed about the subject, enhanced my understanding that a purely inductive method should have been employed within the methodology. This would have enabled me to comprehend human experiences through the analysis of the participants' description of consciousness and direct experiences. So much so, phenomenologists recommend that a skilled interviewer can facilitate deep understanding and get at the essence of the phenomenon by using one open question and nothing else.
Thus, ideally I should not have approached the participants with any preset questions, but I should have asked one open question to open up the dialogue between myself and the participant, and then used prompts to enable the latter to give more detail (Hallila, L., 2002 – personal communication).

My slightly heavier degree of structure in the interviews may have impeded the participants to open up completely and interfered with the flow of data provided by the participants.

4.10.2 Sample size.

This research is a small scale study which involved a sample of six participants. More interviews would have enhanced the rigour of this research, since they would have generated more data for a deeper understanding of the phenomenon studied. Mindful of this fact, the low response of nurses to my research information letter rendered a larger sample improbable. Nevertheless, Sandelowski (1995) recommended a sample size of six participants for a phenomenological study directed towards discerning the essence of experiences.

4.10.3 Presentation of findings.

Koch (1996) highlighted that a phenomenological research study may be judged by the detail provided in the contextual information because this affects the degree of transferability of findings. However, due to the small sample size and the sensitivity of the phenomenon studied, I thought that it was essential to present the data in such a way as to disguise any obvious participants' individual characteristics. This was done to preserve their anonymity.
Another very important issue in the presentation of findings is the balancing of description, analysis and interpretation (Sandelowski, 1998). Though I paid maximum attention to this point, I feel that my presentation of data has a greater element of description and less analysis and interpretation, although these are not lacking. I attribute this flaw to my inexperience in doing research.

Nonetheless, I consider this research project a positive learning experience which enriched my personal development and my comprehension of nursing research and phenomenology.
Chapter 5

Presentation of Findings
CHAPTER 5. PRESENTATION OF FINDINGS.

5.1 Introduction.
In this research I studied the feelings and experiences of general nurses providing care at a Maltese psychiatric hospital. Three major interrelated themes were identified from the interview data. These were:

- Psychiatric nursing practice,
- Hospital culture,
- The meaning of nursing to nurses and patients.

These themes, together with their related concepts will be presented within this chapter. Extracts of the conversations will also be presented as exemplars to illustrate them. As shown in Table 1 in section 4.5, I shall be using pseudonyms to identify participants and their quotations from interviews. Furthermore, I intend to refer to the psychiatric hospital in question as “St. John’s Hospital”, when using quotes in which participants referred to the hospital by its proper name. This I shall do so that anonymity of participants will be preserved.

5.2 Psychiatric nursing practice.
Within this broad theme of psychiatric nursing practice, participants were focused on their feelings about the discipline and how prepared they were for clinical practice. This focus is illustrated by concepts emerging from the data that were related to the broader theme of how psychiatric nursing was practised.
5.2.1 Career choice.

This concept is included within the broader theme of "psychiatric nursing practice" because I felt that the circumstances under which a person enters the discipline of psychiatric nursing, determine his / her commitment towards practice and the quality of psychiatric nurse he / she is likely to be.

All the participants recounted their experiences and feelings related to the days when they started work. Kathrina, a 30-year old nurse described her rationale for choice career in the following manner:

"...anyway, when I started my career I chose to work at St. John's Hospital. I wanted a challenge...

This is concordant with Moir and Abraham's (1996) findings which highlighted that psychiatric nursing is appealing to student nurses who like challenging work and prefer to work autonomously and on their own initiative.

Experiences like that of Kathrina, however, are but a few, with only Esther stating that at the end of her nursing course she was particularly interested in working within the mental health sector.

The reasons behind the choice of nursing speciality and those, which make nursing in the mental health sector a less favoured choice, were discussed by Stevens and Dulhunty (1992). They identified personality and individual preference as playing a key role in a nursing student's career selection. They highlighted that fear and mistrust of the mentally ill and a negative impression of the psychiatric nursing environment were the most common explanation for the nursing students' aversion to psychiatric nursing.
The other participants gave other reasons why they started working at this psychiatric hospital. The most significant of these were voiced by Francesca and Sandro. Francesca, a 41-year-old nurse related the reason why some twenty years before she was posted at this hospital.

“Well...I didn't have much choice. I was sent to St. John's Hospital because I didn't do very well in my final exams. Well, I did pass. But not with flying colours. My colleagues who got the first thirty placing were posted in high tech, poshy areas...but me, me, having placed 78th, I was posted at this psychiatric hospital - at this Cinderella hospital where nobody wants to work...”

Some nurses working at the psychiatric hospital in question perceive that they were transferred to this hospital and made to work there, as a punishment for various reasons, including political affiliation different from that of the party in government. Sammut (1998) alluded to this fact, in his ombudsman report on the treatment of mental patients in Malta. To further substantiate this, plenty of newspapers reported nurses' unions' condemnations of nurses being transferred from one department to another, simply because of their political opinion. To mention but two of these, The Times of Malta on the 11th November 1996 reported the Malta Union of Midwives and Nurses (MUMN)'s claim that “vindictive transfers” were taking place, where “nurses supporting the party in government were posted in minimal risk wards whilst others were placed in high security wards with dangerous patients”. Concordant with this on the 1st March 1997 the same newspaper reported the Union Haddiema Maghqudin (UHM) condemnation of transfers of St. John’s Hospital employees stating that “the move smacked of partisanship”.

Nevertheless, none of these and other reports captured the feelings behind these transfers, as did Sandro’s description of his experience. This 51 year old nurse recounted, whilst clenching his fists:

“It was the 1981 election ... some three months after... My family is a known supporter of the then party in opposition... and as a punishment I was sent to work in this hospital – in this God-forsaken place...

“From happily working in a surgical ward, I ended up surrounded by crazy people...”

My literature search did not identify any studies discussing the postings of nurses in various departments and the reasons behind them. The only literature, which can support my findings, are the newspaper reports and the Ombudsman report mentioned earlier. Besides, quotations from other interviews may further support this finding. Though not experiencing it first hand, Kathrina reported:

“I used to firmly believe that Malta was a democratic country and that such punishments and favouritism did not occur in a democratic setting. I must have been naive...”

Furthermore, Francesca’s comment supported the above:

“Well, here, in this place, you can feel and touch clientilism and favouritism with your own hands...”

5.2.2 Feelings at the beginning of the career.

This concept is complementary to the previous one. It captured the feelings with which the nurses started working at this psychiatric hospital. I felt that it fitted the broader theme of “psychiatric nursing practice”, since I assumed that the attitudes of nurses towards their speciality are likely to influence the way they practice nursing.
All interview participants without exception asserted that the beginning was tough. Martha recounted that:

“When I was sent there -- I mean -- at St. John's, I felt completely lost...”

This finding is consistent with that of Prebble and McDonald (1997). Their qualitative descriptive study dealt with the comprehensive nursing graduates’ adaptation to the mental health setting. Their findings highlighted the participants’ somewhat difficult experience as they attempted to fit their own values and beliefs about nursing with those of the acute psychiatric setting. This is understandable for beginner nurses as they follow their trajectory from novices to experts (Benner, 1984) and whilst bridging the theory-practice gap (Prebble and McDonald, 1997). So much so, in a study carried out by Admi (1997), when beginner nurses were asked about what they found most stressful, they mentioned amongst others, possession of inadequate skills and the education-reality conflict.

Contrary to Moir and Abraham (1996), Stevens and Dulhunty (1992) and Rushworth and Happell (1998) found that psychiatric nursing is not a popular career choice. Thus, one would expect the experiences of nurses who have been made to work in this speciality when they did not choose it themselves, to be much harder to endure, as described by Sandro:

“I felt in dire straits. I, I didn’t know what to do. When I entered the ward, patients around me were speaking what sounded nonsense to me. Some of them gazed questioningly at me, others walked in circles around me, some others came over to touch me ... others begged for cigarettes... “And, and, and I stood there, staring back at them [pause] ... like a complete idiot... encouraging myself by saying that I'm not letting political bastards ruin my life. But I was scared. And, and nobody came to my rescue. I felt [long pause] like defenceless prey in a lions’ den!”

61
Francesca stated that at the beginning

"I felt disappointed and downhearted, unable to get myself to think of what to do..."

However she coped well with her situation:

"...it was my religious parents. Yes, they told me that everything happens with a reason and my posting in this hospital meant that God wants me to help these people... "I may not be brilliant, but I always wanted to be a good nurse. Thus I decided to be a good nurse to these people... "After all, somebody had to do the job..."

5.2.3 Nurses' lack of knowledge about mental health and psychiatry.

Four of the participants appeared to be very much perturbed by the fact that they started to work within a nursing speciality, about which they did not have a clue. Martha outlined her lack of knowledge within the psychiatric nursing discipline:

"I started work at St. John's with no knowledge at all. No knowledge of what psychiatric illness is..."

Whereas Lucia described herself as feeling "green" in the beginning:

"...I was never exposed to a psychiatric ward and I was completely unknowledgeable about mental illness..."

As stated by Incorvaja (1999) since the first diploma in psychiatric nursing course in Malta started only in 1992, the local psychiatric nursing education is still in its infancy. Prior to this date, psychiatric nursing was not given much importance. As pointed out by Francesca:

"In my student days we had only a couple of lectures about mental illness, which none of us students took seriously!"

Within the psychiatric setting, patients need to form a therapeutic nurse-patient relationship, based on empathy, genuinenss and trust (Egan, 1994; Reynolds
and Scott, 1999; Forchuk and Reynolds, 2001). This was identified, by clients themselves, as crucial to their overall recovery (Forchuk and Reynolds, 2001). However, a nurse is unable to form such a relationship if he/she is not equipped with the necessary skills to do so (Egan, 1994).

The report of the National Inquiry into the Human Rights of People with a Mental Illness, published in Australia, emphasised the importance of specific-skill training for nurses working in psychiatry (Burdekin, 1993). These skills are essential to ensure positive consumer outcomes (Rushworth and Happell, 1998). As asserted by Incorvaja (1999) they will help to replace the traditional and outdated custodial nursing practices with modern methods of care.

It was with this reasoning in mind that I related the concept of lack of knowledge about mental health and psychiatry to the main theme of "psychiatric nursing practice".

5.2.4 Difference between general and psychiatric nursing.

Since their course focused mainly on general nursing, with only a couple of lectures in psychiatry, the participants described the difference they felt between these two branches of nursing. Esther referred to this issue in some detail.

"There's quite a difference between the general hospital and this psychiatric hospital. It's not, like, say, you have your own patients and that's it. The main difference, which I found, is that there is no patient allocation. In psychiatry, if there are thirty patients on the ward, it means that you have to care for the thirty of them. If a patient approaches you, you will try to help her to the best of your ability. You can't say 'she is not my patient'. Communication is crucial in this place ..."
Kathrina described psychiatric nursing as different from general nursing:

"... in the sense that there is less bedside nursing, but more communication with the patients and their relatives ...
"

Whereas Martha, whilst agreeing with Kathrina, illustrated her role in psychiatry as one which emphasises more interpersonal relationships:

"...can socialise with the patient and the relatives. I get to know them more; therefore they trust me more. The working relationship – its build up – you see it happening under your eyes..."

These views of psychiatric nursing are concordant with Peplau’s (1990 in Reynolds and Cormack, 1990). This author asserted that psychiatric nursing practices are primarily verbal. They consist mainly in talking with patients informally or in scheduled individual, group, or family interview sessions. She continued that all contacts which nurses have with patients are potential learning experiences for both parties: nurses enrich and refine their expertise, and patients expand and improve their competencies and their self-knowledge (Peplau, 1990 in Reynolds and Cormack, 1990).

Moir and Abraham’s (1996) study compared psychiatric nursing with general nursing and like my interview participants, theirs described the former branch of nursing as requiring more communication with patients, involving a therapeutic acumen and a personal concern for patients. They also continued that psychiatric nursing is less technical-oriented, less routine, more challenging and more autonomous (Moir and Abraham, 1996). To further substantiate this view, Walker et al (1998) emphasised the importance of communication and counselling of patients in the psychiatric setting. Moreover, Cowman et al (2001) examined the role and function of psychiatric nurses in clinical practice in Ireland. In this study
a major proportion of psychiatric nursing related to caring interactions and these emerged to be a central nursing element.

The findings, which emerged from the previous concept, clearly showed that the participants did not possess the appropriate knowledge to provide care within the psychiatric nursing setting. Surprisingly, however, the differences pinpointed by them between general and psychiatric nursing, highlight the substance of psychiatric nursing, as described by Peplau (1990 in Reynolds and Cormack, 1990).

5.2.5 How nursing is carried out.

This concept is directly linked with the previous ones. It fits the major theme, since it shows how nursing at this particular psychiatric hospital is carried out. It also highlights this hospital’s state of neglect, as clearly delineated by Sammut (1998).

All of the participants commented on the process they had gone through until they got used to the idea that nursing at this hospital was very different from what they were used to. This difference was noted in all forms of nursing delivery - from the administration of treatment to the basic nursing care like attending to the hygiene needs of patients.
The most representative account of such a cultural shock is that of Francesca, who recalled her experience at the beginning of her nursing career at this psychiatric hospital:

"...Oh! The washing of patients ... Oh God! Horrendous! It was and still is so much undignified. I found that about thirty patients were washed in showers. I say 'washed'. Only a few washed themselves! No more than five to six showers for thirty patients. And all patients are washed at the same time of the day. They queue naked waiting for their turn. [closing her eyes] I was shocked. I could not bring myself to look at them naked ... But they didn't even bother ... They were so used to this treatment ..."

As Sammut (1998) asserted, the physical conditions of the institution and staff resources have a bearing on the kind of treatment patients are given. So much so, with a subdued look on her face, Francesca continued:

"... here we don't have any facilities – screens, adequate showers and bathrooms [pause] ... so we have to make use of what we have ...

Prebble and McDonald (1997) identified “conflict” and “contradiction” as two themes experienced by newly graduate nurses in the process of their adaptation to the mental health setting. Nonetheless, these conflicts and contradictions referred mainly to the nurses’ philosophies and those they perceived dominated the clinical area (Prebble and McDonald, 1997), and not about the lack of resources and undignified nursing care, as experienced by the participants in my study.

The only research, which mentioned the lack of resources found in psychiatric hospitals, was that of Dawkins et al. (1985). They mentioned the “finding out that the warehouse does not have ward supplies or clothing for the patients ...” as causing high stress to the nursing staff (Dawkins et al, 1985: 11).
Considering the date when Dawkins et al's study was carried out – 1985 – an appropriate question at this stage would be: "Is this Maltese psychiatric hospital still so backwards?" An answer for this would be that of Muscat (1993 cited in Cocks, 1993) were he asserted that the mental health sector in Malta is "thirty years behind the times".

5.2.6 **Dilemmas in psychiatric nursing.**

Within the practice of psychiatric nursing, nurses are faced with ethical dilemmas. These were mentioned by all the participants, who focused mainly on the issue of restraining and secluding patients. In their responses they explained their feelings when they have to make such decisions and how they feel afterwards. Besides the ethical dilemmas of secluding and restraining patients, I included within this concept, participants' feelings of inability to integrate and form a therapeutic nurse-patient relationship with certain patients.

Many a time these nurses were faced with whether or not to restrain or seclude a patient. Francesca voiced this quandary when she narrated:

"At times we're in physical danger. Some patients do become aggressive. Some patients do threaten us ... ...Most of my colleagues believe in the use of force. They still believe in tying down the patients and injecting them then. But this is undignified ... treating patients as criminals ... However, at times, even I myself feel that I have to go by force to administer some parenteral treatment. Then afterwards I feel really guilty – ashamed of myself – I really do."

Lucia justified her actions when restraining a patient by saying:

*We don't have much choice, do we? It's either them [patients] or us. Nobody wants to get hurt... Even though afterwards, after secluding a patient, I feel wicked ..."*
Baxter et al (1992) described assaults by patients as a major problem in many psychiatric units. They found that the level of violence at a metropolitan psychiatric hospital is unacceptably high. Furthermore, however, the nurses studied by them accepted the possibility of an assault as part of their work.

Seclusion and restraint are still widely used in countries where involuntary treatment is still given to patients (Olofsson et al, 1995).

The findings of my study are consistent with those of Olofsson et al's (1985) and Marangos-Frost and Wells' (2000). In both studies it was discovered that the use of physical restraint created great discomfort and guilt feelings in nurses, and the reasons given for the use of force were twofold. On one hand were the conscious paternalistic reasons, those to protect the patient and others from harm. On the other hand were the involuntary reasons where the interviewees could not control the circumstances especially when the ward was understaffed or the nurses were inexperienced (Olofsson et al, 1995; Marangos-Frost and Wells, 2000).

Opposing the findings of these two studies are those of Muir-Cochrane's (1996) research. Whilst agreeing with the above mentioned studies, on the reasons why patients should be restrained or secluded, the participants in her study felt comfortable in using seclusion in the management of disruptive patient behaviour (Muir-Cochrane, 1996).

Another issue that can be mentioned within this concept, is that of the difficulty to interact with certain patients. This issue was mentioned by four participants, who
related the difficulty they find when patients with borderline personality disorders are in their wards. Martha showed her unease with these patients:

"I do empathise with patients, honestly I do. But it's so difficult to interact with borderlines. They take advantage of the system, other patients. They split the staff. They drive us crazy. They make me so angry."

This finding is congruent with that of Fraser and Gallop (1993) which provided evidence that in actual practice situations, nurses respond to patients with borderline personality disorders in a less empathic manner than to patients with other disorders.

5.3 Hospital Culture.

Within this theme, all participants talked in detail about the culture existing at this psychiatric hospital. From their responses, it could be concluded that this is very stressful and not appealing to work in. So much so, when describing it, Francesca said with a half smile on her face:

"so here I am, after almost twenty years, struggling to keep sane in an insane place – not because of the patients, but because of the rotten culture which exists in this place [pause] ... which is getting worse day by day..."

This kind of atmosphere jeopardises quality care to patients (Dawkins et al, 1985) and is detrimental to staff's mental health (Escriba-Aguir et al, 1993).

When interviewed by McDonald (1995), the then lay administrator of this psychiatric hospital was reported to say "the neglect of the infrastructure and the decorum of the hospital are silent witnesses to gross neglect, bareness and cheerlessness. Experts maintain that it does not induce therapeutic confidence
in patients and staff and reinforces the stigmatisation of mental health within the local population.”

Nevertheless, in their responses, my participants did not just refer to the physical environment of the place. They talked about their relationships with their colleagues, the day to day running of the hospital and the general feeling within this place. Their focus is clearly demonstrated by the concepts emerging from this broad theme of “hospital culture”.

The general feeling in the hospital could be shown by Kathrina’s statement

“Look ... look at them the way they wear their uniforms. Male nurses unshaven. The way certain nurses walk, the way they talk ... [shaking her head] Disgusting...”

Furthermore, she called her colleagues “stagnant” and “institutionalised more than the patients themselves”.

Esther recollected her perception of the hospital and nursing staff at the time she started working at this psychiatric hospital:

“I had to get used to the mentality of people ... [forced laugh] completely different from what you’d expect ... “This hospital is like a village. There is a lot of gossip. To have a newly qualified nurse choosing to work at this hospital was not the order of the day [smile]... They must have thought that I come from outer space...”

The situation has changed since that time – approximately seven years ago. Since then, newly qualified nurses with a Diploma in Psychiatric Nursing and who willingly chose to provide care at this hospital were employed (Incorvaja, 1999). However, no research has been carried out on the openness of the staff at this particular psychiatric hospital to new blood and new ideas. The only
research identified was that of Incorvaja (1999) which studied the educational attitudes of 290 nurses working in the Maltese psychiatric practice. He found that nursing staff working in this sector are willing to further their education by in-service training (Incorvaja, 1999). Moreover, another finding of this study was that newly qualified registered nurses were being considered incompetent even though the nursing courses offered by the Institute of Health Care are based on EU standards and considered to be of a high level (Incorvaja, 1999). This corroborates with the complaint of three of my participants. Francesca verbalised this very clearly:

"I was sincerely hoping that the newly qualified nurses with the Diploma in Psychiatric Nursing would make a difference in this stagnant culture. But I was wrong...
"I thought that these will be young, enthusiastic, motivated. Yet most of them turned out to be young, immature nurses ..."

5.3.1 Relationships of nurses.

Two of the participants narrated in detail how they perceive their relationship with their colleagues, as well as the nurses' relationship among themselves. Though not all the participants talked about this, I felt that I should include this concept within the major theme of "hospital culture", since I felt that relationships of nurses influence the general atmosphere within a hospital.

Francesca, vividly related about how difficult it is to work in a situation where there is plenty of staff conflict:

"It's tough to work with such people. My colleagues are lickers. They lick the people in management to get what they want. They go to top managers and report what happens in the ward behind the nursing officer's back. They tell him about the problems and how the ward is run ... There is a lot of backstabbing amongst us nurses. You cannot have friends in this place."
Kipping (2000) asserted that if staff relationships are poor, then it is less likely that support will be available, thus the stress inherent in mental health nursing is compounded. The same author continued that while some aspects of mental health nursing might be considered to be inherently stressful, the stress they generate can be moderated or exacerbated by the context within which the event(s) takes place. Thus poor staff attitudes and lack of support make experiences of stress more intense (Kipping, 2000).

An event, which seems to have made things worse and to which most participants alluded was the strike organised by the nurses' unions.

Esther narrated with a disappointed look on her face:

"Since then, the relationship of nurses changed for the worse ... and things will never be the same again",

Anger in Francesca's voice was undeniably noticed when she talked about this industrial action. She recounted:

"... an aftermath of these industrial actions is the great rift between strikers and strike breakers ...
"... the patients suffered because of them ... [pause]
Hell! Not just the patients. Even us suffered. Even us nurses have to bear the consequences of the unions' nonsense ..."

Consistent with Dawkins et al (1985), Farrel and Dares (1999) pointed out that lack of harmonious relationships between nurses make it difficult for them to provide optimum care for their patients. They also effect their motivation negatively besides causing them major stress.
5.3.2 Multiprofessional lack of co-operation.

This concept goes hand in hand with the previous one. The same two participants continued to talk about how they perceive the relationships of their colleagues within other professions.

As Nolan (1999) pointed out, despite the emphasis on collaboration, there is little evidence of it in staff working in psychiatric settings. He continued that there seem to be many factions that do not work and do not communicate well with each other. Esther had this to say about the team caring for patients:

"Then I can observe some of the consultants. Some of them discharge the patients too quickly. Others take it easy, and by the time they discharge a patient, the latter will be already institutionalised! I don't agree with this. Some of the consultants wait for the social worker to pay a home visit before they discharge a patient. Fair enough. However by the time they do it, months will pass and the patient remains in hospital! I used to speak in ward rounds, but then you realise that you're not counted ... it's no use ..."

She continued to talk about staff conflicts, which she could observe:

"... a lot of backstabbing in the doctor's community, as well. A consultant subdued by another... On call psychiatrists don't care and don't dare adjust treatments of patients having problems ... At the end of the day, the patients get the brunt of all this ..."

Besides talking about the multiprofessional conflict, Esther and Francesca voiced their fear that social workers will take over the nurses' role within the mental health setting. Esther described this as:

"... You know what scares me most? What scares me most is that in our mental health system, the social workers will take over our [nurses'] role. Er, ... I'm saying this - how can I explain it? - because I'm noticing a trend that some psychiatrists relate better with them and, are increasingly giving them more work that is more responsibility... things which we can do ourselves ..."
Francesca mentioned something similar. However, through her portrayal of social workers, though in a sarcastic and mocking tone, she seemed to have understood the meaning and role of nursing – that of looking at and caring for a patient holistically.

"Now the social workers don't know anything about medications. If they look at a patient's pill box [forced laugh] how can they recognise the pink tablet from the blue one?!? They're no smarties!!! ...

"... And if a patient pees under, would they clean him? Can't imagine them dirtying their hands! Them!!!! Dirtying their hands!! Ha ha! That's the joke of the year!!!

"... How can they help a patient holistically?"

Apparently, the question of whether nurses are still needed by patients is not just my participants' concern. Kitson (1997), Barker et al, (1998) and Reynolds (2001) addressed the question of why do people need nurses, or to put it more bluntly, why clients need members of one profession rather than another. As a matter of fact, Kitson (1997) specifically asked whether nursing had a future, at all.

To answer this question, Reynolds (2001) asserted that since professions shared knowledge, technology and activities, the only thing that is unique about a profession is its focus. As Peplau (1988 cited by Reynolds, 2001) argued, mental health nurses have a responsibility to define the focus of their practice, because it is the main focus of the work, which determines what the public needs and wants from nurses for the self maintenance of their health. She views being and caring with people-in-care as the process which distinguishes nurses from all other health and social care disciplines, and needs to be recognised also as the process underpinning all psychiatric nursing (Peplau, 1952 in Barker, 1998).
5.3.3 Lack of job description.

Another issue which pertains to the hospital culture and is directly linked to how nursing is carried out is that of who does what. All participants without exception voiced their opinion about this concept. Esther reported:

"I noticed that there is no job description. An enrolled nurse does the same things as a staff nurse and vice versa ... "There's no place for the staff nurse ... Staff nurses are not much valued at this hospital ..."

Francesca had something similar to say, whilst Sandro confided:

"I stopped considering myself a nurse ... I am more like an orderly. What I do here can be done by anyone..."

Considering these narrations, it comes as no wonder that these participants ask themselves whether the role of a nurse is at all useful at this hospital – a question which was dealt with in section 5.3.2

There seems to be a dearth of literature and research about this issue. Nevertheless, though not discussed specifically, it was hinted at in Incorvaja's (1999) study, which was carried out within Malta's mental health field. He found out that third level nurses – referring to care assistants – were increasingly left to carry out basic nursing care on the wards. Consequently, these so called third level nurses, felt that they were just as good as registered and enrolled nurses and that promotion should be granted to them automatically according to seniority rather than by qualification (Incorvaja, 1999).
5.3.4 **Lack of discipline.**

The following account by Kathrina bridged the concept of the discordant relationships existing among the nursing staff at this hospital, with the present concept of lack of discipline:

"There was this patient. Severely physically handicapped. Paranoid. Started shouting at one of the nurses. Called her all sorts of names, including a whore. The nurse retaliated. Shouted at the patient: ‘You are a whore and that mother of yours!’ ... "To my knowledge, the little I have in psyche, one way to manage anger is by extinction... So, I called this nurse in the office and politely though firmly told her to ignore the patient. Her reply was ‘Don’t you dare tell me what to do, Ms Dragon. Don’t ever tell me how to handle patients. I have been working here for thirty years, and you – you have just qualified. I don’t give a damn of who is in charge of whom in here. I do what I want in here – do you listen?’  "Believe me, I can still remember her exact words... the anger in her eyes... can’t forget her pointing her finger at me."

Kathrina, who had just recalled the above account looked very cross. All the participants mentioned this lack of discipline; however, her comments are the most poignant:

"... this brings me to the lack of discipline which reigns at St. John’s. People who have been working here for most of their lives don’t respect authorities... "... if a nurse asks for a day vacation leave, right? and the ward manager says that it isn’t possible for her to take it, the former will go to the DNM [departmental nursing manager] shouts, screams, bangs on his desk and amazingly enough she takes this day ‘off duty’ – even to the detriment of her own colleagues who may be short of staff on that particular day ..."

No research relevant to this theme was found in the course of my literature review. Of partial relevance is the study of Dawkins et al (1985) who pointed out the difficulty that occurs when one tries to take action against incompetent staff, as highly stressful. In support of Dawkins et al’s (1985) findings, Trygstad (1986) found that stress was more likely to occur when the organisational climate
was experienced negatively and that stress was increased when others failed to validate the importance of the situation for the individual.

To further illustrate how stressful this lack of discipline may be, Esther said whilst referring to it:

"The top management is so passive. Nobody cares. I know of a person who has been abusing of the system since the day she was employed ... How could I ever expect to change all this on my own ...? It's my health down the drain ... To survive in this place, one should be able to close both eyes not to see the unruly! Otherwise, if one is a person of conscience, there is no way of survival in here."

5.3.5 Ignorance about the role of nurses at psychiatric hospitals.

To further understand the broad theme of "hospital culture", one has to get a feel of what these nurses go through when they meet their counterparts who work in other hospitals. I felt that this concept fits the major theme since the negative opinions of others may influence the motivation of nurses who work at this hospital.

Esther's account sums up all the observations and criticisms from other nurses, which all the participants mentioned in their stories. One has to keep in mind that I am presenting this account in English, with all the comments translated from the Maltese language to the English language. In doing so, some of these comments lost much of their impact and may seem "softer" and less depreciative than they really are:

"Then there is the issue of being looked down upon by my own colleagues at the other hospital especially those at the general hospital..."
"...When I accompany a patient to casualty they pass a lot of comments such as: 'Oh! You come from St. John's! How do you manage to work there?! How do you stick working there?!'; "There you don't have anything to do ...'; 'Nurses at St. John's are not good for anything'; 'St. John's is like a prison'.

"Nursing is stigmatised as well. Besides the patients even us nurses at this psych hospital are stigmatised..."

To further illustrate the ignorance about the role of nurses in psychiatric hospitals, there is Kathrina's episode. She recollected:

"After a year working at St. John's I met the ward manager of a surgical ward with whom I worked when I was a student. She told me: 'What the hell are you doing there? You are wasting your time, your talents!'"

There seems to be very little research on society's perception about the role of nurses at psychiatric hospitals. Nonetheless, Walker et al (1998) in a pilot study on the perception of the psychiatric nurses’ role found that an element of stigma towards mental illness coloured the interviewees’ perception of psychiatric nurses’ role.

A vox pop carried out by Spiteri (1998) amongst the Maltese people confirmed that they are very much influenced by what they see on television. When asked about what he thinks about St. John's Hospital, a respondent said that he imagines the nurses tying down the patients to their beds, whilst the latter scream and shout. Another respondent declared that she would never dream of working at St. John's, not even if she is paid in gold coins at the end of the month.

In congruence with McKeown and Clancy (1995) and Lehane and Rees (1996), Walker et al (1998) argue that media seems to cover the mental health services only when the system is alleged to have failed. Besides, media tend to portray the
mental health setting as scary and mysterious. It further enhances people's fear of the unknown (Walker et al, 1998). The following episode by Francesca corroborates with the above:

"...when there was the strike, they filmed the hospital. The cameramen filmed the back wards – those with the worst environment. They dared film a cobweb, doors squeaking and somehow the film was darkened. The hospital seemed like a horror house. No wonder that people stigmatise patients and us nurses as well"

5.4 The meaning of nursing to nurses.

Without the need of any prompts, all participants talked about the meaning they give to their role as nurses within this hospital. Though they did not always agree, they focused their responses on how they perceived themselves, their attitude towards psychiatric nursing and other stressful experiences. However, at the end of their interviews all participants without exception discussed job satisfaction and the meaning it has on the care they provide.

5.4.1 Nurses' perception of themselves.

There was a lack of agreement among the research participants about how they view themselves in their role of psychiatric nurses. They also compared themselves to their counterparts within other healthcare fields. Kathrina stated:

"I am proud of working at St. John's ..."

whilst Martha asserted:

"I don't feel any less than my counterparts at other hospitals. No, not at all."

On the other hand, Francesca talked at length about how she feels:

"I hate stating that I'm a nurse at this particular hospital ..."
“Many a times did I overhear my counterparts – even those who once were my classmates – saying that we are as crazy as the patients ... that we are stupid, good for nothing ... But I never answered them back, lest I reinforce their opinion of us being mad ...

“At times I feel drained and ashamed of myself because I work with the mentally ill. Even though I know that somebody has to do this job. That if it is done well, it gives a lot of satisfaction ...

“Besides, I furthered my studies. I'm not as stupid as they think ...”

Throughout my literature review, I did not encounter any literature, which deals with the way psychiatric nurses feel about themselves.

5.4.2 Attitudes of nurses towards their work.

All the participants talked about how they feel in their role as nurses and their attitudes towards it. These attitudes may be put on a continuum with the very positive attitudes and the very negative attitudes on both extremes. Nonetheless, in all levels of this continuum, all of them cared for the patients in their own unique way.

On the extreme negative end was Sandro, who earlier on was quoted as saying that he stopped considering himself a nurse, and feels rather like an orderly. In an instance of apparent nonchalance he said:

"I don't know a damn thing about whatever illness exists in here ... I was never interested and I simply don't want to know anything about the subject.

"I come to work to earn money for my family to be able to lead a decent life...

"When the party in government changed, I was given the opportunity to go back to surgical. But I refused. Here - less responsibility, less work. During night duties, I settle the patients - see they are sleeping and I sleep with them. It allows me to feel fresh in the morning and I go fishing ..."
But he does care for the patients and shows this by carrying out the physical tasks well, to the best of his abilities:

"...what I do, the little I do, I try to do it well ... I wash the patients, change their nappies, feed them and see them to bed at night. Well, I give out treatment and make sure that they swallow the tablets ..."

On the other end of this continuum, there is Francesca who although she never planned nor thought of providing care at a psychiatric hospital, she took her work seriously and even considered it as a vocation once she was posted at this psychiatric hospital. Pensively, she recounted.

"Everything happens with a reason, as my parents say. My posting in this hospital meant that God wants me to help these people. I took my work seriously ...
"Until I decided to further my knowledge in psychiatric nursing. I thought that once I'm working here, I might as well get some appropriate knowledge about how to carry out my job in the best way possible."

Kathrina, who chose to work at this psychiatric hospital because she wanted a challenge, related that now that the novelty of the experience wore off, she feels safe working at this hospital and cannot even imagine changing her situation. She also found a positive meaning for the care she provided for the patients and felt that her presence on the ward made a difference to the patients.

"...I feel safe in this place. I know the people. I know who's nice or and who's not ... St. John's has become my comfort zone.
"...but I'm proud of working here. Despite the adversities, the management system, the physical environment, I know that the patients benefit from my presence on the ward."

Francesca's experience is a clear example of rationalisation and reaction formation (Stuart and Sundeen, 1991; Skodol-Wilson and Ren-Kneisl, 1992).
From her early disappointment and disillusionment when she was posted at this psychiatric hospital, she turned out to be a dedicated nurse and furthered her knowledge in psychiatric nursing. On the other hand, Sandro’s overall attitude towards his work is apathy, whilst Kathrina and other participants conformed within the system and tried to cope with the day-to-day stressors by looking at the positive outcomes in their work.

5.4.3 Stress and Burnout.

By its very nature, nursing is a stressful occupation (Skodol-Wilson and Ren-Kneisl, 1992). The way nurses view and cope with this stress gives a meaning to their work and motivation towards it.

Work seems to be more stressful in acute wards rather than in wards housing chronic patients. Lucia, who works in one of the back wards but had a few years working experience in an acute ward recounted:

"At the admission ward work is so stressful. With all those patients under constant supervision, patients with impulsive behaviour, others trying to abscond ... Having to administer treatment to patients who are too sick to realise they need it, having to deal with aggressive patients ... Personal threats ... the list goes on and on ...

"In this ward, nursing is routine, I know what to do and just do it. My mind is at rest ..."

Francesca also recalled the stress she faces at work:

"Nobody appreciates how stressful our work can be...
"Day in day out I have to deal with impulsive patients, others who are paranoid, others still with personality disorders. One has to be there heart and soul. There’s no place for scroungers here."

In congruence with this finding there is that of Dawkins et al (1985). They found that working with patients having negative characteristics – referring to patients
posing physical threats such as ‘struggling, kicking patients’ and ‘suicidal patients obsessed with committing suicide’ – produced high-level stress in psychiatric nursing staff (Dawkins et al, 1985).

Surprisingly, notwithstanding the stressful nature of work, and all the stressors mentioned previously in other sections, it was Esther only who mentioned that she felt burned out and considered leaving the job.

Plenty of studies were identified which state that burnout is predominant in nurses working in psychiatric hospitals (Yiu-Kee and So-kum Tang, 1995; Fagin et al, 1996; Melchior et al, 1997; Levert et al, 2000; Maslach-Pines, 2000). On the other hand Carson et al’s (1999) findings showed that burnout is a much less significant problem for mental health nurses than other researchers have indicated.

Maslach-Pines (2000) asserted that for the majority of nurses, the most difficult stresses were related to frustrated hopes, goals and expectations. This is perfectly evident in Esther’s quotation:

“Honestly I’m thinking of leaving. I can’t go against the current for much longer. I can’t change the attitudes and mentality of these people, which have been building up for over thirty years – on my own. They are a barrier to carry out my work professionally. These days I attend work thinking to myself ‘Good God it’s another day duty – Damn!’. I go to work with a heavy heart. Gloominess today, gloominess tomorrow ... 12 hours in, 12 hours out ...[pause] ... I’m feeling burned out.”
5.4.4 **Job satisfaction.**

Despite the stress they encounter, all the participants talked about the satisfaction they gain from their work. Such satisfaction, was described by five of the participants, as giving meaning to their work and allowing them to keep on going albeit the adversities. The other participant, Sandro, was hesitant to disclose what aspect of his work gave him satisfaction. So much so, when prompted to say whether he gained any satisfaction from his work, he reluctantly replied:

"There's nothing much which gives me job-satisfaction in here. Perhaps when a duty goes by uneventful, I feel good. [Very long pause, then pensively] "But to be honest, even though they are nuts, some of the patients appreciate what we nurses and nursing aides do for them. Many a times do I finish a day duty with a couple of them shouting to us: 'Good night nurse. Thank you.' This does make me feel satisfied ..."

Several research was carried out on the subject of psychiatric nurses’ job satisfaction (Coward et al, 1995; Robertson et al, 1995; Farrell and Dares, 1999; Thomsen et al, 1999). However none of these authors used a descriptive qualitative methodology in their research, thus they did not and could not capture the sense of fulfilment and elation which job satisfaction brings in nurses’ lives.

In my study, these could be read in the participants’ faces when they spoke about experiences, which made them feel satisfied and fulfilled. This happened also in Sandro’s case, even though he did not find much to say about the issue.
Nevertheless, two accounts, which clearly capture these feelings, are those of Lucia and Kathrina. The former stated:

"Yes, I find that my work does provide me with a sense of fulfillment. Without this, life is unbearable in here. I wouldn't work here without it ...

"Last year, when I returned to work from a fortnight sick leave, I could not believe how happy the patients were. There was a pandemonium in the ward when they saw me again. They hugged me, kissed me, and told me how much they missed me. It was unbelievable ...

"They do value my work with them. They know who loves them and cares for them. Patients are the only people in this hospital, in the whole country, who appreciates what we do in here. They are grateful towards us ... and this keeps me going."

Kathrina ended the interview by recounting the following:

"I feel I'm a good nurse. I know that the patients benefit from my presence on the ward. This I can tell because as you know patients tend to choose the nurse with whom to speak and share their problems. Most patients gather around me – 'Kath, may I tell you this...' or 'Kathy, do you have a minute for me please?...' etc, etc ... This may be described as exhausting but, no, to me it's nothing but fulfilling.

"[with a genuine smile] It's amazing how enlivening and inspiring it can be when I see a patient rejoining her family after a period of illness. The termination of our relationship - a hug, a 'good luck', a pat on the relatives' back, the last advice for compliance with treatment, the last encouragement and telling them that they can always contact us on the ward if they need help. And then [pause]... the look on the patient's face and that of her relatives. Their gratitude. After ten years this setting still brings tears to my eyes!"

From these quotations, one can deduce that patients' gratitude and recognition for their work are common aspects of work, which all my participants found fulfilling. This is congruent with findings from other research which pinpoint "recognition for work done" as a very important aspect of nurses' work (Farrell and Dares, 1999; Thomsen et al, 1999).
5.5 Conclusion.

Throughout this chapter, I presented my research findings, which focused on the feelings and experiences of general nurses providing care to patients at a Maltese psychiatric hospital. I classified these findings under three interrelated broad themes and their major concepts. Quotes form transcripts of interviews enabled me to demonstrate my participants' responses and the essence of their lived experiences as they work day in day out with mentally ill patients at this psychiatric hospital. Various other research studies, which I identified in a thorough literature review, enabled me to compare and contrast them with those of other well-known authors.
Chapter 6
Recommendations
CHAPTER 6: RECOMMENDATIONS.

6.1 Introduction.
In this chapter, I shall be discussing the insight provided by my research findings into what needs to be done to improve nursing care delivery and the nurses' working conditions at the hospital in question. Recommendations for further research will also be given.

6.2 Recommendations for the improvement of nursing care delivery and nurses' working conditions.
From my findings, it became apparent that working at this Maltese psychiatric hospital is not at all popular amongst Maltese nurses. So much so, four of my participants alluded to the fact that they work at this hospital only because they did not have another choice.

The reasons why working at this psychiatric hospital is not popular amongst nurses, may be multi-fold. Findings emerging from all the themes might shed a light on these motives.

Political transfers and not gaining a good placing in the final exams were presented in section 5.2.1, as two of the reasons why my participants work at this hospital. The fact that working at this hospital is pictured as humiliating may influence nurses' choice not to provide care to patients hospitalised in it.
Improving the image of this hospital in the public eye is imperative. This may be done by a number of ways. Firstly, the general public needs to become aware of what the care for mentally ill people entails, thus stop associating this psychiatric hospital with a horror house where screaming and kicking patients are tied to their beds (Spiteri, 1998 in section 5.3.5). Thus media coverage of this hospital should be objective, without sensationalism.

In section 1.3, I mentioned the ombudsman’s comment that refurbishment at the psychiatric hospital in question are constantly being carried out. Nevertheless, in section 5.2.5, my participants revealed that it is very difficult for them to deliver optimum nursing care, due to lack of facilities. Adorning wards within this hospital is considered to be positive, both for improving its image and for the nurses and patients themselves. Nevertheless, providing the basic amenities in wards, such as proper bathrooms, is of greater importance. It is strongly recommended that funds should be allocated solely to meet the most fundamental needs of this hospital.

Sorting out and improving organisational motivating factors may be another way of making work at this hospital more appealing. Iles (1997) discussed organisational motivating and demotivating factors in terms of Maslow’s hierarchy of human needs.

Within the ‘safety and security’ level, Iles (1997) pointed out “told exactly what to do and how to do it” as a motivating factor. The quotes in sections 5.3.2 and 5.3.3 gave the impression that the participants feel unimportant and that there is
no place for them at this hospital. A job description cannot convey the “how” but only the “what to do” part of the mentioned motivating factor (Iles, 1997). Nevertheless, it helps to avoid difficulties, which may arise due to role confusion (Vaughan and Pillmoor, 1989). Thus the nurses’ unions and the department of health are urged to meet and outline a job description for all levels of nurses working at this hospital.

On another level of Maslow’s hierarchy there are the “social needs”. Iles (1997) discussed these in terms of the relationships which individuals seek to form. She pointed out that for many people, this is one of the most important goals to achieve. Thus, the formation of good relationships among colleagues is considered by Iles (1997) to be an important motivating factor.

The findings emerging from the concept “relationships of nurses” (section 5.3.1) highlighted the backstabbing among nurses, their competitive nature and the fact that one cannot have friends in such an environment. These issues were mentioned by Dawkins et al (1985) and Iles (1997) as demotivating factors, which cause major stress. Thus nurses’ relationships need to be seriously addressed. Of course, one cannot force any two or more persons to respect each other and be friends. However, team-building seminars, in which nurses are encouraged to share their feelings, to recognise each other’s needs and to work together, may be helpful.

By addressing the relationships issue, “lack of discipline” – the concept discussed in section 5.3.4, may be tackled. If, a culture where staff cares for
each other and in which staff learns to work as a team is created, the differences between the nursing staff and their authorities may be bridged.

Another way to tackle the lack of discipline problem is by training people in the top management to be assertive and objective when making decisions. This would enable the nursing staff to be treated with fairness and respect.

Other research findings presented within the theme "psychiatric nursing practice" (section 5.2) provided a dismal picture of the participants' preparation for clinical psychiatric nursing practice. Their expressed feelings of being "completely lost", "green" and "in dire straits" (section 5.2.2) are further supported by the complaint made by half of them that newly qualified nurses are "young and immature". Furthermore, nurses are continuously facing ethical dilemmas, with consequent negative feelings aroused by them (section 5.2.6). All this gives rise to feelings of stress, which all the participants described in section 5.4.3.

All this implies the need for clinical supervision and support for all nurses working at this psychiatric hospital. As Kipping (2000) suggested, this clinical supervision should serve a three-fold function:

- **formative** for the development of knowledge and skills,
- **normative**, which is concerned with quality control and the maintenance of policies and procedures, and
- **restorative** for the provision of support.
The six participants in this research were but a small sample of general nurses working at this psychiatric hospital. Thus the findings of this research cannot be generalised. However, in section 5.2.3, the participants’ clearly demonstrated that they lacked specialised education in mental health nursing. They highlighted that they were not equipped with skills, which enabled them to form therapeutic nurse-patient relationships. Besides, in section 5.2.6, my participants also expressed the difficulty they find to interact with patients with a diagnosis of borderline personality disorder. This evidence calls for regular in-service psychiatric nursing education.

In-service training should aim at providing nurses with insight into the nature of human suffering. This aim may be achieved by employing an eclectic approach of the bio-psycho-socio-cultural aspects of mental illness, as suggested by Gallop and Reynolds (2002). Such in-service courses will equip nurses with knowledge, which enables them to be truly empathic towards their patients. This empathy, will in turn form the basis of a therapeutic nurse-patient relationship as desired by patients themselves (see Forchuk and Reynolds, 2001).

Another recommendation aimed to assist nurses at this hospital to further their knowledge in their nursing speciality is by providing them the opportunity to read the Diploma in Psychiatric Nursing Course on a part-time basis. This may be an attractive occasion for them, because it will allow them to continue working and gain their usual monthly salary whilst enhancing their knowledge about mental health nursing.
Nurses’ attitudes towards their work, as pointed out by themselves in section 5.4.2, especially those on the extreme negative end, may be improved if the above mentioned security, social and educational needs are addressed. This will enable nurses to become more motivated to provide patients with outstanding nursing care, which will in turn lead to optimum health outcomes for the latter.

6.3 **Recommendations for further research.**

When I discussed the limitations of my study, I mentioned that I used a semi-structured interview as the research method for my study (section 4.10.1). My pre-set questions and prompts might have restrained the participants from expressing themselves fully. Thus, I suggest that a redesigned study, using an in-depth interview and, perhaps, a larger sample should be carried out. This may elicit deeper understandings of how general nurses, who work at this Maltese psychiatric hospital, view the world.

A survey among nurses at other hospitals in Malta may be carried out to discover the reasons why working at the psychiatric hospital in question is not popular among them. The survey methodology will allow generalisability of the results. Thus the reasons elicited may be specifically addressed.

Although my research finding cannot be generalised, it would be interesting to study the feelings and experiences of general nurses working at other psychiatric hospitals. The findings may be, then, compared and contrasted to generate new ideas from which both nurses and patients may benefit.
There is plenty of space for change within the psychiatric hospital in question, as described by participants themselves. Thus action research projects may be ideal to study the variety of problems existing and slowly introduce this change (Martin and Tallman, 2001). As described by Bernauer (1999), Dermarrais (2000) and Glanz (1999), one has to, first pinpoint a problem – for example, lack of discipline, lack of job description, or negative attitudes towards work, and determine why it is important. Data about the problem may be collected and analysed to clarify exactly what is happening. Literature should then be reviewed to find out about the problem and how other people dealt it with it. Carefully considering all options and planning and implementing a strategy should follow this. This action research cycle may be used to tackle most problems identified within this chapter.

6.4 Conclusion.

This Heideggerian interpretive phenomenological study brought to light the feelings and experiences of general nurses working at a Maltese psychiatric hospital.

The findings, which emerged from this study, are considered to be of utmost importance to the nursing profession in Malta and to mental health services users. By studying them in detail and acting upon recommendations given above, the directorate of nursing will be in a better position to address the needs of nurses working at this hospital. Thus psychiatric nursing care delivery may be improved.
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Appendices
APPENDIX A. Research Information Letter. Maltese Version.

Ghaziza

Bhala parti mill-kors tal-MSc fin-nursing, jiena qieghda naghmel ricerka dwar l-esperjenzi u –mod kif ihossuhom l-infermiera li jahdmu fi sptar mentali.

Il-partecipanti huma mistiedna jiehdu sehem f’intervista li ser naghmel jiena stess. Il-mistoqsijiet f’din l-intervista jkunu jiffukaw fuq:
- L-esperjenza fil-qasam tas-sahha mentali
- Il-mod kif ihossuhom u kif jahsbuha dwar ir-rwal ta’ l-infermiera f’dan il-qasam
- Is-sodisfazzjon li ghandhom fix-xoghol taghhom.

L-intervista tiehu madwar 60 sa 90 minuta. Jiena se nirrekkordja dawn l-intervisti b’tape recorder peress li hekk ikun aktar facli ghalija biex nibagtor l-informazzjoni li nkun iddiskutejt mall-partecipant. Hadd aktar, minbarra jiena, m’hu ser ikollu access ghal dawn it-tapes u ghall-informazzjoni li ser ikun fihom.

IL-PARTECIPAZZJONI HI VOLUNTARJA. DAWK LI JIGU MAGHZULA BIEX JIPPARTECIPAW JISTGHU MAGHZULA MA JIPPARTECIPAW JISTGHU JIRRIFJUTAW LI JIEHDU SEHEM JEW JIEQFU MILL-INTERVISTA X’HIN IRIDU MINGHAJR MA JAGHTU RAGUNI GHALIEX QED JAGHMLU DAN. MA JKUN HEMM EBDA KONSEGWENZI HZIENA GHALL-KARRIERA TA’ MIN JIRRIFJUTA LI JIEHU SEHEM, U L-ANQAS GHAL DIK TA’ QRABATU. L-ISMIJIET TA’ DAWK LI SER JIEHU SEHEM MA HUMA SER JIDHRU MKIEN F’DIN IR-RICERKA. MINFLOK ISMIJIET, SER IKUNU WZATI NOM DE PLUMES.

Jiena lesta li nispjega u nirrispondi kwalunkwe diffikulta li jista’ jkun hemm. Jiena nista’ nigi ikkuntattjata :
Id-dar – 641479.
Ix-xoghol – 25951309 jew 25951454
e-mail – jbason@mail.global.net.mt

Jekk tixtieq li tiehu sehem f’dan l-istudju, jekk joghgbok imla l-formola (form B) ta’ hawn taht u ibghathieli sa mhux aktar tard minn __________.

Nirringrazzjak bil-quddiem,

Josanne Bason.

Form B

Jiena qrajt sewwa l-informazzjoni dwar ir-ricerka fuq l-esperjenzi u l-mod kif ihossuhom l-infermiera li jahdmu fi sptar mentali (Form A), u nikkonferma li jien gejj spjegat x’tinvolvi l-partecipazzjoni tieghi f’din ir-ricerka.

JIENA FHIMT X’TINVOLVI L-PARTECIPAZZJONI TIEGHI F’DAN L-ISTUDJU U NACCETTA LI NIEHU SEHEM FIH.

Numru tat-telefon tiehek: __________

Firma: ___________ Data: ___________

Dear [Name],

As part of an M.Sc course in nursing studies which I am presently reading, I am carrying out a research to identify the experience and feelings of Maltese nurses providing care at a Maltese psychiatric hospital.

Participants will be invited to participate in a semi-structured interview, which I will be carrying out myself. The focus of the interview will include:

• Length of experience in mental health nursing.
• Feelings, views and attitudes about the role of the mental health nurse.
• Satisfaction gained from the provision of care.

The interview will take from 60 to 90 minutes. I intend to audiotape these interviews using a tape recorder, since this will make it easier for me to gather all the information discussed with participants. Nobody, except myself, will have access to this information. Strict confidentiality will be maintained.

PARTICIPATION IS VOLUNTARY. THE CHOSEN RESPONDENTS MAY REFUSE TO PARTICIPATE OR CHOOSE TO WITHDRAW FROM THE STUDY AT ANY TIME WITHOUT GIVING A REASON. WITHDRAWAL FROM THIS STUDY WILL HAVE NO EFFECT WHATSOEVER ON THEMSELVES, THEIR CAREER AND THEIR SIGNIFICANT OTHERS. RESPONDENTS' NAMES WILL NOT APPEAR IN ANY RELATED REPORTS AND PSEUDONYMS WILL BE USED INSTEAD OF NAMES.

Questions about participation can be asked at any time. I may be contacted:
At home – 641479.
At work – 25951309 or 25951454.
e-mail – jbason@mail.global.net.mt

If you wish to participate in this study, kindly sign the consent form below and send it to me by not later than ________.

Thankyou with anticipation.

Josanne Bason.

Consent Form (B)

I have thoroughly read the information sheet (Form A) about the study on the experiences and feelings of Maltese nurses working at a psychiatric hospital and confirm that it has been explained to me what taking part in this study involves.

I HAVE UNDERSTOOD MY INVOLVEMENT AND AGREE TO PARTICIPATE IN THE STUDY.

Your telephone number: ___________

Signature: _______________ Date: ________________.
APPENDIX C.

Background information questionnaire.

Pseudonym: ____________________________

1. Age: _______

2. Gender: Male / Female.

3. Length of experience as a nurse: _______

4. Previous experience as a nurse – where:

   ______________________________________
   ______________________________________
   ______________________________________
   ______________________________________
   ______________________________________.

5. Length of experience at psychiatric hospital: _________.

   ______________________________________
**APPENDIX D.**

**Interview guide.**

♦ **Question 1:**

Can you tell me about your experiences at the psychiatric hospital?

♦ **Prompts:**

1. You may start by telling me about the days when you started working at this psychiatric hospital ....
2. Tell me about your role at this psychiatric hospital ....
3. Tell me how you feel in your role as a psychiatric nurse ....
4. Talk about how your colleagues at other hospitals feel about your role as a mental health nurse ....
5. Tell me about how you feel when you compare yourself to your counterparts at other hospitals ....

♦ **Question 2:**

Is there anything else that you feel is important to talk about that we have not covered?
APPENDIX E.

Colaizzi's (1978) seven steps for data analysis.

1) Read through the entire protocol (the subject’s description) for a sense of the whole. (taped interviews need to be transcribed).

2) Extract significant statements that directly pertain to the investigated topic.

3) Formulate meanings as they emerge from the significant statements. This involves creative insight, which remains faithful to the original data.

4) Repeat the above steps for each protocol and organize the formulated meaning into clusters of themes:
   • validate the clusters of themes by referring back to the original protocols to see if any data have been ignored or added to;
   • if there are contradictory themes, this may reflect the real and valid experience. These data should not be ignored or discarded.

5) The results of the analysis so far are then integrated into an exhaustive description of the investigative topic.

6) Formulate the exhaustive description of the phenomenon into a statement of identification of its fundamental structure.

7) To validate the analysis, return to each subject (co-researcher) and ask if this analysis describes their experience. If the co-researcher adds or deletes any information, incorporate this new data into the final product.
APPENDIX F.

E-mail to Students' Advisory Section of the University of Malta and its reply.

Date: Thu, 08 Mar 2001 08:32:27 +0100
Subject: Ethical clearance for research
From: jbason@mail.global.net.mt
To: sas@um.edu.mt

To whom it may concern,
I am reading a Masters Degree in Nursing (distance learning) with the Royal College of Nursing. I am in my final module, which is the dissertation for which I am to conduct a research study. For this project, I am interested in studying the feelings and experiences of nurses who provide care to the mentally ill. To meet this end, I intend to carry out interviews with a set of nurses working at [name of hospital].

However, prior to embarking on this project, I need ethical clearance from a research ethics committee. Kindly could you please advise me whom to contact.

Thankyou with anticipation.

Josanne Bason B.Sc (Hons) Nursing.

Reply:

Date: Thu, 08 Mar 2001 14:06:08 +0100
Subject: Bioethics Committee
From: Laura Mifsud Bonnici lmifl@ihc.um.edu.mt
To: jbason@mail.global.net.mt

Dear Ms Bason,
The contact you require is: Ms Maryln Schembri, Bioethics consultative committee, Department of Health, 15 Merchants Street, Valletta.

I hope this information prove to be useful.

Laura Mifsud Bonnici
Communications Officer,
Institute of Health Care.
APPENDIX G (1)

Letter to secretary of Bioethics Consultative Committee.

“Amethyst”,
St.Martin Str.,
Zurrieq.
ZRQ 02.
08.03.2001

Ms Maryln Schembri
Secretary Bioethics Consultative Committee,
Department of Health,
15, Merchants’ Str.,
Valletta.

Dear Madam,
I am reading a Masters degree in Nursing (distance learning) with the Royal College of Nursing. I am in my final module, which is the dissertation. For this project, I am to carry out a research for which I need to gain ethical clearance prior to starting it. I am interested in studying the experiences of nurses who provide care to the mentally ill, in order to understand how they help patients cope with their illness. To meet this end, I would like to carry out interviews with a set of nurses who work at ____________ [name of hospital].

Kindly could you advise me how to proceed to gain clearance from the ethical committee?

Thankyou with anticipation.

Yours truly,

Josanne Bason B.Sc (hons) Nursing.
APPENDIX G(ii).

Reply from secretary of Bioethics Consultative Committee.

16th March 2001

Ms. Joanne Buson, BSc. Hon. Nursing
Amelita
St. Martin Str.
Zurrieq

Dear Ms. Buson,

With reference to your letter dated 16th March 2001, please refer to Ethics Committee of Faculty of University of Malta (Prof. N. Scicluna, Ingelby).

Ms. M. Scicluna
PD Dr. Pierre Mallia M.D. MPhil
Secretary Bioethics Consultative Committee
APPENDIX H:

Letter from M.Sc. Programme Director.

Dear [Name],

Your Research Supervisor, Dr. [Name], has recently alerted me to your concerns about finding a research ethics committee willing to support your project. I appreciate that ethics committees do not operate universally and while they do they often have different sensitivities to what we are used to in the U.K. For that reason it is important to proceed in a principled and thorough way. I suggest the following steps:

1. First you contact any Malta-based authority or association that might have an ethics committee that reflects the availability of research ethics committees and their remit. Please do so in writing and keep a copy of your correspondence.

2. If no committee is identified, please contact the agency where you plan to conduct research to see if there is a policy or research forum where this matter could be discussed and a response offered. Once again, they may not be interested in your research or research ethics committee.

3. In the absence of a research ethics committee in Malta, you should contact the Malta Postgraduate Medical Association (MPMA) where you plan to pursue research. A single document stating the purpose of the research and asking for permission to proceed is usually the first step to securing permission to proceed. It is usually wise to seek permission from a school or department of health if you wish to interview or observe staff (an appointed member of the MPMA). We make no requirements for you to consult a medical director but I am keenly aware that at Malta the relationship between nursing and medicine is different. Should you need to discuss this with Medical or Nursing ethics taking it up with your supervisor.

Whilst your research isn’t in the national public health care system, it is important to ensure you comply with any other requirements for research in Malta. This is a reflection of how value is placed on patient care and protection of patient confidentiality. It is also a reflection of how research is funded and conducted, so you may need to consult colleagues there that you are working towards that end rather than an expert familiar in journalism.

I hope this means helpful and if it does involve some additional complexities, please come back in line and we will discuss further difficulties.

Yours sincerely,

[Name]
Programme Director
M.Sc. in Nursing
APPENDIX I(i)

Letter to the Ethics Committee at the University of Malta.

“Amethyst”,
St. Martin Str.,
Zurrieq.
ZRQ 02.
05.04.2001

Prof A Serracino Inglott
Ethics Committee,
University of Malta,
Msida.

Dear Sir,
I am reading a Masters degree in Nursing (distance learning) with the Royal College of Nursing. For my final module, I am to carry out a dissertation, in which I would like to study the feelings and attitudes of nurses providing care at [name of hospital], to help me understand better how they help patients cope with their problems. To accomplish this, I plan to carry out in-depth interview with a number of nurses working at the above-mentioned hospital.

With this letter, I am enclosing the section of my research proposal, which deals with the ethical implications of this study. With all these ethical implications in mind, I would like to gain your kind permission to carry out this study.

Thankyou with anticipation,

Josanne Bason B.Sc (hons) Nursing.
APPENDIX I(ii).

Reminder letter to the Ethics Committee at the University of Malta.

“Amethyst”,
St. Martin Str.,
Zurrieq.
ZRQ 02.
24.04.2001

Prof A Serracino Inglott
Ethics Committee,
University of Malta,
Msida.

Dear Sir,
With reference to my letter dated 5th April, 2001, regarding ethical clearance for my dissertation, I am enclosing a copy of the formal written consent from the Manager Nursing Services of the Psychiatric In-patient Services, to carry out my study.

Whilst awaiting for your reply, I thank you with anticipation.

Yours truly,

Josanne Bason  B.Sc (hons) Nursing
APPENDIX J.

Letter to Director of the Malta Institute of Health Care.

“Amethyst”,
St. Martin Str.,
Zurrieq.
ZRQ 02.
07.03.2001

Ms Isabelle Avallone,
Institute of Health Care,
St. Luke’s Hospital,
G’Mangia.

Dear Madam,

I am reading a Masters degree in Nursing (distance learning) with the Royal college of Nursing. I am in my final module, which is the dissertation. For this project, I am interested in studying the experiences of nurses who provide care to the mentally ill, in order to understand how they help patients cope with their illness. To meet this end, I would like to carry out interviews with a set of nurses who work at [name of hospital].

However, prior to embarking on this project, I need clearance from a research ethics committee. Kindly, could you please advise me whom I shall contact to get permission so that I shall be able to go ahead with my research?

Thank you with anticipation.

Josanne Bason B.Sc (hons) Nursing.
APPENDIX K.

Letter to Manager of the local Psychiatric In-patient Services.

“Amethyst”
St. Martin Str.,
Zurrieq.
ZRQ 02.
07.03.2001.

Mr _____ [name],
Manager Nursing Services,
___________ [name of hospital],
Attard.

Dear Sir,

I am reading a Masters degree in nursing (distance learning) with the Royal College of Nursing. I am about to start my dissertation in which I would like to study nurses’ experiences of working with the mentally ill in order to understand how they help patients. To reach this aim, I would like to carry out interviews with a set of nurses providing care at _________ [name of hospital].

Enclosed with this letter, you will find my research proposal.

I would like to gain your kind permission to carry out this study.

Thank you with anticipation,

Yours truly,

Josanne Bason B.Sc (hons) Nursing.
APPENDIX L:

Reply from Manager of local Psychatric In-Patient Nursing Services.

4th April 2001

Ms. Joanne Dincu
'Amethyst'
St. Martin Street,
Zurrieq

Dear Ms. Baron,

Thank you for your letter of 3rd April, 2001, requesting consent to conduct interviews with nurses working at [hospital name] Hospital as part of your research being undertaken.

I would like to offer you my support in this project which I think would be useful both for your personal advancement as well as because the information coming out of this study could be useful to the local health services.

Kindest regards,

MANAGER NURSING SERVICES.