COVER BOOK

Development of a support programme for nurses who care for patients with chronic mental illness in three Limpopo Province mental health institutions

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T.G. RIKHOTSO

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Development of a support programme for nurses who care for patients with chronic mental illness in three Limpopo Province mental health institutions

by

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DECLARATION

I declare that **Development of a Support Programme for Nurses who care for Patients with Chronic Mental Illness in Three Limpopo Province Mental Health Institutions,** hereby submitted to the University of Limpopo for the degree of Doctor of Philosophy, has not been previously submitted by me for a degree at this or any other university; that it is my work in design and in execution; and that all material contained herein has been duly acknowledged.

_____ _____

RIKHOTSO T.G. (Dr) **Date**

DEDICATION

This thesis is dedicated to the almighty God, who was with me throughout my PhD journey. It is also dedicated to my family, and to my late mother (may her soul continue to rest in peace) for believing in me and encouraging me to study. My sister always says *'dyondzo ya wehe I dyondzo ya hina tati'.*

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XIANDLA A HEHLE KA XIANDLA!!!

ABBREVIATIONS

PN	Professional nurses
MHIs	Mental health institutions
WHO	World Health Organisation
CMI	Chronic mental illness
MHUCs	Mental health care users
MDT	Multidisciplinary team

ABSTRACT

Nurses working in mental health institutions experience enormous challenges sometimes without formal support structures and programmes to ease their caring duties. This study sought to develop a support programme for nurses caring for patients with chronic mental illness in three mental health institutions in Limpopo Province. A qualitative descriptive phenomenological design was used. A total of thirty participants (male = 7; females = 23) between 27 and 64 years were selected using a purposive homogeneous sampling method. Data were collected using in-depth semi-structured interviews. Hycner's adapted phenomenological explication method was used to analyse the data. Six primary themes and twenty-four sub-themes emerged during data explication. The six major themes include: the nature of chronic mental illness, professional nurses' phenomenological experiences, challenges experienced by professional nurses (PNs), coping mechanisms used by PNs, support structures and programmes for PNs, and suggested support programmes for PNs. The first theme comprises common diagnoses as a sub-theme. Receiving and giving reports, personal hygiene, morning devotions, health education, giving patients medication, physical assessment, and administrative tasks emerged as sub-themes of the second theme. The third theme includes these sub-themes: shortage of staff, lack of social support, safety and security problems, lack of incentives, shortage of resources, and shortage of treatment. Prayer, belief in God, teamwork, self-counselling, and absenteeism are coping mechanisms used by nurses in the fourth theme. The fifth theme focuses on support structures and programmes. According to these PNs, there are no formal support structures or programmes available for nurses, except union forums, monthly meetings, and nurses' day. Family support, support by colleagues and supervisors, psychological support, and general social support are sub-themes that emerged in the sixth theme. The study findings suggest that nurses would like a formal structured support programme to empower them with skills to manage their caring duties. From the findings of the study, a support programme was developed. The support programme emphasises the importance of social support systems, financial support, general support, and psychological support from relevant stakeholders. It is recommended that

a developed support programme should be evaluated and implemented in mental health institutions. The findings have implications for nursing and psychology to work together to provide optimal and holistic support for nurses working in mental health institutions.

Keywords: Professional nurses, chronic mental illness, patients, mental health institutions, and caring.

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CHAPTER 1

INTRODUCTION

The present study is introduced in Chapter 1. This chapter entails five sections. The background of the study is explained in the first section. The research problem is presented in the second section. In the third section of the chapter, operational definitions of concepts are highlighted. In the fourth section, the purpose of the study is outlined. The chapter's final section focuses on how this thesis is organised.

1.1 Background to the Study

Globally, caring for mental healthcare users (MHUCs) is a major task that nurses face (Sobekwa & Arunachallam, 2015). According to studies, nurses who treat chronically mentally ill institutionalised patients are often confronted with multiple unique challenges (Yusuf et al., 2006; Sobekwa & Arunachallam, 2015; Mokoena, 2017; Joubert & Bhagwan, 2018). Barman (2021) reveals that when caring for patients with mental illness, nurses faced various difficulties. According to Joubert and Bhagwan (2018), psychiatric nurses face ominous and diverse challenges within the mental health setting. These challenges include patients refusing medication, those who deny having a mental illness, nurses being exposed to patients' flutuating behaviour, patients who are aggressive and violent, lack of support and dissatisfaction in the workplace, inadequate facilities, stress and emotional fatigue, shortage of staff, negative perception about patients and feelings such as anger, burnout and frustration, (Joubert & Bhagwan, 2018).

In line with the study by Joubert and Bhagwan (2018), Sobekwa and Arunachallam (2015) point out that caring for mental ill patients is a huge duty that nurses are confronted with worldwide. Nurses participating in a study by Sobekwa and Arunachallam (2015), encountered challenges such as shortage of support from authorities which lead to sediments of unappreciation. Similarly, research by van Rensburg (2010) found that i210n acute psychiatric wards, nurses encounter challenges such as providing care to critically sick patients, a severe nursing shortage, extremely

busy, high-stress situations, higher workloads, and dealing with patients who have a variety of mental health issues. For instance, a study by Mokoena (2017) suggests that shortage of personnel, shortage of material resources, equipment and supplies negatively affect provision of quality patient care. Correspondingly, Mthombeni (2021) discovered the that nurses come across the following challenges when providing care: shortage of safety in the ward, results of patient violent behaviour, stigma amongst professionals, not complying with treatment, compromised healthcare, no value of the registered nurse, and lastly, alternative treatment.

According to Eren (2014)'s research in Turkey, the primary causes of psychiatric nurses' unethical behavior were a lack of personnel, a high workload, a lack of in-service training, and poor working conditions. A study done in Palestine by Marie et al. (2017) reveals that nurses are overworked as a result of the staffing crisis that healthcare workers are dealing with. Congruently, a Nigerian study finds that the provision of high-quality healthcare is significantly impacted by the shortage of nurses in facilities that provide mental health care (Jack-Ide et al., 2018).

The results of the qualitative study by Barman (2021) reveal that the main difficulties faced by nurses include workload, a lack of staff, a lack of personal safety and security, a lack of hospital facilities, abnormalities of critically ill patients, a lack of support from family members, and a lack of opportunities for ongoing knowledge advancement. In addition, According to Mulaudzi et al. (2020)'s South African research, professional nurses in mental health care facilities face a variety of difficulties that could interfere with their ability to deliver high-quality care. These barriers were divided into four themes, namely: work-related challenges, shortage of personnel, inadequate safety measures and inadequate resources. These four themes were further broken down into sub-themes, such as the violent behavior of MHCUs, the lack of drugs, the lack of funding, stress, burnout, insufficient security measures, the lack of running water, the state of the infrastructure, the lack of trained mental health care professional nurses, and the lack of psychiatrists.

Because of the demanding, difficult, and stressful nature of nurses' professional responsibilities and duties, nursing is a stressful job and comes with a lot of pressure

(Al-Sagarat et al., 2017; Molehabangwe et al., 2018). Alburquerque-Sendn et al. (2018) mention the following as some of the difficulties faced by mental health nurse specialists: professional recognition, long shifts, low pay, and burnout. Staffing shortages, a lack of adequate infrastructure and resources, and subpar human resource procedures are cited by Morton et al. (2020) as problems that make nurses' jobs less satisfying. Issues that directly impact mental health nurse specialists as well as challenges that are directly influenced by the government were found in a study by Setona et al. (2020). Lack of recognition, lack of a scope of practice for mental health nurse specialists, inadequate financial compensation and rewards, promotion difficulties and restrictions, a shortage of mental health nurse specialists, a lack of support from hospital administration, and poor infrastructure are some of the issues that directly affect these professionals.

The provincial government's lack of support, the lack of a mental health directorate, the lack of a budget for mental health, and the insufficient number of institutions providing mental health care are difficulties that are also directly influenced by the government (Setona et al., 2020). Ambikile and Iseselo (2017) concur, stating that despite the World Health Organization and the Department of Health providing guidelines, policies, and protocol, South Africa still faces issues with mental health. These issues include a lack of human resources for mental health, particularly at the primary level; inadequate training of human resources on mental health; a lack of drugs; the wrong priorities; and the stigma associated with mental illness.

Psychiatric nurses' jobs are complex and call for effective communication with patients who appear with a range of mental health concerns, both locally and globally, according to Joubert and Bhagwan (2018). For instance, a study by Gunasekara et al. (2014) shows that nurses are expected to manage other administrative chores on the ward in addition to supporting and caring for patients admitted for the treatment of mental diseases. This includes admission of patients, meeting attendance, dispensing of medication and communication with patients and / or relatives. Furthermore, they are also faced with challenges such as serious understaffing and interpersonal issues such as bullying, aggression, verbal and physical abuse, and harassment by chronic mental

patients (Yusuf et al., 2006). In addition, physical abuse, insufficient staff, excessive workload and burnout were experienced by these nurses (Sobekwa & Arunachallam, 2015). A study carried out by Khamisa et al. (2016), reveals that 86 per cent of nurses experienced personal stress in relation to financial strains; 58 per cent presented with high levels of work-related stress regarding staff shortage; 65 per cent uncounted high degrees of burnout due to a lack of personal accomplishments; a lower work gratification ratio of 66%; and unreported poor overall health due to anxiety and sleeplessness in 60% of cases.

A study by McKinley (2009) suggests that nurses dealing with patients suffering from complex mental health issues in in-patient psychiatric units show high levels of stress compared to nurses in ordinary wards. These results are in line with the findings of other similar studies, which reveal that nurses caring for institutionalized patients are impacted psychologically, emotionally, and cognitively (Konstantinos & Ouzouni, 2008; Bimenyimana et al., 2009; Ngako, et al., 2012). Consequently, nurses so impacted may respond by displaying psychological reactions such as substance abuse, absenteeism, anger, anxiety, frustration, hopelessness, helplessness, despair, retaliation, and the development of a negative attitude (Bimenyimana et al., 2009). A study by Cleary (2004) discovered that nurses often exposed to stressful work conditions end up feeling disempowered, fearful, emotional, and distressed. Findings of a study by Costa and Pinto (2017) showed that nurses reported high levels of emotional exhaustion that include stress and burnout. Furthermore, community psychiatric nurses often use individual coping strategies on daily practice. Consequently, a support programme would be essential and beneficial for these nurses.

1.2 Research Problem

The current study's research problem encompasses a topic of concern in which a gap in the body of knowledge required for professional nursing. A research problem is typically comprised of a single remark that provides the essence and context of a challenge as well as the shortfall in the body of knowledge required for discipline (Burns et al., 2009). Similarly, according to Hofstede (2010), a problem statement is the recognition of the particular problem as well as a discussion of the reasons it is a challenge. In the

introduction section, the researcher highlights challenges encountered by nurses while rendering care to people with mental illness. Moreover, Nurses' quality of life may be significantly impacted by ongoing stress if they lack good coping mechanisms (Fathi & Simamore, 2019).

Given the varied psychological experiences and consequent responses associated with their caring roles, nurses often use a numerous coping mechanisms to manage their experiences. These may include physical and psychosocial strategies (Blonna, 2006; Kravits et al., 2010). Some use maladaptive coping mechanisms while others use adaptive coping mechanisms. According to McCann et al. (2013), coping can involve positive methods and maladaptive methods. Support-seeking, problem-solving behaviors, and maintaining a work-life balance are examples of adaptive methods, also known as positive ways. Maladaptive methods, on the other hand, are centered on feelings which included repression, suppression, and procrastination. A study by Bimenyimana et al. (2009) discovered that nurses use maladaptive method as a coping mechanisms, namely, resentment, apathy, substance abuse, absenteeism, and violence in the form of retaliation.

According to Opare et al. (2020), nurses working in psychiatric hospitals experience emotional stress because of aggressive behaviour in the workplace and use various coping strategies to endure under this condition. These mental health caregivers experience exhaustion and burnout when they are subjected to emotional turmoil. Consequently, most caregivers are impacted by a number of things as a byproduct of the psychological work environment. In addition, for self-care and management of their high stress levels, the nurses identified four individual coping strategies which are crucial on a daily practice. From the study by Opare et al (2020), the four coping styles that emerged from the findings of the study are reduced number of home visits, religious faith reliance, self-disguise and self-motivation. An Indonesian study by Fathi and Simamore (2019) reveals that the much more frequent coping mechanisms employed by nurses are planning, religion, positive reframing, and instrumental support. According to Laranjeira (2012), self-controlling was used as the most frequent nurses' coping

strategy, followed by asking for social support and planful problem-solving. Notably, self-control was also discovered to be the coping strategy that nurses prefer.

Global studies reveal the following regarding coping mechanisms utilized by nurses: Zhou and Gong (2015) found active coping mechanisms were strongly correlated with resource and ecological difficulties, whereas passive coping strategies were certainly associated with time pressure, workload, social interactions, and management problems. Moreover, excessive documents, work criticism, shortage of equipment, night shifts, and professional ranking were discovered by Lu et al (2015) to be contributing factors to passive coping styles. According to Li et al. (2017), coping strategies that are positive minimise the harmful impacts of job strain while coping strategies that are unfavourable increase the negative effects.

Studies by Cruz et al (2018), and Chang and Chan (2015), reveal that coping ways like proactive and optimism when trying to deal with stresses that are associated to work positively affect the nurses' quality of life and they are also productive in prohibiting burnout indicators. Yu et al. (2013) also discovered that active and planning coping strategies were certainly linked with health-connected life quality. Additionally, social support has an impact on one's quality of life. (Sun et al., 2017). According to Kowitlawkul et al. (2019), nurturing and improving support system from friends, family, co-workers and superiors can assist someone to manage stress and can also improve the quality life of nurses. Smith et al. (2017) agree by saying that a well-timed and enough organizational support is critical to produce positive coping strategies for nurses and to improve the well-being of nurses.

Although there is ample evidence to show that nurses caring for patients with chronic mental illness have to cope with many psychosocial stressors, there are no known studies in Limpopo Province that have sought to develop programmes aimed at supporting nurses caring for patients with conditions such as chronic mental illness. It is against this background that the current study seeks to develop a support programme for nurses who care for patients with chronic mental illness in Limpopo Province mental health institutions. More specifically, the researcher seeks to develop the support programme based on the phenomenological accounts of the nurses who are drawn

mainly from a rural environment, which is often characterized by limited support or resources.

1.3 Operational Definitions of Concepts

1.3.1 Support programme

This refers to a kind of support plan for people to improve their knowledge, skills, and attitude, according to their needs (Hamric et al., 2014). In the present study, support programme will refer to a planned series of activities that will help to enrich the knowledge, practices and coping skills of nurses caring for patients with chronic mental illness.

1.3.2 Nurses

According to the Nursing Act 33 of 2005, a nurse refers to a licensed person who nurtures, assists, and treats clients, who can be an individual, family or group, sick or well, to attain or maintain health or optimal recovery and rehabilitation or to a peaceful, dignified death. In the present study, a nurse will be understood as defined by the Nursing Act.

1.3.3 Chronic mental illness

This refers to any long-term mental disorder or condition that interferes with physical, emotional, intellectual, social, or spiritual functioning (APA, 2013). In this study, chronic mental illness will hold the same meaning.

1.4 Purpose of the Study

1.4.1 Aim of the Study

The aim of the study was to develop a support programme for nurses who care for patients with chronic mental illness in Limpopo Province mental health institutions (LPMHIs).

1.4.2 Objectives of the Study

The study's objectives were as follows:

- To describe the lived experience of nurses caring for patients with chronic mental illness in Limpopo Province mental health institutions;
- To determine support structures that nurses caring for patients with mental illness perceive to be useful;
- To identify mechanisms utilised by nurses to deal with chronic mentally ill patients;
- To describe strategies used by nurses to cope with chronic mentally ill patients; and
- Based on the phenomenological accounts of the participants, to develop a support a programme for nurses who care for patients with chronic mental illness**.**

1.5 Significance of the Study

The researcher is unaware of any documented scientific researches that sought to develop a support programme for nurses caring for chronic mental ill patients in Limpopo mental health institutions. This study, therefore, intends to give valuable insights into the situation in Limpopo Province, and also to add value to the existing broader literature linked to mental health or illness in South Africa as a whole. The current study could also contribute towards efforts aimed at developing policies that will incorporate and involve nurses caring for patients with chronic mental illness. It is also hoped that the results of this study will provide evidence-based information about the needs of nurses, their challenges and coping mechanisms, and their experience regarding social and psychological support structures and support programmes to manage and minimise caregiving stress. Lastly, this study may boost efforts by policymakers in implementing support programmes for nurses and families affected by chronic mental illness.

1.6 Organisation of the Thesis

This study will be divided into eight chapters. The first chapter begins with a presentation of the introduction, which includes the study's background and research problem. A presentation of operational definitions of important topics follows this. The study's goals and relevance are then described, along with its purpose. Chapter 2

comprises the following sections: history of mental health care delivery, demands and challenges associated with caring for institutionalized mentally ill patients, nurses' coping strategies, nurses' support programmes, and theoretical framework. Practice-oriented theory, as the theoretical framework, is used to guide this study and will be outlined in Chapter 3. The research methodology used to carry out this study is presented in Chapter 4. The following topics are covered in this chapter: research site, research design, sampling, data collection, data analysis, and quality criteria. This chapter also discusses the ethical considerations that were employed when conducting this study. The study's findings are summarized in Chapter 5, and they are discussed in the context of existing literature on the subject. The results are discussed in Chapter 6. In Chapter 7, guidelines will be outlined for developing a support programme for nurses. The final chapter, Chapter 8, provides a summary of the findings, makes recommendations, and draws conclusions in light of the research's findings. .

1.7 Concluding Remarks

The first chapter introduced the problem under investigation encompassing the background of the study, the research problem, operational definitions of concepts, the aim and objectives of the study, the importance of the study, the organisation of the thesis and the conclusion. Chapter 2 will review relevant literature respecting the history of mental health care delivery, demands and challenges associated with caring for institutionalised mentally ill patients, nurses' coping strategies, and nurses' support programmes, and will conclude with a theoretical framework. Chapter 3 presents the research approach that was employed to complete this study. Research site, research design, sample, data collecting, data analysis, quality criteria, and ethical considerations are among the topics covered in this chapter. The study's findings are presented in Chapter 4 and their commentary is covered in Chapter 5. Guidelines for creating a support program for nurses working with patients suffering from chronic mental illness are provided in Chapter 6. The overview of the results, the suggestions, and the study's conclusion are the main topics of the final chapter, Chapter 7. This thesis will go into great detail about each of these chapters.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Chapter 2 focuses on the literature reviewed. Coughlan and Cronin (2017) define a literature review as an organized search and identification of collected works on a specific topic for the purpose of offering new insights regarding the problem studied. Similar to this, Langford and Young (2013) emphasise that a literature review entails looking for data that is relevant to a particular area of interest in so as to demonstrate how the issue fits within the overall body of available evidence and the framework of a research.

Literature review seeks to make connections between the sources and texts on which the researcher draws. This results in the researcher bringing up the arguments where they position themselves and their study among different sources. The literature used in the current study was gathered from published research articles, journals, books, laws, and other reliable sources of scientific work, including Google Scholar, Science Direct and others. The search terms utilised in the process of literature search were support programme, registered professional nurses / psychiatric nurses, mental health care users, chronic mentally ill patients, challenges faced by nurses, coping strategies, support structures, and lived experiences of psychiatric nurses.

The researcher searched topics that are associated or are similar to the title of the study and any of its objectives. The researcher then critically looked at the abstracts of the articles and briefly perused the articles to check their relevance to the present study. These articles and the written literature were reviewed by researcher to check the thoroughness, accuracy, relevance to the study, and how latest they were. Going through the literature helped the researcher to gain comprehension of the knowledge that already exists on the topic being studied to be able to develop a suitable support programme for nurses caring for patients with chronic mental illness.

The literature review will be structured as follows: The first part will comprise the history of mental health care delivery. This is followed by a presentation of the phenomenological experiences of the professional nurses (PNs), demands and challenges associated with caring for institutionalized mentally ill patients, nurses' coping strategies, and lastly, nurses' support structures and programmes are discussed.

2.2 History of Mental Health Care Delivery

Ure (2015) claims that from 1904 to 2004 in the USA and UK, there were four secular transformations in the way that mental health services were provided. These shifts are vital because they contributed to mental health development and related to political and social changes between the late 18th century and the 21st century. The first change occurred in the 19th century, and it was during this shift that the National Mental Health Act of the Union's maiden gazette appeared in 1916. As the first Commissioner for the Mentally Disordered and Defective Persons, Dr. Dunston drafted the first comprehensive piece of legislation, known as the Mental Disorder and Defective Persons Act. His mandate was to make enhancements in the psychiatric hospitals of those days. This change also aided in the Union's rapid economic and human capital growth and the ensuing influx of people into and out of the various provinces (Ure, 2015). This Act has undergone numerous alterations and amendments throughout time to accommodate new customs and conditions.

As per Arendt (2006), the 1960s saw a change in the Western world that set the way for the second shift in mental wellbeing. During this time, the Second World War's effects were clearly seen, demonstrating how vile man's behavior could be toward his fellow man. It had become clear that circumstances of abuse could arise at any level of disparity if one group believes itself to be superior to another (Arendt, 2006). A third shift changed the way care for mental illness was provided in South Africa in the 1970s. It covered a reticent, antagonistic era in which clinical care and institutional procedures were the subject of accusations, denials, political amours, and a multinational conspiracy. These unintentionally had a significant impact and established the groundwork for the subsequent deterioration and mistreatment of patients in both public and private mental health institutions (Arendt, 2006).

The fourth shift discussed yet another parliamentary turning point in the development of South Africa's system of mental health treatment. A new government commission for service delivery that prioritizes human rights was established in 1994 after the first constitutional elections. The Mental Health Care Act No. 17 of 2002 was subsequently drafted. In terms of securing rights for all of its residents, South Africa made headway and eventually was able to form an alliance with the US and the UK. However, there is still a problem with the slow progress of chronic mental health institutional treatment in South Africa; this alignment through time permeated chronic mental health facilities. This may occur for a variety of reasons, including the enormous financial disparity that currently exists between the policy's aspirations and the resources allocated by the government to ensure that laws are in line with human rights obligations (Ure, 2015).

According to Gillis (2012), a considerable number of healthcare facilities were constructed in the 19th century, some of them were designed after structures abroad and others after abandoned military camp. In South Africa, the following hospitals were constructed: The first hospital was Fort England Hospital in Grahamstown, which opened in 1876. Other hospitals that followed were Tower Hospital in Fort Beaufort, Eastern Cape, in 1897; Kowie Hospital in Port Alfred, which was also located in abandoned camps; Valkenberg Hospital in Cape Town; Weskoppies Hospital in Pretoria; Oranje Hospital in Bloemfontein; and Townhill Hospital in Pietermaritzburg, which opened in 1882. Later, more hospitals were constructed, including the Lentegeur Hospital on the Cape Flats in 1974, Stikland Hospital in Bellville in 1963, and Komani Hospital in Queenstown in 1922. The Alexandra Care and Rehabilitation Centre opened in Cape Town in 1922, while Witrand Institute began housing patients with mental retardation in Potchefstroom in 1923. With Union in 1910, the responsibility for psychiatric hospitals was centrally transferred to the state Department of Health, which was also accountable for new legislation. These organisations were governed by the so-called Lunacy Laws and specific regulations dealing with the mentally ill, which differed in the Boer Republics (Mental Disorders Act of 1916, as cited in Gillis, 2012).

Gillis (2012) indicates that there was a vital development, which was that undertaken by the South African Department of Health in 1974. This development resulted from the

relocation of numerous chronic patients to a for-profit healthcare facility known as the Smith Mitchell Organisation due to the large number of chronic patients and the limited number of beds in its psychiatric facilities. Due to the majority of patients being black, several people opposed this step, but the American Psychiatric Association's investigative team and the Society of Psychiatrists were satisfied with the facilities and services following thorough inspections. There were plenty of hospital beds available, which allowed psychiatric facilities to concentrate more on serious disorders and difficult treatments. However, the strain on psychiatric facilities quickly increased once more.

According to Gillis (2012), several inclusive and comprehensive acts, laws and regulations on mental health were promulgated in the passing years. Current trends include the provision of integrated mental health services at the basic care level and a variety of specialized units needed in urban areas where particularly trained personnel and suitable facilities are available for the treatment of specific disorders. For example, acute emergency centers, which are always located in health institutions, eating disorder units, psychogeriatric units, child and adolescent units, addiction u (Gillis, 2012).

In terms of enlarging and improving its mental health systems, South Africa has made progress. According to the South African National Department of Health (1997a, 1997b), there is some degree of policy protection for mental wellbeing, as evidenced by the White Paper for the Transformation of the South African Health System and the National Health Policy Guidelines for enhanced Mental Health in South Africa. With the adoption of the Mental Health Care Act 17 of 2002, legislation governing mental health has also been updated in accordance with international human rights norms. The establishment of mental health review boards, the growth of in-patient services offered by general hospitals, and the establishment of 72-hour evaluation facilities in district-level general hospitals are only a few of the measures that Lund et al. (2007) point out are the results of the Act.

Only 19 African nations, including South Africa, have a dedicated and officially supported mental health policy. South African mental health policy is committed to delivering substantial, community-based services that are integrated into general health

care, in accordance with the WHO recommendations (Jacob et al., 2007). In comparison to other African nations, South Africa offers better and more comprehensive mental health treatment, including personnel, facilities, and access to hallucinogenic drugs. Additionally, South Africa offers free basic emergency psychiatric services, in contrast to many other African nations, and people with mental illness are given disability grants. However, numerous challenges remain. These include stigma and discrimination against mental health care users (MHCUs), over-dependence on psychiatric hospitals, the shortage of an officially endorsed mental health policy, low priority given to mental health, inequity of services and budget between provinces, unequal allocation of mental health human resources in rural and urban areas, shortage of accurate continuously collected data regarding service delivery, and under-usage of Primary Health Care services to provide care to those who suffer from anxiety and depression disorders (Draper et al., 2009; Kakuma et al., 2010; Khunou & Davhana-Maselesele, 2016).

Both nurses and patients have experienced the above-mentioned challenges, making it hard to implement the Act properly (Vergunst, 2018Given the significance of nurses' physical and mental health and an organisation's moral and statutory obligation to safeguard staff members' wellbeing, it is crucial to assess the personal experience of mental health nurses in order to comprehend them and, ideally, use that understanding to improve their working conditions and, in this case, develop a support program for them (Zarea et al., 2012).

In conclusion, in South Africa there have been positive changes and improvements since the introduction of the Mental Health Care Act 17 of 2002. What is essential is to make sure that the Act is completely implemented. Government should really give attention to outstanding parts of the Act, like the shortage of resources, the shortage of personnel, and the shortage of medication. The Act should not focus entirely on mental health care users but should also involve other stakeholders such as nurses, family members of the patients, and the community at large since one person’s mental state has a direct effect on the individual, family, and society. Considering the needs of

nurses, family members and community is imperative and will, in turn, benefit the patients.

2.3 The Nature of Chronic Mental Illness

Globally, approximately 792 million people suffer from mental disorders (Ritchie & Roser, 2018). These statistics agree with the World Bank Group (2020), indicating that approximately 10 per cent of people worldwide suffer from mental illness. In South Africa, an estimated 18 million people suffer from mental disorders rounding it up to a prevalence rate of approximately 30 per cent, as noted in a large-scale study by Herman et al (2009). In 2017, approximately 20 million people were reported to be suffering from schizophrenia globally. This figure accounted for males and females equally affected by the disorder (Ritchie & Roser, 2018).

The World Health Organization (WHO) has focused on the growing worldwide burden of mental diseases as well as the most recent developments in our knowledge and treatment of these disorders. In 2000, the burden of disease across the globe was 12% due to mental disorders. After HIV/AIDS, neuropsychiatric illnesses account for the second-highest percentage of local disease burden in South Africa. The leading causes of disability-adjusted life years, accounting for 7.4% of them globally, are mental and drug use disorders. Between 1990 and 2010, the prevalence of mental and drug use disorders increased by 37.6% for the majority of diseases. This rise was caused by population growth and aging. Mental disorders are responsible for approximately 14.3% of all deaths worldwide each year, as well as approximately 10 years of potential life lost.

The most common mental disorders reported include depression, anxiety, bipolar disorder, schizophrenia, and substance misuse disorders (WHO, 2010). In South Africa, 0.18 per cent of the population was recorded as suffering from schizophrenia in 2017 (Ritchie & Roser, 2018). In a study conducted by Alosaimi et al. (2017), it was revealed that the commonly psychiatric diagnoses among inpatients were schizophrenia with 55.8 per cent and bipolar disorder with 23.3 per cent. In outpatients, the frequent psychiatric diagnoses were major depressive disorder with 29.3 per cent and

schizophrenia with 28.9 per cent. Another amusing outcome is the low rate of anxiety disorders of 1.6 per cent for inpatients and an out-patient sample of 16.3 per cent.

According to the National Institute on Drug Abuse (NIDA) (2018), the occurrence of two disorders presenting simultaneously within individuals is a common phenomenon, known as a dual diagnosis. Dual diagnosis can encompass a broad range of comorbid disorders, which interact and consequently affect the course and prognosis of each disorder. In a study by Alosaimi et al. (2017), Less than 10 percent of patients had two or more diagnoses, while the majority of patients only had one diagnosis. Studies show that MHCUs with a dual diagnosis display higher incidence of treatment non-adherence, relapse, and rehospitalisation (Mthombeni, 2021).

2.4 Professional Nurses' Phenomenological Experiences

Research by Hamaideh and Ammouri (2011), and Cleary et al. (2012) disclose that Nursing is one of the few helping professions that provides hands-on care twenty-four hours a day, seven days a week. It is a difficult and challenging line of work. According to Cleary et al. (2012), this may imply that nurses are more likely to encounter unforeseen or unexpected conditions than other health professionals who typically work set hours. According to Joubert and Bhagwan (2018), nurses make up the largest group of medical professionals providing care to those utilising mental health services in the field of psychiatric services. This places them in a crucial position where they must deliver high-quality care while controlling the problems these patients cause. Additionally, they run into complex and depressing obstacles when they are among others who are receiving mental health care. Every day, nurses provide psychiatric care to individuals with psychiatric issues in inpatient wards in psychiatric hospitals as well as in communities (Western Cape Department of Health, 2009).

Research by Uys and Middleton (2010), as cited in Joubert and Bhagwan (2018), has discovered that psychiatric nursing endeavors extend to domestic and administrative supervisory tasks, serving psychiatric patients' meals, admitting psychiatric patients, administering medication, and the constraining of violent psychiatric patients. Psychiatric nurses in South Africa struggle to define the precise functions performed in this specialised background.

There are numerous critical jobs that nurses do in mental in-patient wards, and each of these roles is dependent on each nursing group. According to a 2015 study by Rangwaneni et al., professional nurses are responsible for providing comprehensive care. Rangwaneni et al. (2015) reveal roles such as collaboration, patient advocacy, and information offering. The nature of the mental health care services provided encompasses assessment of the psychiatric patients, giving treatment, and assisting the patient with activities of daily living. A study conducted by Fourie et al. (2005) in New Zealand, it was shown that nurses perform a number of key responsibilities that are all connected to the provision of mental health treatment in a disaster management scenario.

According to a research by Uys and Middleton (2004), nurses' duties included patient assessments, symptom stabilisation, discharge planning, administering psychiatric medications, providing general nursing care, and dealing with difficult and demanding patients who are acutely ill. Other tasks mentioned in the Scope and Standards Draft Revision (2006) include patient advocacy, counseling patients and their families through psychoeducation, personnel management, administrative roles, risk management, and many others. By identifying mental health challenges, preventing mental health problems, and providing care and treatment to those who have psychiatric disorders, nurses in the field of psychiatric nursing promote mental health and wellness (Scope and Standards Draft Revision, 2006). Additionally, many individuals with mental illnesses need a significant amount of help and support from family members and/or other professionals to do basic tasks like daily self-care. The current study found that the daily routine or duties of PNs in the three psychiatric hospitals include giving and receiving feedback, self-care, morning devotions, giving patients medication, health education, physical assessments, and administrative duties. The above-mentioned daily routine or duties of PNs will be presented below.

2.4.1 Receiving and Giving Feedback

As part of the PNs' duties, they give and in turn receive feedback from other nurses when they come to work and later when they go home. This process of giving and receiving feedback is called handover. Handover, as defined by Millar and Sands (2012)

as cited in Waters et al. (2015), is the conversion of spoken and written communication of patient data among the healthcare team's members. Handover, or the exchange of patient information between professionals, is a critical component of healthcare. Furthermore, psychiatric environments are dynamic environments that rely on easy and accurate interaction to plan care and manage risk (Waters et al., 2015). Spoken handovers and ward rounds, according to Eivergrd et al. (2016), are reporting structures for correspondence that model psychiatric personnel's ability to recognize, comprehend, and construct patients, as well as patients' ability to construct themselves.

In settings related to mental health, handover is a custom that can take up a lot of daily time. The requirement for the effective and rapid transfer of critical information has increased as a result of an increase in staff turnover and a rise in the use of temporary workers, as staff members frequently encounter patients they are unfamiliar with (Waters et al., 2015). In this situation, efficient and prompt handovers are essential giving and receiving feedback amongst nurses optimally to enhance service delivery, this is supported by Cleary et al. (2009), who said handovers can reduce information loss and increase accuracy.

2.4.2 Personal Hygiene of Patients

Generally, people who suffer from schizophrenia are often not concerned with personal hygiene. Hsu et al. (2017) discloses that schizophrenic patients commonly have poor grooming and self-care techniques. A study by Joubert and Bhagwan (2018) discovered that 50.6% of respondents believed that psychiatric patients needed help maintaining their personal hygiene and taking care of themselves. Any person who is unable to maintain their own hygiene suffers both physically and psychologically. Personal hygiene, cleanliness, and oral health are just a few of the fundamental needs that nursing personnel must attend to for the patients in their care. Personal hygiene, cleanliness, and oral health are just a few of the fundamental needs that nursing personnel must attend to for the patients in their care. Helping patients with personal hygiene is an essential part of nursing care, according to Lawton and Shepherd (2019), and it provides an opportunity for nurses to do a comprehensive assessment of their

patient. Good personal hygiene is important for skin health but it also has a crucial role in maintaining quality of life and self-esteem (Coyer et al., 2011).

Hair, skin, nails, lips, eyes, ears, nose, facial shaving, and perineal care are all part of personal hygiene (Dougherty & Lister, 2015; Parveen et al. 2020). Junior staff are frequently tasked with helping patients dress and wash, however the time spent caring to a patient's hygiene requirements is a crucial opportunity for nurses to do a holistic assessment (Dougherty & Lister, 2015). Additionally, it allows nurses the chance to address any worries patients may have and offers a crucial chance to evaluate the health of their skin. Additionally, nurses should use this opportunity to talk with patients about any cultural and religious concerns they may have with personal care (Dougherty & Lister, 2015). For instance, a nurse of the same gender should preferably care for Muslim patients (Rassool, 2015). According to the Department of Health (2001), nurses in particular must be able to provide for the basic needs of patients under their care. The personal hygiene of patients is taken care of by nurses, who pay close attention to their bodies, mouths, faces, hair, fingernails, and clothing. Other studies have produced different results; for instance, in the United Kingdom, researchers discovered that only 12% of psychiatric patients need the assistance of nurses to meet their self-care needs (Higgins et al., 1999). This basically means that not all patients with mental illness require help with self-care.

2.4.3 Morning Devotions

Numerous studies have shown that patients frequently and favorably use prayer as a coping mechanism (Kim-Godwin, 2013). According to Hefti (2011), persons who suffer from psychiatric problems frequently use religion as a coping mechanism. Additionally, he said that between 70% and 80% of people engage in the following religious or spiritual practices to deal with their daily challenges and frustrations: praying, doing meditation exercises, and attending religious services. Additionally, encouraging patients to discuss their spiritual beliefs and issues increased their degree of comfort in the existing relationship with the healthcare provider (HPC). Patients typically appreciate that HCPs evaluate what is important to them and how this is connected to their care (e.g., prayer, art, reflection).

2.4.4 Giving Patients Medication

A study by Joubert and Bhagwan (2018) illustrates that patients with mental illness have a tendency to refuse medication. Taj et al. (2008) agree by saying that major psychiatric problems increase a patient's likelihood of not taking their medication as prescribed. Non-adherence to medication, according to the WHO (2003), describes a situation in which a person's behavior in taking medication does not coincide with accepted advice from health professionals (WHO, 2003). Inability to originally fill or refill a prescription, taking less or more of a medication than recommended, taking a dose at the wrong time, and stopping a medication before the full course of therapy are all examples of purposeful or unintentional drug use (Al Qasem et al., 2011). Understandably, severe psychiatric problems have an impact on patients' insight and thinking, which might harm adherence. Maintaining treatment compliance is crucial for the effective management of chronic mental diseases; otherwise, relapse is common and treatment outcomes are compromised (Mokwena & Ndlovu, 2021). According to a research by Ansah et al. (2021), treatment failure frequently results in relapse, which may necessitate the patient being readmitted to the hospital in order to stabilize them before being sent home as an outpatient.

2.4.5 Health Education

One of basic healthcare's duties is to promote health (Hamidzadeh et al., 2019). Hätönen et al. (2010) assert that it is the duty of healthcare organizations to promote the implementation of patient education in clinical settings as well as national and international health policy. The fundamental goal of patient education is to provide patients with adequate and pertinent clinical information in order to increase their understanding of their illness and promote health-promoting behaviors. Giving patients and their families' information and education regarding their psychiatric disease is a key point of mental health care, according to Fluent et al. (2013), who also suggest that patient education will continue to be a useful and expected feature of effective care. Discussions concerning the implications of diagnostic tests, available therapeutic alternatives, and the risks and advantages of those therapies vary and are tailored. Patients with psychiatric illnesses are in dire need of helpful tips on how to deal with their symptoms (Chien et al., 2001). Understanding how medicine can treat psychiatric

symptoms can help patients with mental health difficulties adhere to their treatment regimens and manage their illness better. Furthermore, it appears that patient education goes beyond boosting compliance and may even improve quality of life (Hätönen et al., 2008).

In many therapeutic settings, patients with psychiatric illnesses and their loved ones receive educational material. According to studies by Chien et al. (2001) and Gümüs (2008), patients were generally quite eager to learn more about psychiatric disease and strategies for dealing with common issues. These results agree with those of earlier studies. Focus issues, rage, violence, aggressive conduct, sleep issues, and patient self-help organisations were the subjects for which patients reported the most desire for health education (Yilmaz, 2012). According to research by Marmot (1999) and Rootman et al. (2001), clinicians working on individual patients as well as public health program designers targeting bigger population sections can apply preventative and promotive methods. Public health initiatives linked to promotion and prevention have been shown to have positive effects on people's physical, mental, and social well-being (Marmot, 1999; Rootman et al., 2001)

2.4.6 Physical Assessment

Physical assessments form part of the duties that PNs perform as a daily routine. PNs who participated in this study revealed that they do physical assessments for patients. The physical assessments are done once a month, during the week; not on weekends. Owing to the higher number of patients, physical assessments are done throughout the week. Every day, new patients are seen by the doctor. The PNs, with the help of other nurses, divide patients into equal numbers of groups and allocate dates and times for physical assessments. By the end of the month, all the chronic mentally ill patients have been physically assessed.

2.4.7 Administrative Duties

As stated earlier by Gunasekara et al. (2014), in addition to supporting and caring for patients who are hospitalised for the treatment of mental diseases on their rehabilitation paths, nurses working in a psychiatric environment are also responsible for managing other ward administrative duties. These duties include admitting patients, meeting

attendance, administering medication, and communication with patients and / or relatives. These administrative roles are often time-consuming, tiring and strenuous for nurses.

2.5 Demands and Challenges Associated with Caring for Institutionalised Mentally Ill Patients

Based on the brief positive history of mental health care systems and the phenomenological experiences of the PNs presented in the previous sections, it is evident that chronic mental illnesses affect not only the person who is sick, but also those who care for the sick person. Generally, it is not easy to care and look after a sick person. Caregiving for someone that has chronical illness is usually an emotionally strain and physically draining experience, which is chacterised by constant stressful challenges (Land & Hudson, 2002). More often than not, nurses are the main caretakers for patients with mental conditions in an institution context and have regular interaction with these patients. This is accordance with a study by Joubert and Bharwan (2018), who state that nurses comprise the largest group of healthcare professionals caring for mental health care users in the psychiatric services environment. Additionally, nurses in South Africa are the guardians of the nation's healthcare system, particularly the mental health system (Department of Health, 2008).

According to research, nurses commonly provide psychiatric and mental health treatment to patients in inpatient psychiatric wards who are experiencing mental health and psychiatric issues on a daily basis in mental health institution and communities (Western Cape Department of Health, 2009). They are therefore in a crucial position to provide quality care while attempting to control the issues that come with these mentally ill patients. Being aware of the different duties played by psychiatric nurses as well as the unique and frequently painful obstacles that come with caring for mentally ill patients is necessary for dealing with this as part of nursing education (Joubert & Bharwan, 2018).

Psychiatric nurses, according to Zarea et al. (2012), play a crucial part in the process of caring for patients with mental illness, but they also frequently encounter multiple difficulties and other problems specific to their profession. Udod et al. (2017) concur by

stating that a caring role can be naturally stressful and challenging. In addition, psychiatric nurses face a complex range of stressful incidents, which include caring for violent and aggressive patients, reoccurring relapse episodes and poor prognosis of mental illnesses (Hasan, 2017). Furthermore, nurses in a psychiatric setting are subjected to constant stressful work disciplines, which may lead to psychological and/or emotional issues as a result of chronic exposure to active and passive trauma in the units (Christodoulou-Fella et al., 2017).

A study conducted by Ngako et al. (2012) reveals that psychiatric nurses experienced working with psychiatric patients as entering an environment that is not safe and where care became a burden; they encountered negative attitudes and emotional reactions toward these mental health care consumers, which tempered with the quality of nursing service. Using a five-point Likert scale, Joubert and Bharwan (2018) examined the degrees of agreement of psychiatric nurses with the most common issues encountered in practice. They discovered that a resoundingly large majority of respondents agreed—many of them strongly—that 95,7% of people who have mental illnesses deny having them. The constant exposure to the unexpected behavior of psychiatric patients, which represented 95.2% of the task, was another enormous obstacle. Psychiatric nurses also expressed concern about being exposed to high levels of patient hostility and violence, however at a lower rate of 88.6%. Insufficient facilities and patients who refuse medication were two other issues mentioned in the same research (88.38% and 88.35%, respectively). More than 75% of respondents agreed that psychiatric nurses often experience feelings of aggravation and worry linked to these issues, and 73.1% thought that these challenges often lead to higher levels of burnout in psychiatric nurses (Joubert & Bharwan, 2018).

A study conducted by Sobekwa and Arunachallam (2012) discovered that nurses experience both negative and positive aspects of challenges during the process of rendering care to patients with mental illness in an acute admission unit. Positive experiences include MHCUs' recovery, passion for caring, and teamwork. They further stated that the positive aspects come as a motivation to their work and keep them going. Negative experiences include: working environment that are unsafe, afraid of

assault by psychiatric patients, aggressive psychiatric patients, inconsistent behaviours by patients, lack of staff, overwork and burnout, unsatisfactory nursing care, a lack of authority support, and a sense of being underappreciated by supervisors (Sobekwa & Arunachallam, 2012).

Zarea et a. (2012) agree with Sobeka and Arunachallam (2012) by highlighting that nurses in mental health institutions experience challenges such as the organisational politics and rules, privacy and protection concerns, ambiguity about their responsibilities, and a lack of educational opportunities. Consistent with studies by Sobeka and Arunachallam (2012), and Zarea et al. (2012), this study discovered that PNs caring for patients with chronic mental illness encounter numerous challenges. These difficulties include a lack of staff, a lack of social support, safety and security problems, shortage of resources, shortage of treatment facilities, and lack of incentives. The above-mentioned challenges will be outlined below in details.

2.5.1 Shortage of Staff

Joubert and Bhagwan (2018) found that nurses are globally confronted by huge difficulties and significant challenges. A study by Chikudu (2016) reveals that the nursing profession currently suffers a globally severe shortage. He further mentions that the shortage of professional nurses continues to be a huge problem for both public and private mental ihealth institutions worldwide and that South Africa is included in this difficulty. This is consistent with the current study, which reveals the shortage of staff as a serious problem in the three MHIs. The WHO estimates that there is a shortfall of over 43 million nurses, midwives, doctors, and other healthcare workers. The quality and sustainability of health systems globally are threatened by a global shortage of these medical experts, according to Aluttis et al. (2014). Zarea et al. (2012) agree, saying that the shortage of staff has been found to be a challenge amongst psychiatric nurses. The same opinion is held by Ngako et al. (2012), who also point out that there is a severe shortage of nursing staff in acute mental hospitals, which makes it difficult for nurses to care for patients who are severely sick.

According to the South African National Council (2013), as cited in Van Graan et al. (2016), the current proportion of nurse to patient is enough proof that there are

shortages of nurses. Currently, nurses are overburdened as there are ordinary too many patients per nurse. The problem intensifies when nurses are unavailable from work, or are on lengthy leave such as maternity leave (SANC, 2013). Shortage of personnel is a hurtful reality to psychiatric nursing. According to Zarea et al. (2012), some nurses are often pressurised by their management to work within the psychiatric units against their will owing to low personnel numbers. Sometimes nurses use aggressive behaviour towards the patients with the aim of pushing them away so that they are able to do the other duties that have to be done. A study by Bimenyimana et al. (2009) found that shortage of personnel, inadequate management support, a lack of cooperation from multidisciplinary team members, and a lack of systematic and thorough orientation.

A study by Marie et al. (2017) reports that shortage of staff is a challenge to healthcare professionals and results in overworked nurses. Personnel shortages have resulted in high workloads for mental health nurses, and while there is a nurse's shortage in all areas of nursing, there is a severe shortage of nurses in the psychiatric setting. (Zarea et al., 2012). They also state that shortage of personnel usually led to strenuous workloads for psychiatric nurses. In addition, increased staff turnover, personnel absenteeism, and the performance of non-nursing duties also led to high workload. According to Bimenyimana et al. (2009), the lack of personnel causes exhaustion amongst mental health nurses which, in turn, results in fatigue and job displeasure. Gradually, these nurses become dismayed and resort to not going to work as a way of being heard. This predicament farther and farther diminishes the already overworked staff, causing more fear and tension for those on duty (Bimenyimana et al., 2009). Longer, more frequent, and more intense patient contact, using oneself, and susceptibility to stress all contribute to fatigue, which is the end result of a progressive and accumulative process.

Booyens et al. (2015) claim that, with the assistance of rehabilitative professional therapists in the healthcare system, healthcare workers make up the majority of the front-line and referral health teams in South Africa. All types of healthcare workers, particularly doctors, but also paramedics, dentists, nurses, physiotherapists, and

occupational therapists, are in serious short supply in South Africa. Additionally, South Africa faces an 80,000-professional shortfall in the field of healthcare, which creates significant obstacles for the provision of high-quality healthcare in the state services. Due to a staffing shortfall, new categories of healthcare workers, such as clinical associates, have been established (Booyens et al., 2015).

The scarcity of pharmacists makes it difficult for nurses to provide care (Larson, 2006). Medication delivery can be hampered when there is a shortage of pharmacists. Furthermore, due to a shortage of pharmacists to meet the needs of a hospital, nurses may have to wait longer to collect and administer medication to their patients. Larson (2006) goes on to say that when other staff members are unavailable, nurses may be called upon to help out. This can slow down the delivery of patient care and may contribute to the already growing discontentment that several nurses are articulating about their working conditions (Larson, 2006). Hlongwa and Sibiya (2019) agree, adding that many clinics cited a lack of staff, particularly psychiatric nurses, psychiatrists, and advanced psychiatric nurses, as the main impediment to integrating mental health care into primary care. They also state that there is no residential psychiatrist in any clinic, that a psychiatrist only visits once a week, and that a general practitioner sees all patients, including those in MHCUs.

Vergunst (2018) highlights the unequal distribution of mental health human resources between rural and urban sectors in South Africa. For example, there are 3.6 times as many psychiatrists in or around the largest city as there are in the entire nation. It is unknown how many mental health nurses work in rural and urban hospitals. In South Africa, it is typical for rural areas to lack psychiatrists and psychologists, therefore medical professionals, occupational therapists, and nurses are typically the primary providers of mental health therapies. Typically, patients are directed to the nearest city, which can present transportation challenges for those in need of a psychologist or psychiatrist (Vergunst, 2018). According to Ngako et al. (2012), staff shortages make it difficult to provide MHCUs with essentials like careful monitoring and emotional support.

According to Booyens and Bezuidenhout (2014), staff shortages can be attributed to the following factors: pension, resignation, a desire for new adventures, a higher level of job

discontentment, and outstanding job offers in terms of rewards or good salaries. According to Chikudu (2016), the main motivation for staffing shortages is financial independence; many nurses suffer financially. A large number of nurses are in debt and are compelled to perform extra shifts to supplement their already pitiful pay (Mokoena, 2017). Salary disparities between people with similar qualifications and job experience working for different hospitals are enormous and unjust. Chikudu (2016) found that the majority of nurses also leave because of high levels of crime. He adds that unsatisfactory working circumstances are a further factor in nurses leaving their existing positions to work in other industries. Additionally, it is challenging for nurses to feel enthusiastic and motivated about their work because of the lengthy and uncomfortable work hours.

According to research, the lack of employees is a contributing factor to absenteeism and burnout (Garcia et al., 2015). There are many people that miss work for various reasons. Singh (2012) asserts that there are three general categories into which absenteeism can be divided: authorised absenteeism, unexcused absenteeism, and absenteeism due to illness. Unauthorised absence is any absence that is not included in sickness absence or approved absence; it occurs when an explanation is not supplied for the absence or when the employer does not approve the excuse. Sickness absenteeism is when an employee appears to be absent due to illness. According to Nyathi and Jooste (2008), absenteeism causes a high workload for nurses who fill in for colleagues who are absent, which can lead to a lack of motivation among nurses and a reduction in the quality of patient care. Furthermore, personal and organisational factors, as well as managerial and working conditions, can all contribute to workplace absenteeism.

They go on to say that nursing leaders may face difficulties in modifying timetables and redistributing nursing services of those who are not present to nurses who are present to ensure patient care in the facility continues. Absenteeism may be directly related to work challenges, reflecting on the quality and productivity of the nursing profession as well as its personal life. Absenteeism has become a source of concern for organisations, and it has a negative impact on nursing as a profession as it reflects on

the quality of care. The absenteeism among nurses disrupts teamwork and impart the quality of patient healthcare (Huber, 2008).

Burnout is a prevalent psychological phenomenon among nurses. Burnout is associated with exhaustion, frustration, anger, and depressive symptoms (Maila, 2019). Burnout is defined as regular exposure to an stressful, emotional, stressful, and maladaptive occupational conditions, by which challenging and interesting duties turn into depressing and pointless ones (Khamisa et al., 2015). Burnout is seen as global phenomenon and influences people working in different professions (Moodley, 2010). Healthcare professionals in psychiatry are more likely than any other professionals to experience burnout, according to Garcia et al. (2015). Sadly, this has a negative effect on their productivity and results. According to Bimenyimana et al. (2009), burnout has negative effects on the entire facility as well as the mental nurses that work there.

2.5.2 Lack of Social Support

According to Takalo (2015), social risk factors for mental diseases are numerous and linked. Distress in relationships is one of the most frequent primary or secondary issues people seeking mental health professionals' assistance with report, and it is strongly linked to issues with adult partners' and their children's psychological and physical health (Lebow et al., 2012). Johns et al. (2007) discovered that the MHUCs who do not have social support and visits from their family while hospitalised are prone to be re-admitted to the hospital. However, with the proper support system in place, many MHUCs find themselves overcoming what they perceived to be an impossible struggle.

According to Dunér et al. (2011), social support is seen as one of the mediating factors that helps cares manage the difficulties of caring for a patient with severe mental illness. According to Dunér et al. (2011), there are five main types of support that can be divided into five categories: advice or direction, emotional security or socialising, tangible or intimate aid, and financial assistance. Different forms of social support exist and can be categorized as either formal or informal. Professionals from health and social service organizations make up the formal sources of social support, while the informal sources, which can be divided into two subgroups: family, friends, and neighbours, and the community (Dunér et al., 2011).

According to Smith et al. (2014), having a solid support system will increase recovery. With this support, the MHUCs will be aware that there is always someone who understands their issues and is available to talk to and assist them when necessary. Takalo (2015) states that families should assist the MHUCs by doing the following: being supportive of the MHUC, treating them as fellow humans, learning more about psychiatric condition, assisting the MHUCs in becoming mentally healthy by alerting them about treatment and follow up timeline, considering their own mental wellbeing, and seeking assistance where required. Land and Hudson (2002) outline that it is common that caregiver burden is greater when nurses do not have a strong of social support.

Ngako et al. (2012) reveal that the nurses claimed that they found the conduct and attitudes displayed by MHCU family members, medical professionals, management, and security personnel to be unrealistic and insufficient. They claimed that the absence of assistance from many stakeholders combined with their lack of support for one another made their task difficult. Participants in this study also stated that they did not have social or emotional support from MHCUs' families. Participants' conclusion is that the families didn't know enough about mental illness. According to a research by Nyati and Sebit (2002) on the impact of mental illness on family members, many relatives did not support MHCUs because they had appropriate awareness about the condition.

According to Johns et al. (2007), MHCUs who don't have family visitations or social support while in the institution are more likely to be readmitted. Patients with persistent mental and physical health disorders are readmitted for a wide variety of reasons, according to Takalo (2015), citing the American Hospital Association (2012). These individuals struggle to follow treatment plans, may have a variety of medical issues, and may not have a strong support system. These elements may impede healing and raise the possibility that MHCUs may visit the hospital again.

2.5.3 Safety and Security Problems

To increase efficiency at work, mental health facilities need safe working environments (Alhassan & Poku, 2018). A study by Alhassan and Poku (2018) shows that 87% of nurses are aware of workplace health risks at their places of work and that working in a

psychiatric facility is more dangerous than working in other hospital environments. Nurses working in the psychiatric field have a twenty-fold higher risk of experiencing physical violence than those working in public hospitals, according to Magnavita and Heponiemi (2012). In comparison to nurses working in medical-surgical units, mental nurses deal with patient aggression more frequently, with 0.55 violent cases per bed per month on average in acute mental institutions (Pekurinen et al., 2017).

A study conducted by Manyedi and Dikobe (2016) reveals that PNs felt unsafe when caring alone for psychiatric patients with chronic mental illness. They require help from other nurses because they feel uncomfortable and uneasy. The reason for this is that psychiatric patients are physically aggressive, unpredictable, and not cooperative (Zarea et al., 2012). Additionally, many nurses emphasized their concern about their patients' bodily harm, suicide, and homicide. Moreover, nurses also reported being fearful regarding the possibility of being physically assaulted by the patients.

According to Mani and Abutaleb (2017), it is considered hard to care for violent patients in inpatient psychiatric hospitals. This is due to the fact that the in-patient section, where nurses are prone to conflict or irrational aggression, had a number of patients with various mental conditions. Violence and unexpected hostile behavior also signal an unsafe atmosphere to nurses and other patients. Such an environment is perceived to be full of stress for mental health nurses, which made them passive to the degree that they consider their mental patients to be harmful, immature, dangerous, and pessimistic (Mani & Abutaleb, 2017). Cho and Lee (2018) discovered that physical and verbal and aggression such as intimidation, was constantly faced by nurses in psychiatric wards.

Internationally, psychiatric facilities are known to be experiencing a certain level of violence and aggression (Bimenyimana et al., 2009). Health care clincians working in mental health institutions face high level of violence and aggression from patients (Bimenyimana et al., 2009). Aggression is a common feature in psychiatric in-patient awads in Africa. Nurses in in-patient units in Nigeria are frequently subjected to aggression (James et al., 2011). Aggression is defined as a behavior intended to increase harm to someone else who is trying to avoid that harm. It can manifest itself in

a variety of ways, ranging from relatively minor acts, such as verbal abuse, to unprovoked mild to severe acts, such as physical attacks (Al-Omari et al., 2019).

Patient aggression on staff remains a concern and poses regular complications to in-patient psychiatric hospitals and staff. Both verbal and physical aggression may Patient aggression on workers continues to be a source of concern for in-patient mental wards and staff. Verbally or physically aggression can cause bodily or emotional harm to employees. This harm can manifest as physical injury, distress, or strained interpersonal interactions (Ezeobele et al., 2019). result in physical or emotional harm to the staff. This harm may occur in the form of physical injury, hurt feelings, or damaged social relationships (Ezeobele et al., 2019).

Psychiatric patients' aggression is considered to be a significant problem both locally and globally. 86% of nurses who were affected by violent and aggressive patient behavior reported experiencing aggression toward them (Bekelepi et al., 2015; Al-Omari et al., 2019). Healthcare professionals, especially nurses, are frequently subjected to violent behavior in acute care psychiatric settings, including verbal assault (46.0% to 78.6%), threats (43.0% to 78.6%), and sexual harassment (9.5 per cent to 37.2 per cent). As a result of this aggressive behavior, staff nurses may suffer from physical injuries, psychological harm, depressed mood, post-traumatic stress disorder (PTSD), anxiety, sleep disturbances, and burnout, which also has a negative impact on staff work productivity (Lantta et al., 2020).

At the same time, a number of other factors may play a role in patient aggression. Some factors are related to the staff, such as their youth, lack of educational qualification, and lack of work experience, as well as the nurses' gender and whether the work is full-time or shift-based. Aggression is the display of violence, which can be directed at oneself, others, or objects, and it is a common act in psychiatric wards (James et al., 2011). However, globally MHCUs are known always to have been associated with some form of aggression (Gule, 2013). Aggression towards psychiatric nurses influences them mentally and emotionally. Furthermore, nurses consider aggression to be hostile, dangerous, and burdensome. These nurses reported being subjected to abusive language, demeaning aggression, aggressive dividing behavior, threatened physical

aggression, destructive aggressive behavior, and, on rare occasions, physical violence (James et al., 2011).

Female psychiatric nurses in South African facilities for mental health were subjected to sexual abuse and a hazardous working conditions during weekend shifts, according to a study by Maluleke and van Wyk (2017). Depending on the environment and geographic location, different forms of violence against nurses are committed. However, they also comprise threats, sexual assault, verbal and physical abuse, and bullying (Boyle & Wallia, 2016). In addition, two-thirds of nurses have experienced psychological violence, and close to a quarter have experienced sexual harassment. It has been discovered that about a third of nurses worldwide experience physical abuse and bullying, and about a third have reported suffering an injury as a direct result of violence (Spector et al., 2014). After any violent episodes, nurses require managerial guidance and assistance on an individual and emotional level (Baby et al., 2014; Christie, 2015, as cited in Zhang et al., 2021). The performance of professional nurses' duties is impacted by a lack of security. Participants expressed concern about being attacked by MHCUs who are allowed to roam the ward at will. Participants went on to say that the courts had referred some of the MHCUs to their facility for observation. Marshall et al. (2017) emphasized this and discovered that professional nurses in New Zealand are vulnerable to violence at work. According to Duncan et al. (2016)'s results, MHCUs physically and emotionally assault professional nurses in Canada.

Employees from a multidisciplinary team, including nursing, social work, occupational therapy, psychology, and administration professionals, participated in a study by Tonso et al. (2016). 411 members in all answered to the poll; 83% of the sample overall reported experiencing some form of violence in the preceding 12 months. The most common form of violence was verbal abuse (80%), which was subsequently followed by physical assault (34%), and bullying/mobbing (30%). 33 percent of victims of violence reported experiencing psychological difficulty, with 54 percent of those reporting severe psychological anguish. The victims of various forms of violence described being in terrible emotional distress. For those working in the mental health field, the nature,

severity, and impact of this violence on their health pose major safety problems (Tonso et al., 2016).

A study conducted by Nui et al. (2019) alludes to psychological violence being higher than physical violence. They added that 78.8% of incidents involved verbal abuse, with patients accounting for 91.1% of those who engaged in it. According to Niu et al. (2019), four out of five acute psychiatric nurses had suffered psychological violence in the preceding year, and more than half had experienced physical violence. Patients made up the vast bulk of the assailants, followed by patients' families. Verbal warnings were used as the main defense against attackers. According to Forté et al. (2017), nurses caring for persons with chronic mental illness experience fear and are hypervigilant owing to verbal and physical abuse, aggression, and violence that some patients display towards them.

2.5.4 Shortage of Resources

The physical surroundings in which healthcare is provided, according to Booyens et al. (2015), has a consequence for patients, healthcare workers, materials, and equipment. Any impediment to healthcare professionals practicing effectively should be removed. The physical facilities that provide care are as important as the quality of the care itself for productive care. As a result, facilities should receive constant attention, be kept in good condition, and be painted on a regular basis. The only way to provide quality care is to provide adequate equipment of high quality to meet the needs of patients while also increasing the productivity of health workers (Mokoena, 2017). Another important requirement for high-quality patient care is the availability and upkeep of equipment. Aveling et al. (2015) found that the influence of resource shortages on patient care quality in low-income nations. Healthcare professionals recognized inadequate staffing and a lack of material context as barriers to patient safety (Mokoena, 2017).

The work of frontline nursing staff who operate in mental hospitals in Ghana is concluded to be risky and maybe unsafe given the suboptimal health infrastructure conditions in these healthcare facilities based on research findings by Alhassan and Poku (2018). Societies experience medical resource shortages relating to high life expectancy and limited health budgets and because of constant physical scarcities of

resources. This makes it difficult to meet the medical needs of patients (Krutli et al, 2016). Lack of resources has been identified as a factor impeding the inclusion of mental health services into primary healthcare. Hlongwa and Sibiya (2019) reveals that clinics in rural areas face with problems such as shortage of space, medication and consulting rooms for treatment mental illness. Contrarily, clinics in urban areas have adequate space and consulting rooms. Inadequate space leads to lack of privacy makes it difficult for personnel to provide patients with mental illnesses with counseling. (Hlongwa & Sibiya, 2019).

A study conducted in South Africa by Docrat et al. (2019) also reveals that MHCUs are kept with other patients in over 80 per cent of district hospitals in Limpopo, KwaZulu-Natal, Mpumalanga, and Northern Cape provinces due to inadequate infrastructure in public mental health care facilities. This was also supported a study by by Manyisa and van Aswegen (2017), who found the poor physical conditions of the structures, wards and the general setting of psychiatric hospitals as concerns when rendering mental healthcare. In Nigeria, a study conducted by Nwaopara et al. (2016) discovered that an inappropriate environment puts nurses to physical and emotional danger that affects psychiatric care provision.

Van Rooyen et al. (2019) claim that years of underspending have led to destroyed, unusable infrastructures, which are to blame for the terrible condition of South Africa's mental healthcare institutions. A study conducted in Tanzania indicated that an appropriate setting aids patients in their recovery process because it is perceived as a good therapeutic environment, even if there is no evidence to imply that the physical environment affects the results of mental treatment (Ambikile & Iseselo, 2017). As a result, governments in developing countries, including South Africa, should try to take priority mental health in order to improve the results of treatment (Sunkel & Viljoen, 2017). Mulaudzi et al. (2020) discovered that poor building condition may impede MHCU recovery because the environment is unappealing and thus does not promote calmness.

Shortage of flowing water in a mental institution is a major issue because the facility needs drinkable water for cleanliness. Bartram et al. (2015) reveal that in developing

countries, one in three hospitals lack running water. According to Bartram et al. (2015) sanitation, adequate water, and hygiene are crucial features for rendering a health service. Furthermore, continuous supply of water in hospitals assists to prevent deadly diseases outbreak, which can have impact on patients and healthcare workers. An interruption in water supply at mental health units affects the quality of healthcare services provided to MHCUs because it affects food preparation and hygiene, increasing the risk of contracting other diseases. Disruptions in meal stipulation may influence MHCU medication intake, increasing the risk of relapse and delaying recovery (Bartram et al., 2015).

According to DENOSA (2013), shortage of essential resources such as medicines, medical equipment, medical supplies, for instance, linen such as sheets and pillowcases, beds, and furniture put a strain on nurses and reduce their morale. Malfunctioning or non-working medical equipment, such as machines to measure the blood pressure and temperature of patients are other examples of insufficient resources contributing to the decline in nursing morale (Mokoka et al., 2010).

2.5.5 Shortage of Medication

Shortage of critical resources such as medicines (De Beer et al., 2011) is a profound problem, which affects both patients and nurses. The WHO considers lack of drug to be a diverse challenge worldwide. This challenge of shortage of drug affect both developing and developed countries seem to increase in the recent years. According to Griffith et al. (2012), insufficient medication have become a common occurrences for professionals and hospitals in the United States. McLaughlin et al. (2014) indicate that shortage of drugs pose a serious concern for healthcare facilities, constant disruption of treating patients. During drug shortages, choosing an alternative treatment procedure is a normal practice; however, these drugs frequently present difficulties and may develop safety issues.

Drug shortages in the United States of America have an impact on all Drug shortages in the United States of America affect all key players in the distribution network, particularly MHCUs and healthcare facilities, raising people's concerns (Mokoena, 2017). Nurses recommended that in every primary healthcare clinic, there should be

sufficient distribution of patients' treatment, to enable primary healthcare nurses to offer effective care to psychiatric patients and to alleviate relapse and re-admission to psychiatric hospitals (Hlongwa & Sibiya, 2019). According to Marais and Petersen (2015), there are significant worries about the drugs and technologies connected to the district-level delivery of psychiatric medications. This is typically related to a breakdown in communication between hospitals, clinics, and pharmacies. They go on to say that a lack of pharmaceutical supplies causes MHCUs to go into default, which could lead to relapse.

It is evident that patients suffer when medicines are not available, resulting in treatment delays or completely unavailable. Alternative medicine may not be as effective as the prescribed medicine, and may result adverse patient results (Bateman & Fonagy, 2013). Medication shortages can pose only little disruptions in healthcare when medication has restricted indications and there are appropriate therapeutic alternative available, but it may have a crucial influence on public health for medications such as vaccines or when therapeutic alternatives are not available (De Oliveira et al., 2011). Patients may also experience medication mistakes, negative outcomes, and high healthcare costs (Yang et al., 2016). Patients may also lodge complaints because of shortage drugs.

2.5.6 Lack of Incentives

Nurse managers cited the importance of monetary and non-monetary benefits as a means of boosting retention, according to Mokoka et al. (2010). Non-monetary rewards include additional leave, promotions, and creating frameworks for recreation and childcare, whereas monetary rewards include strong pay, performance bonuses, and compensation for rare abilities. Participants in the study by Mokoka et al. (2010) believe that salaries are the primary factor in professional nurses' job discontent. They also believe that encouraging comments and congratulations notes recognizing good performance will have no impact on nurses' motivation..

According to Chiduku (2016), involving employees in policy development and decision-making, raising wages and benefits, possibly implementing hiring and retention bonuses, and providing financial support for education and staff training will all help retain current employees, draw in new ones, and narrow pay inequality between

organizations. Because of the global nursing shortage and factors specific to the healthcare environment, professional nurse retention in the sector faces ongoing issues. Retention efforts are more difficult than in other industries due to long working hours, a heavy workload, low pay, and hard working.

2.6 Nurses' Coping Strategies

According to Hasan (2017), psychiatric nurses encounter numerous stressful events. These stressful events affect many areas of nurses' lives, such as physical and mental health. Consequently, they use various coping mechanisms to deal with the challenges. There is a variety coping strategies which people use to deal with challenges, including physical, psychological, spiritual, and behavioural coping strategy. Coping strategies are basic categories utilised to classify how individuals often react to stress. As a result, coping mechanisms are the actions and thoughts a person takes in response to a circumstance or an event. This allows them to successfully deal with situations or occurrences in different ways (Huang et al., 2008). Coping mechanisms can be perceived as negative or positive, either enhancing the well-being of someone or being dangerous to the well-being of someone (Hogan, 2016). Any cognitive or behavioral attempt to control, reduce, or endure circumstances that people see as potentially dangerous to their well-being is referred to as coping, according to Folkman et al. (1986). Additionally, coping mechanisms could be cognitive and behavioral with the goal of managing, tolerating, or minimising demands and conflicts from both the inside and outside of the person (Abdalrahim, 2013).

Coping is conceptualised as a multidimensional construct, including both cognitive and behavioural endeovers (Ptacek et al., 2002). Holton et al. (2014) state that coping strategies maybe multidimensional and multifunctional. The degree of stress, the type of the stressful experiences, and individual traits like age, gender, Level of intelligence, and character and its supplies are all important components of coping. Typically, coping is psychological in nature. In terms of psychology, Lazarus and Folkman (1984) defined coping as continually changing mental and behavioral attempts to handle certain external and/or internal requirements that are considered as challenging.

Nurse like other people use various mechanisms to cope with stress. There are many things that influence the individual as a result of the emotional stress in the workplace. When emotional stress and aggressiveness are present, psychiatric nurses employ a variety of coping and defense strategies (Delport, 2013). When faced with emotional stress and aggressiveness, psychiatric nurses used coping and defense techniques (McGibbon et al., 2010). Their encounters with aggressiveness in the aforementioned kinds caused them emotional discomfort, leaving them with sentiments of animosity, mistrust, and disillusionment. As previously mentioned, the psychiatric nurses employed defense mechanisms as a result of experiencing emotional discomfort. Both immature and developed defense mechanisms are among them.

Non-mature defense mechanisms include repression, neurotic defenses like withdrawal and isolation, narcissistic defenses like anger projection, and immature defenses like passive-aggressive behavior. These defenses differ from mature defense mechanisms (Kaplan & Sadock, 2007, as cited in Roets, 2018). In the end, the passive way that mental nurses handled aggressiveness was similar to the way they dealt with aggression from coworkers. The defense mechanisms that the psychiatric nurses used to deal with their emotional anguish were a result of experiencing emotional distress themselves.

At times, passive-aggressive behavior may be used as destructive coping mechanisms. This behavior contributes to the workplace aggression once more. It is obvious that efforts should be made to provide opportunities for psychiatric nurses to manage experienced aggression from colleagues (Roets et al., 2018). According to Holton et al. (2014), psychological coping mechanisms are commonly referred to as coping strategies or coping skills. According to Song et al. (2018), coping does not always entail being capable of handling difficult circumstances since coping reactions to stresses. Individual reactions to stress may range from seeking assistance and counsel to engaging in wishful thinking, self-blame, avoidance, and/or problem-solving. As a result, it may be claimed that coping serves two distinct functions: it can be a process that occurs after an evaluation or it can be a variable that changes from person to

person, allowing people to use various behavioral coping patterns that may be stable or that fluctuate through time and distance (Abdalrahim, 2014).

According to Bland and Foster (2012), coping mechanisms are essential for people to use in order to manage the daily difficulties of adult life and to achieve long-term developmental goals. Similar to this, Martins et al. (2014) define coping strategies as ways of thinking and doing that are used to lessen the difficulty that is experienced in a specific situation, either internally or externally. The coping technique that a person employs can affect how they respond to and handle a stressful event as well as how they feel overall (Uchino, 2006). Uchino (2006) goes on to say that coping mechanisms frequently serve as intermediaries in determining how much stress an individual experiences. For instance, an individual with a greater perceived stressors appears to have less coping mechanisms.

Generally, coping refers to adaptive or constructive coping strategies (Holton et al., 2014). Exercise, meditation, and seeking out social support are examples of adaptive coping mechanisms, whereas avoidance, overeating, and drug use are examples of maladaptive behaviors. In addition to personality, the social context, particularly a stressful situation, also influences how people cope (Carver & Connor-Smith, 2010). Some coping mechanisms, however, may also be seen as maladaptive. Maladaptive coping is defined as failing to cope or using unhealthy coping mechanisms in a given situation (Lu et al., 2015). Psychiatric nurses must handle their frustration and stay healthy in order to deliver the finest care possible to their patients. As a result, it is critical that they maintain good health and wellbeing, as well as employ healthy coping strategies that strengthen their ability to cope effectively (Al-Azzam et al., 2017). This, in turn, will alleviate the stress and tiredness that they are experiencing.

Supervisor assistance is cited by Fathi and Simamora (2019) as an illustration of encouragement coping techniques. In their study, self-blame, denial, and behavioral disengagement were the least used coping mechanisms. According to this study, coping mechanisms like self-distraction, self-blame, denial, and behavioral disengagement were significant predictors of the severity of post-traumatic stress disorder symptoms. These coping mechanisms were deemed to be maladaptive. It was

discovered that depersonalization and emotional weariness were somehow connected to dysfunctional coping. Remarkably, this study revealed that nurses preferred avoidant coping mechanisms (Fathi & Simamora, 2019).

Hasan (2017) points out that many nurses deal with stress by assuring themselves that their work would be acknowledged, having faith in their own capacity to carry out their duties competently, and finding solace in completing tasks successfully. These tactics are centered on having a positive outlook on oneself and one's job. The fact that nursing is a fantastic job and that caring for patients has a spiritually uplifting effect on nurses may be one explanation for this. This enables them to offer the best care possible. Another argument is that most people use self-talk to cope, believing that God will reward them for their good deeds and that what nurses do is appreciated (Hasan, 2017). Studies carried out in Muslim nations support this, and mental health professionals see this as a coping strategy for workplace stress (Wang et al., 2015).

According to McTiernan and McDonald (2015), psychiatric nurses employ attention-diversion and a positive outlook on work as coping mechanisms for dealing with daily workplace pressures. In a similar vein, Gholamzadeh et al. (2011) state that the majority of nurses attempt to achieve adaption to their job stressors by having confidence in and a positive self-image, gaining knowledge and experience, and depending on their abilities or skills. The three most popular coping strategies, according to Wang et al. (2015), are positive thinking, having an optimistic outlook, and making positive comparisons. According to a study by Edwards et al. (2000), shifting attention was one of the coping mechanisms that psychiatric nurses who work on secured wards employed the least.

According to Ngako et al. (2012), suppression of emotions has been found to be used by nurses as a coping mechanism. Ngako et al. (2012) discovered that ineffective management of emotional reactions was used by psychiatric nurse practitioners (PNPs). These PNPs claimed that they ultimately suppressed their feelings in an attempt to manage emotional reaction ineffectively. Fear and rage were repressed emotions. According to Moran et al. (2009), PNPs were required to repress their emotions in order to do their duties because they worked in an environment with a high

level of hostility and violence. As was previously established, these PNPs felt emotions like fear and rage but tried to suppress them in order to deny having them. As a coping strategy, suppressing these feelings is harmful to one's mental well-being. The morale and mental health of the PNPs may be compromised by routine suppression. (2012) Ngako et al.

Despite the fact that there are many different coping mechanisms, including avoidance, seeking social support, confrontation, distance, accepting responsibility, and religious coping, researchers frequently classify these coping mechanisms as active or passive, or emotion-focused versus problem-focused, particularly when assessing the impact of coping on psychological health. Coping strategies can be divided into several categories. There are two basic categories of coping methods, problem-focused (adaptive) and emotion-focused (maladaptive), according to Lazarus & Folkman (1984). The words problem-focused (adaptive) and emotion-focused (maladaptive) coping techniques are used interchangeably in this study. Positive coping strategies include problem-focused behaviors, seeking out assistance, establishing a work-life balance, and so on. Maladaptive emotional coping strategies include denial, avoidance, and suppression (McCann et al., 2013). The researcher will go over three popular coping mechanisms in the sections that follow: problem-focused (adaptive), emotion-focused (maladaptive), and appraisal-focused.

2.6.1 Problem-Focused Coping Strategy

According to Lazarus and Lazarus (2005), those who use emotion-focused coping strategies are primarily concerned with controlling their emotional pain, as opposed to those who use problem-focused coping strategies, who concentrate on what they can do to change their unfavorable situations. While alleviating emotional suffering is the primary goal of both coping mechanisms, how that distress is alleviated makes a difference. An emotion-focused coping technique is used to change one's response to a stimuli, as opposed to a problem-focused coping strategy, which is used to make the stimulus more intense (Lazarus & Lazarus, 2005). According to Folkman et al. (1986), persons who deal with stress effectively reframe stressful situations in a positive way, utilise goal-directed problem-focused coping techniques, and turn to spirituality for

solace and comfort; they provide purpose to everyday occurrences to gain psychological space from discomfort and exhibit traits including adaptability to unforeseen changes in life, showing the ability to seek social support, viewing stress as a challenge, and being in harmony with nature. They exhibit love, playfulness, and enthusiasm.

Problem-solving strategies such as establishing objectives to sort out problems, adopting various strategies to solve problems, and determining the meaning of stressful events are among the most prevalent defense mechanisms used by nursing students (Labrague, 2016, as cited in Bhurtun, 2019). Furthermore, nurses employ a variety of positive coping strategies, such as problem-focused coping, taking time off, and providing and receiving support from workmates. The findings imply that while maladaptive coping (suppression and denial) may greatly exacerbate the detrimental consequences of stress, positive coping may not be sufficient to diminish these effects. The majority of nurses' coping mechanisms, according to Deklava et al. (2014), were problem-solving and self-control.

Teamwork was also found in the current study to be used as a positively focused coping mechanism. This is supported by a study conducted by Sobekwa and Arunachallam (2015), who discovered that nurses working in the acute admission ward mentioned the importance teamwork and helping one another in resolving the struggles come every. One participant mentioned that they work as team, and that they regard themselves as a family. Another participant presented an illustration of a scenario in which an MHCU would turn hostile and require confinement. In order to calm the patient and move the MHCU into a seclusion room, the participant said that the nurses banded together.

This results are in line with that of Shattel et al. (2008), who discovered that except working under compromised environments, nurses, teamwork offered them mental strength. They also found that nurses aided one another when it came to teamwork, supporting MHCUs, and helping one another with patient care. Some participants stated that the team helped them through difficult periods emotionally. One participant, for instance, claimed that after being assaulted by an MHCU, her nursing coworkers provided her with the necessary support to deal with the situation (Sobekwa &

Arunachallam, 2015). According to Cleary et al. (2011), mental health nurses view teamwork's various benefits and roles in an acute mental health unit as crucial. According to Totman et al. (2011), the nurses highly regarded effective cooperation and excellent connections with colleagues as factors that helped boost their morale.

Religion and believing in God was also found to be one of the coping strategies used by the majority of the PNs. The humanitarian origins of the nursing practice attest that religion and spirituality have always been imperative in the profession (Carson, 1989). According to the study's findings by Bakibinga et al. (2014), all of the nurses said that their religious beliefs have a beneficial impact on their work and help them find meaning even in the face of tragedy. The majority of them stated that they used their faith in God to help them deal with difficult conditions and to continue working even when circumstances eventually required it. The participants said that they were able to achieve this through individual and group prayer activities with other nurses, which they said gave them the strength or ability to cope while at work (Bakibinga et al., 2014).

According to El-Islam (2015), religion is used to code rights and wrongs according to a superego formed by the internalisation of socially shared religious criteria. In addition, religion assists to provide a meaning for stress and its evaluation according to religious cognitive schemas. It provides hope in relief of the ensuing distress and sometimes emphasises that it is only the blasphemous who feel hopeless about the future. It encourages an appeal to God by praying to relieve distress and elicits support of members of the same religion in the mist of stress. The findings of the study by Bakibinga et al. (2014) show that all of the nurses acknowledged that religious principles had a beneficial impact on their performance, allowing them to find purpose even in the face of tragedy. The majority of them stated that in order to deal with difficult circumstances, their trust in God helped them cope better and continue working even when circumstances eventually required it. This was accomplished through participating in both individual and group prayer exercises with other nurses, which, according to the participants, gave them the courage or ability to cope while at work (Bakibinga et al., 2014). Religious leaders are sometimes mediators between man and God, for instance, in the confession of wrongdoing and repentance (El-Islam, 2015).

According to AlZayyat and AlGamal (2014), problem-focused strategies were the most commonly used coping strategies by nurses, while social support was the least commonly used. As a result, it is reasonable to conclude that problem-solving coping has a positive connection to job satisfaction and health.

2.6.2 Emotion-Focused Coping Strategy

The goal of emotion-focused coping techniques is to change the internal environment rather than the external situation. According to Abdalrahim's (2014) research, coping strategies that are emotionally driven and are considered to be of the "negative type," such as wishful thinking, self-blame, and/or avoidance, are expected to be linked to an increase in unfavorable health. Negative psychological states such as emotional stress, poor support among themselves, and depersonalisation were observed leading to their inability to work as teams or to complement one another.

Studies show that a high absenteeism rate from work is due to various reasons. It can be linked to understaffed facilities, unstable personnel, and other elements that might have an adverse impact on patient care (Unruh et al., 2007). When using avoidant coping, a person tries to control their own unpleasant emotional reactions rather than addressing the stressor that is causing them. When the ratio between stress demands and available resources is unbalanced or the person lacks healthy coping abilities prior to their meeting with the stressful occupational scenario, there is a danger of developing a maladaptive coping approach, such as substance misuse (Litt et al., 2009).

Hange and Khare (2021) indicate that to cope with work stress, psychiatric nurses primarily employ problem-solving strategies. Problem orientation and social support are two common problem-focused strategies. Overall, psychiatric nurses regard social support, particularly family support, as an essential component of stress management. It is suggested that health organisations recognise the need to provide adequate support to nurses, possibly in accordance with Western initiatives (Abdalrahim, 2013).

2.6.3 Appraisal-Focused Coping Strategy

By changing how one evaluates dangerous situations, Chukwuere et al (2021)'s appraisal-focused constructive coping is a helpful method of managing stress. By altering their perceptions of difficult situations, people can avoid their emotional responses to stress. By changing their aims and beliefs, such as by finding the humor in a circumstance, people can change the way they think about a problem. Some people have hypothesized that humor may moderate stress more effectively in women than in men. An adaptive cognitive strategy is one that is appraisal-focused. Appraisal-focused strategies aim to challenge one's presumptions and change one's method of thinking. Disassociating oneself from the issue or challenge, changing objectives and values or recognising the humour in the situation to put a positive spin on it are all examples of this. Appraisal-focused strategies attempt to alter stress-related thought processes. Denial and distancing oneself from the problem are two examples of appraisal-focused strategies (Worell, 2001). People who use appraisal-focused coping strategies purposefully alter their standpoint on their environment in order to have a more optimistic perspective on it (Senanayake et al., 2018). Appraisal-focused strategies are minimally used, compared to problem-solving coping strategies and emotionally focused coping strategies.

2.7 Nurses' Support Structures and Programmes

As stated earlier, nurses are essential in the treatment of patients with mental illnesses. All nations' comprehensive plans for mental health need to acknowledge its role and include it. In order to design policy, plans, laws, and service programs, nurses should be fully involved. The nurses who took part in this study grumbled about the hospital administration's lack of support. This result is in line with Sherring and Knight's (2009) results, which highlight the fact that nurses who felt underappreciated and unsupported lost motivation and experienced burnout.

Social support is characterized as interdependent relationships and ties that help people cope with challenging circumstances in their lives. Social support mitigates the negative impacts of job demands, lessens feelings of weariness, and lessens the severity of these stress elements. Poor social support is one of the major workplace characteristics linked to psychiatric diseases and employee absenteeism in the United Kingdom,

according to Michie and Williams' 2003 study. According to a study by Mohadien (2008), 50% of nurses reported feeling underappreciated and that their extra efforts in a dangerous workplace went unrecognized. To bolster this claim of a lack of support from hospital authorities, one participant stated that there were no debriefing sessions in place to assist staff members who had been traumatized as a result of a patient assault. Another female participant stated that she received adequate support from her coworkers after being assaulted by a female patient (Sobekwa & Arunachallam, 2015).

Considering the challenges mentioned in this study, it is evident that PNs need support programmes. Several studies have come up with support progrmmes that will ease the caring burden. In addition, support programmes such as mentorship programmes, peer support, stress management, group supervision and debriefing are crucial to ease the caring burden of nurses. According to Arvidsson et al. (2000), group supervision in nursing care influences their professional competence. They go on to say that the goal of group supervision in nursing care is to comprehend nurses' experiences in real-world care settings and structure them in a professional and personal context.

Mentorship programmes are recommended by Block et al. (2005) as a way of enhancing nursing satisfaction that ultimately improves patient recovery. A programme called Resilience in Stressful Events (RISE) was created at the Johns Hopkins Hospital in Baltimore, USA, with the aim of providing support for nurses who experience emotional distress (Edrees et al., 2016). According to Foster et al (2018)'s research, nurses can gain from resilience education that gives them the cognitive, emotion regulation, and relational skills they need to handle challenges at work. This education should be combined with any accessible external supports and resources. The findings of this study were that many staff had encountered a shocking adverse incident, and preferred support from their peers. Peer support is also perceived as one of the most effective programmes for primary care nurses.

According to Hasan (2017), a stress management approaches programme is particularly successful in helping psychiatric nurses deal with work-related stress that could have a negative impact on their well-being. Moreover, this programme helps them to employ more effective problem-solving coping strategies. With the main goal of

reducing work-related causes of stress, Madu and Mamomane (2003) advise that there should be stress management programs, training on coping mechanisms, and the creation and execution of techniques for the enhancement of work circumstances and the surroundings for nurses in the remote regions.

There are studies that recommend support programmes for nurses. Land and Hudson (2002) reveal that the provision and implementation of detailed workplace support programmes is needed for nurses. A research by Mavundla (2000) on professional nurses' perspectives of caring for mentally ill patients in a general hospital setting makes recommendations for improving nurses' knowledge and abilities as well as providing them with counseling for emotional support. It was advised that departmental managers provide regular emotional assistance to their staff in relation to issues encountered in their departments. In addition, support groups can also be helpful as nurses are able to express and ventilate their emotions.

Participants in a study conducted by Ngako et al. (2012) requested organizational support in the form of emotional support for staff via debriefing or verbal acknowledgement that they had done a good job. Furthermore, participants stated that they needed mentoring because they believed they lacked the necessary knowledge and skills to work with MHCUs. Emotional exhaustion and social support may play an important role in mediating the relationship between job stress and depression and anxiety. Strategies such as reducing emotional exhaustion, increasing social support in the workplace, and reducing job stressors would be beneficial in preventing depression and anxiety among young nurses.

Participants in a study by Chen et al. described the need for emotional support from management in the form of debriefing (2005). According to one participant, emotional support would help professional nurses maintain their mental health: The necessity for treatment to assist them deal with the difficulties of dealing with MHCUs was also mentioned by participants: Chen et al. back up the requirement for psychological assistance for PNs (2005). According to Chen et al. (2005), debriefing, a sort of psychological support, will help PNs deal with violent occurrences when dealing with MHCUs.

According to Sobekwa and Arunachallam (2015), given that nurses perceive the acute admission wards to be strenuous and demanding, with a heavy workloads that results in some nurses experiencing symptoms of emotional exhaustion and burnout, there is a clear need to implement debriefing consultations for nursing staff. This is critical because they work in such difficult settings with a difficult patient population. After reviewing the literature on personal resilience in nursing, Jackson et al. (2007) recommend that resilience in nurses be strengthened through strategies and mentorship programs. These programs should strive to foster positive and nurturing professional relationships, as well as to promote positivity, emotional insight, life balance, spirituality, and personal reflection (Lu et al., 2015).

The religious and humanitarian roots of the profession demonstrate that religion and spirituality have always been significant in nursing practice (Carson, 1989). Many individuals place a high value on religion, and the nursing literature is full with statements about how crucial it is for nurses to attend to their patients' spiritual needs (Greenstreet, 1999; Baldacchino & Draper, 2001). Previous studies in Uganda have discovered that nurses try to deal with issues at work by transferring care to carers, relying on social support, and practicing their faith (Harrowing & Mill, 2010; Nderitu, 2010). Worldwide, nurses use several adaptive coping mechanisms such social support, self-care, counseling, and religion / spirituality (Ablett & Jones, 2007; Glass & Rose, 2008; Shinbara & Olson, 2010). Additionally, the literature on coping and self-care for professionals emphasizes the importance of nurses taking care of their own physical, mental, spiritual, and social wellbeing (van den Tooren & De Jonge, 2008).

Ugandan nurses providing universal healthcare have described faith in God as a coping method (Nderitu, 2010). Without elaborating on the various ways in which this faith is detailed in order to deal with work obstacles, he continued by citing that faith in God was highlighted as a means of coping. Religiosity has reportedly been shown to play a protective function in Swedish oncology nurses, enhancing ability to cope at work (Ekedahl & Wengstrom, 2010). In the United States, it has been demonstrated that spirituality is advantageous to nurses' daily life and helps them deal with bereavement (Shinbara & Olson, 2010). Religious meaning may be essential in dealing with stressful

situations as the foundation for one's aims and values (Park, 2013). It has an impact on how stressors are perceived and the types of coping mechanisms employed to lessen their consequences. The advantages of religious coping with stress in the face of life's problems have been demonstrated through stress studies conducted worldwide. (Hodge & Roby, 2010; Koenig, 2009)

2.8 Concluding Remarks

Chapter 2 reviewed literature regarding the history of mental health care delivery, the nature of chronic mental illness, phenomenological experiences of professional nurses, demands, challenges associated with caring for institutionalised mentally ill patients, nurses' coping strategies and lastly, nurses' support structures and programmes. In the following chapter, the researcher presents the theoretical framework utilised in the study.

CHAPTER THREE

THEORETICAL FRAMEWORK

3.1 Introduction

According to Lederman and Lederman (2015) a theoretical framework comprises the theory created to project, explain, and understand phenomena and, in many cases, to critique and broaden existing knowledge within the boundaries of critically bound preconceptions. A theoretical framework is the beginning of conceptualisation at the foundation of a research study, which integrate certain beliefs and ideas that are linked to the phenomena being studied (du Plooy-Colliers et al., 2014). A practice-oriented theoretical framework was used to guide and direct this study. The researcher adopted the practice-oriented theory of Dickoff et al. (1968) as a lens through which to develop a support programme for nurses caring for patients with chronic mental illness.

3.2 Description of the Theoretical Framework

A practice-oriented approach is argued to give insights into components of the dynamics of everyday life that can aid to create for sustainability to engage with the

varieties of routines that are not available to current sustainability strategies. The Dickoff et al. practice theory (1968) was utilised to steer the literature review, data analysis and presentation of the results. Dickoff and colleagues (1968) identified six aspects of operations. and their related key questions to consider when developing a programme. These essential points that guided the developed of a support programme are who or what carries out the action? Who or what is the activity's recipient? What framework does the activity take place in? What happened to the activity? What are the guidelines, strategies, or protocol for the activity, as well as its source of energy that assisted the researcher to utter the research findings? The above-mentioned critical points by Dickoff et al. (1968) will be discussed in-depth below.

- **Agent**: Who or what performs the activity? An agent can be an individual executing the activity like giving healthcare services in a hospital (Dickoff et al., 1968). Studies by Maputle (2010), and Bodrick (2011) indicate that the agent's nature encourages inventive, fruitful, and crucial actions within the performance that is centered on achieving the goal. In the case of programme development, the researcher becomes the agent. Equivalently, in the present study, the researcher is the agent who will engage in the specific activity, which is the development of the support programme for nurses caring for chronic mentally ill patients in three mental health institutions in Limpopo Province.

- **The recipient**: Who or what is the recipient of the activity? A recipient is a person who benefits from the activity, according to Dickoff et al. (1968). They also point out that since there is frequently some kind of contact between the pair, a recipient is quite active in receiving actions from the agent. What this means is that the activity that the researcher engages in should target particular recipients. In the present study, the recipients are professional nurses who care for patients with chronic mental illness in three selected mental health institutions. Based on the experiences shared by the research participants, challenges faced by health professionals were highlighted. The experiences shared included both positive and negative experiences of the PNs while they provided care to the MHCUs. The suggested

support programmes by professional nurses were ultimately used for developing a support programme for professional nurses.

- **Framework**: What environment does the activity take place in? According to Dickoff et al. (1968), context refers to the location, environment, territory, and the ward's physical building, and hospital make up different facets of the environment in which the action takes place. Dickoff et al. (1968) state that the context in which the activity is performed must be clearly identified. In the present study, three mental health institutions in Limpopo Province were picked out by the researcher as the context of the study. The names of the MHIs are Evuxakani, Hayani, and Thabamoopo. The support programme was thus developed by considering the context of these three mental health institutions. The support programme will be conducted in chosen public hospitals in Limpopo Province.

- **Terminus**: What results from this activity? Wehmeier (2005) defines terminus as a point where something stops or reaches its end. According to Bodrick (2011), terminus is the goal outcome of the activity. What this means is that the researcher have to be certain about the end-product that will result from the activity. In the framework of the current study, the development programme was established in order to equip and empower professional nurses who care for chronic mentally ill patients with knowledge and skills that will help them handle their caring responsibilities far better.

- **Procedure**: In developing a programme, there is a need to generate guiding procedures, skills or protocols that will be associated with the intervention. Similarly, the development programme envisaged in the current study has guiding procedures, techniques or protocols that include outcomes, strategies and competencies that need to be realised. A support programme includes significant topics to enable professional nurses to have enhanced practice, professional and effective coping strategies to render care to mental ill patients.

- **Dynamics**: What is the activity's energy source? The source of energy emanated from the researcher during the development of the support programme direted by reviewed literature related to the problem and the legislative context that guides the development of the support programme. The participants, who are professional nurses who care for patients with chronic mental illness, participated in interview sessions where they shared their experiences and ideas which guided the support programme. In other words, the researcher and the professional nurses in the present study provided the dynamic energy source required for the development of the programme. A support programme should address prevalent challenges that confront professional nurses and prevents patient care and service delivery. In relation to the theoretical frameworks, a detailed overview of the study's findings will be discussed in Chapter 5.

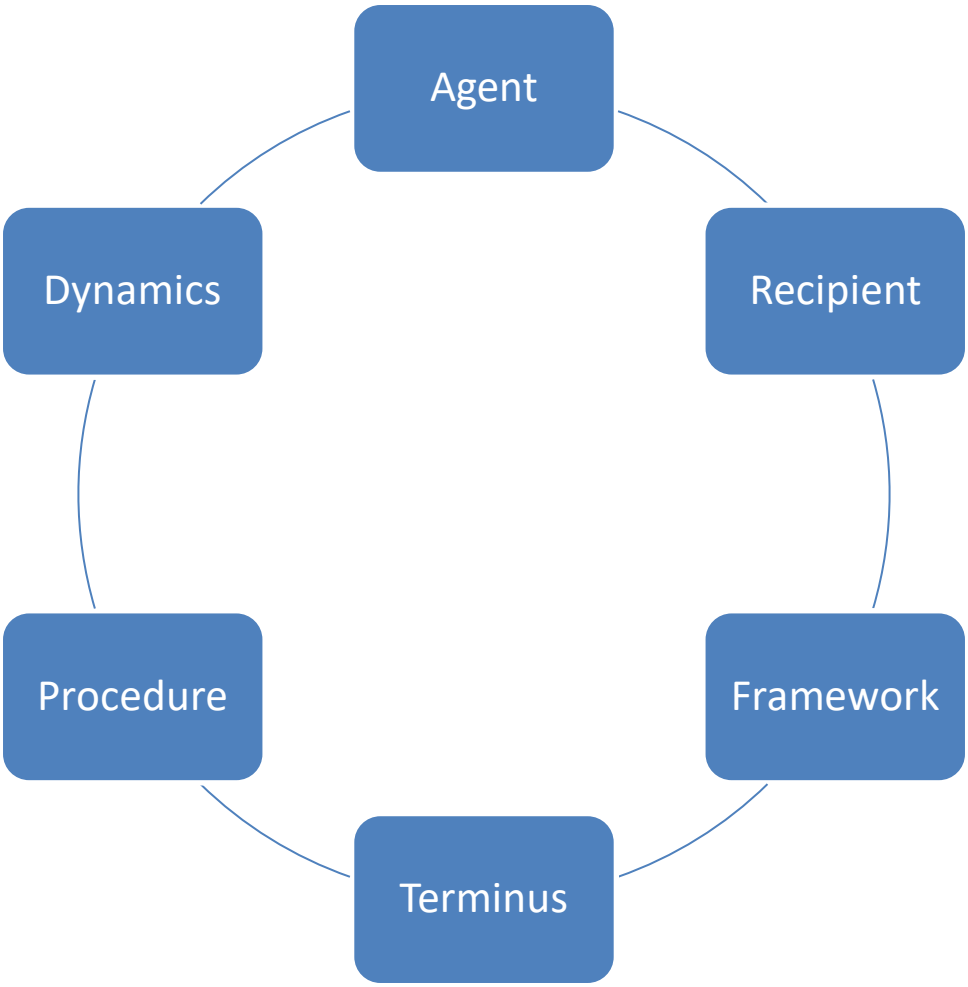

Figure 1: *Six aspects of activities in practice-oriented theory (Dickoff et al., 1968)*

3.3 Concluding Remarks

The theoretical framework used in this investigation was described in this chapter. A support program for nurses who provide care for patients with chronic mental illness was developed using the practice-oriented theory of Dickoff et al. (1968) as a frame of reference. The researcher describes and discusses the research methods employed in the study in the following chapter.

CHAPTER FOUR

RESEARCH METHODOLOGY

4.1 Introduction

This chapter presents the research methodology, which is how the study was conducted. According to Langdridge (2007), method is the specific technique(s) used, whereas methodology refers to the general way to research a topic. In this investigation, the same methodology was applied. This chapter's opening section focuses on the research approach. In this study, a qualitative research methodology was employed. Six different types of qualitative research are covered in the second section of the chapter. Additionally, phenomenology is described as the research strategy and custom that directed the current study, and the justification for selecting this approach is provided. The history of the phenomenology, types of phenomenological designs, and phenomenology as a method are also presented in part three of this chapter.

The fourth part of the chapter entails the study site. Population and sampling are presented in the fifth part of the chapter. In this study, homogenous purposive sampling was employed, and the reason for choosing this method is also stated. Semi-structured interviews as data collection method, are outlined in the sixth part of the chapter. The seventh chapter describes analysis of data and the stages taken in the process. The quality criteria are covered in the framework of a qualitative investigation in the ninth section. The final section of the chapter provides an overview of ethical matters that assisted the researcher perform the study.

4.2 Research Approach

In this study, a qualitative research methodology was employed. In-depth understanding of social processes in a natural context is sought through qualitative research, which draws on personal experiences. It aids in interpreting multiple points of view and narratives and is comprehensive and rich. The goal of qualitative research is to comprehend social issues, and its methodologies produce words rather than numerical data. Inductive in nature, qualitative research typically involves the researcher exploring meanings and insights in a particular context (Levitt et al., 2017). Babbie and Mouton

(2001) claim that qualitative research is useful for examining phenomena that are better understood in their natural surroundings as opposed to artificial onesIn contrast to quantitative approaches, which focus on how many or how much of a phenomenon, qualitative methods aim to answer questions regarding the "what, how, or why" of a phenomenon (Bricki & Green, 2007). According to Merriam (2009), qualitative researchers are motivated to comprehend the meanings that individuals have constructed. In other words, qualitative researchers are interested in comprehending and illuminating how people interpret their experiences and the world around them.

This style of research studies the world in its natural setting, evaluating circumstances to understand the meanings that individuals attach from day-to-day living, with a focus on words rather than figures (Walia, 2015). Logic, ethnography, discourse analysis, case studies, open-ended interviews, participant observation, counseling, therapy, grounded theory, biography, comparative methods, introspection, casuistry, focus groups, literary criticism, meditation practice, and historical research are all examples of qualitative research methods (Cibangu, 2012). Additionally, qualitative information is typically acquired in the field at the location where participants are confronted with the issue or topic under investigation. The advantage of qualitative research is that participants' actions and behaviors are observed within their own context. The researcher will go over both the drawbacks and benefits of qualitative research below:

4.2.1 Advantages of Qualitative Research

According to Richardson (2012), and Flick (2014), the following are the advantages of qualitative research:

- It uses adaptable and unstructured data collecting techniques;
- It collects data without formal, structured instruments.
- Intuitive yet organized analysis of narrative data is used.
- The basis for analysis is words rather than numerical facts.
- Themes and classifications are used as concepts.
- Rather of concentrating exclusively on certain notions, it emphasises understanding the phenomenon as a whole.

- Its main goal is to comprehend the significance that people assign to ordinary life.
- It emphasises the importance of people's interpretations of events and situations rather than the researcher's perspective and has a few small preconceived notions.

4.2.2 Disadvantage of Qualitative Research

- Small sample sizes are typical in qualitative research, making it difficult for the researcher to extrapolate the findings beyond the sample used for the particular study. In order to clarify and operationalize concepts, qualitative research is typically undertaken before quantitative research, especially when the goal of the research is quantification or generalization (Harry & Lipsky, 2014).
- In qualitative research, the reliability of data may be compromised because single observers are describing unique incidents. Objectivity can be lost since the researcher is in intimate touch with the participants (du Plooy, 2001).

Considering all the above-mentioned advantages and the few disadvantages, the current study benefits more from and is better suited to qualitative research than quantitative research. The researcher chose qualitative research over quantitative research because it allows the use of words, and is narrative in nature. This approach aided the researcher to look at the experiences, attitudes, and knowledge of the participants. The participants were given a chance to express their emotions and feelings regarding their experience of caring for patients, their coping mechanisms, support structures and the programmes available to deal with the caring burden. While the participants were expressing their emotions, the researcher was able to understand the meaning these nurses attach to daily life. More attention was given to participants because the sample size was small and manageable. A phenomenological approach was used by the researcher as an overall strategy to receive information on the phenomenon.

4.3 Research Resign

Botma et al (2016) define research design as the customary backbone of the research study, which gives the structure for the research methods and design decisions that

should happen to plan the study. In addition, LoBiondo-Wood and Haber (2010) define research design as a thorough plan that determines how data will be gathered and analysed, including guidelines for enhancing the study's credibility. In qualitative research, there are six types of research design that are predominant and commonly utilised (Hancock et al., 2009). The following are the types of qualitative research design: narrative, grounded theory, case study, ethnography, participatory action research, and phenomenology. Below, each design will be discussed. The researcher decided to discuss the above-mentioned types of research design because they are all relevant to the current study but the researcher adopted phenomenological design as the most suitable design for the present study. The rationale for choosing phenomenological design is explained under phenomenological research design.

4.3.1 Narrative Research Design

Felton and Stickley (2018) define narrative research design as a technique that examines the traits of the narrative text as well as the significance of inter-human connections in social, historical, and cultural contexts. Its focal point is the narrative of the people, either about themselves or about a set of situations. It focuses on how someone's story develops sequentially, placing more of an emphasis on the characters than on any underlying concepts. It takes a lot of time and frequently involves a limited number of instances (Hancock et al., 2009). The focus of narrative analysis is on participant-related stories. The narrative element is seen as having a beginning, middle, and end in and of itself.

When the topic is biographical or a life history, or an oral history of personal observations from one or more individuals, it is appropriate for a study that has a specific contextual focus, such as classrooms and students, or stories about organizations (Grbich, 2007). A project's design may be informed by narrative research's unique understanding of the procedural and delicate aspects of participant experience, as well as its illumination of context-based effects that offer deeper understanding (Mohajan, 2018). It enables one-of-a-kind, context-based analyses using time-oriented structures that reveal how changes happen and develop from a subjective standpoint. It has different communication elements, including a cast of people that

grow during the story, a storyline, a timeline with more or fewer levels of cause and effect, and a narrator or point of view (Constant & Roberts, 2017).

4.3.2 Grounded Theory

Glaser and Strauss, two sociologists, created grounded theory in 1967. This method of developing theory is based on data analysis rather than experimental testing; data are gathered and analysed, and then a hypothesis is developed that is based on the evidence (Glaser & Strauss, 1967). According to their definition, a grounded theory is a hypothesis that is derived from data that has been deliberately gathered and examined during the course of study (Corbin & Strauss 1990). They adopted the notion that meaning is created via the use of signs, languages, and symbols from symbolic internationalists. According to Walia (2015), the primary purpose of this theory is to produce theory from the field through data. According to Creswell (2009), the goal of grounded theory research is to provide an abstract, general theory of a process, activity, or interaction that is based on the opinions of study participants. The fundamental tenets of this idea are as follows: The goal of analysis is to develop or uncover a theory based on potentially simple patterns in life, and the job of research is to create new ways to comprehend or examine social processes and interactions (Glaser & Strauss, 1967).

According to Atkinson et al. (2001), grounded theory develops theories using both an inductive and a deductive method. It examines social dynamics and interactions between people's lives. According to Wolcott (2009), it is an appropriate approach to studying human behavior on a delicate subject, even within different cultural contexts. It is one of the qualitative research methodologies' data collection techniques that is totally grounded in data rather than attempting to construct theory from data (Khan, 2014). Here, instead of testing hypotheses, the researcher develops the theory using unprocessed data or by expanding an already existing theory (Yeh & Inman, 2007).

Grounded theory is developed using a variety of data collection techniques, including interviews and observation. In addition, telephone, focus group, and in-person interviews are used to gather data (Tepper, 2000).A grounded theory comprises of five aspects, namely, explaining the research methods, conducting data analysis to explain

the theory, describing the research question, reviewing the literature, and discussing the implications (Leedy & Ormrod, 2001). Grounded theory has some key components which are as follow (Hancock et al., 2009):

- It emphasises the concept of emergence, which states that research should start from a point where the researcher has no prior knowledge of the topic under study. This will ensure that all concepts genuinely arise from the data.
- Sampling is based on constructs that are pertinent to theory.
- It backs the frequent comparative technique, a helpful formulation of how to conduct qualitative analysis that may be applied independently of the other elements of grounded theory.
- In order to allow researchers to adjust the research topic and data gathering techniques in light of fresh findings, data collection and analysis should be done simultaneously.
- It demands theoretical sensitivity, or the capacity to identify the key elements of the data so that a researcher can give them significance.

As good as this method is, it was not considered for the current study because is mainly used for theory development.

4.3.3 Case Study

Sturman (1997) defines A case study is a broad term for the investigation of a person, a group, or a phenomena. Performing a case study, as a researcher, entails deeply examining a program, an event, an activity, a process, or one or more people, according to Creswell (2009). While an ethnography investigates an entire population that shares a common culture, a case study examines a specific individual, program, or event (Reeves et al., 2013). The problem, the context, the challenges, and the lessons learned should comprise the case study's framework (Creswell, 2014). A case study is regarded as a type of descriptive technique if we continue with such studies at the descriptive level, but if we move up to the causal level, a case study moves in the direction of the causal experimental method (Sagadin, 1991).

Case studies are not used to evaluate hypotheses, but they can be used to generate ideas. Case study is expensive and consumes a lot of time, according to Starman (2013) It collects data from a variety of sources, including observations, questionnaires, interviews, written accounts, and audio-visual resources (Creswell, 2009). A singular case study is a study that only looks at one case, whereas a multiple case study is a study that looks at numerous cases (Gustafsson, 2017). According to George and Bennett (2005), case studies provide the following four benefits:

- They have the ability to obtain high level of conceptual validity.
- They have rigorous procedures for developing new hypotheses.
- In the context of specific examples, they are helpful for closely analyzing the hypothesized role of causative mechanisms.
- They can handle complex causal situations.

4.3.4 Ethnographical Research

The most thorough and in-depth observational qualitative method is ethnographic observation. The word "ethnography" is derived from the Greek words "ethnos" (folk, people, and nation) and "grapho" (I write). Consequently, ethnography, which refers to a people's portrayal, has a place in anthropology. It is a method where the researcher spends a lot of time observing the group's daily activities. In this type of study, the researcher carefully examines, describes, and interprets the behaviors, values, and relationships of the group members (Creswell, 2014). This study focuses on social relationships, beliefs, and behaviors of small groups and interprets the data collected through extensive involvement and observation (Denzin & Lincoln, 2011).

Cameron (1990) defined ethnography as the study of people through their perspectives. An organised procedure such as observing, recording, describing, and analysing particular aspects of a culture (or subculture) in order to understand the people's behavior in their natural environment is known as ethnography (Leininger, 1985). By identifying and characterising the activities and beliefs of the participants, this sort of research aims to characterize and analyze the culture of a specific civilisation. It assists researchers to explain the problem, unveiling customs, and developing cultural alertness and sensitivity. Furthermore, their rituals and customs of the people are

explored. Because the researcher spends a lot of time on the ground, it takes a long time (Hancock et al., 2009).

According to Gance-Cleveland (2004), ethnography is ideal when the topic concerns a whole cultural group. The focus of this research is to describe the cultures, values, and traditions of peoples. For example, a person decides to live in a missionary church to study the belief system and religious practices for ethnographical research purpose. The following are primary features of ethnographical study:

- It is associated with close, face-to-face interaction with participants.
- It closely observes participants' opinions and behaviors; • It involves close, face-to-face interaction with individuals.
- • There are no laboratory used; it is conducted in the open air.
- • It draws on many data sources.
- It employs inductive, interactive, and recurring data gathering and analytic approaches to create local cultural theories and frames all human behavior and belief within a socio-political and historical context. It uses cultural concept as a lens through which to interpret findings (LeCompte & Schensul, 1999).

4.3.5 Participatory Action Research

Participatory action research (PAR) is a type of qualitative study that focuses on taking action to improve practice and evaluating the results of that action (Streubert & Carpenter, 2002). The application of solutions takes place as a real step in the research process in PAR. The solutions are being implemented without delays. The 1940s saw a rise in the use of PAR. Unlike other forms of community-based action research, participatory action research between the study researcher and participants are feasible in all phases of the study. According to Kelly (2005), PAR give the community an opportunity to be involved in the establishment and evaluation of a health programme. The purpose of community-based participatory action research is an autonomous process through which group members, determine a problem, collect, and analyse data, and then develop solutions to make social or political transformation. The main purpose of this approach limited to knowledge discovery but also about raising consciousness and action.

The custom of PAR is based on looking to empower participants using constructing and knowledge. Naturally, PAR does the following: teamwork between study participants and researchers in identify the problem, election of an approach, research methods, data analysis and how results are used. Systematically, it allows a community's voice to plan context-appropriate action. Additionally, it enables study participants to participate actively and equally in all phases of the research endeavor, thereby fostering change.

4.3.6 Phenomenological Research

Phenomenological research is a method for conducting qualitative research. The best way to describe how people experience a certain phenomenon and get meaning from it is through phenomenological study. The researcher can examine the perspectives, comprehensions, and feelings of those who have actually encountered or lived the occurrence in a phenomenological study (Creswell & Creswell, 2018). Knowledge is acquired by experience in this phenomenological method, and the researcher explains the participant's experiences within a specific context. In this design, the significance associated with the phenomenon is conceptualised in the individual's inner awareness. According to Mohajan (2018), it is beneficial when the study focuses on the real-world encounters with an idea or phenomenon that one or more people have had.

According to Creswell (2009) a researcher using phenomenological study investigates subjective phenomena. This describes a variety of data collecting and analysis techniques that make use of open-ended, semi-structured interviews and purposive sampling (Gopaldas, 2016). This research methodology, according to Guerrero-Castaeda et al. (2017), is used to study subjects about which little is known. According to Creswell (2014), this type of research emphasises the universe of consciousness where experiences have both the inward appearance and external consciousness in relation to the picture, memory, and meaning and seeks to uncover the fundamental hidden meaning of the experience. Phenomenological research is an investigative approach that describes participants' first-hand accounts of a phenomenon, in accordance with philosophy and psychology (Creswell, 2014). The goal of phenomenology is to comprehend how people interpret their experiences. It is a well-

known study in both psychology and some branches of nursing. It examines subjective components in order to adopt a unique viewpoint (Tuffour, 2017).

Participants are asked to explain their experiences in phenomenological research from their point of view. They are permitted to write about their experiences, but interviews are used to gather broad information. The researcher must reflect on their own emotions and beliefs in order to comprehend the lived experience from the perspective of the subject. The approach of bracketing requires the researchers to first identify their discovery expectancy before purposefully suspending these concepts. It is only possible to view the event through the eyes of the individual who has lived the experience when the researcher suspends their own preconceptions about the phenomenon. Despite the perception that phenomenology research is soft science, Streubert and Carpenter (2002) dispute that notion by saying that this method of research is meticulous, systematic, and analytical.

After looking at all of the above-mentioned research designs, the researcher decided to adopt a phenomenological approach. The rationale for using this method is that it is one of the mostly used method in qualitative research, according to Creswell and Creswell (2018), which means it can be reliable. A phenomenological research design was adopted because it gave participants an opportunity to describe in-depth their lived experiences, perceptions, and interpretations of the phenomenon, which is the burden of caring.

4.3.6.1 History of Phenomenology

Greek phainein, which means to appear, is the root of the word phenomenology, which was coined by Kant in 1764. While multiple philosophers have progressed and developed phenomenology, most forms of phenomenology come mainly from Husserl or Heidegger's work. Van Manen and van Manen (2014) concur, stating that Husserl is credited as being the creator of phenomenology, a method that has roots in early 20th century European philosophy. Following that, phenomenologists such as Heidegger, Stein, Levins, Merledeau-Ponty and Giorgi appeared and have contributed positively to its advancement.

The existential phenomenology (Spinelli, 2005) or hermeneutic phenomenology (Smith et al., 2009), which can be seen as a continuation of Husserl's descriptive phenomenology, was created by Heidegger as one of Husserl's disciples. According to Heidegger, the observer existed alongside the phenomena and the essences and could not be separated from the act of essence identification. The alternative definition of existential phenomenology comes from the requirement that they keep it in mind while engaging in the phenomenological process (Smith et al., 2009).

According to Heidegger, it is difficult to separate the process by which one determines the essence of an event from being neutral and detached from the things being investigated in order to determine their essences (Langdridge, 2007). The interpretive aspect of interpretive phenomenology refers to the language use and interpretation of a person's meaning-making, their attachment of meaning to occurrences. This is also essential to Heideggerian phenomenology (Smith et al., 2009). Other philosophers and methodologists got interested mostly in the second half of the 20th century after Husserl and Heidegger founded the two traditional schools of phenomenology. They added to and clarified the concepts and methods Husserl and Heidegger had previously introduced. The names of the philosophers and methodologists are as follows Giorgi, Gadamer, Merleau-Ponty, Sartre, and van Manen (Langdridge, 2007; Smith et al., 2009).

In the middle of the 1920s, Gadamer was a Heidegger student and colleague who followed Husserl and Heidegger's work. Gadamer and Heidegger developed interpretive phenomenological ideas into a philosophy that is now known as "Gadamerian hermeneutics" with the intention of adding to hermeneutic phenomenology. Gadamer, with the philosophical stance that all understanding is phenomenological and that understanding can only be achieved through language, concentrated on how language exposes existence. Language, comprehension, and interpretation were in his opinion inextricably intertwined (Langdridge, 2007; Rapport, in Holloway, 2005). According to Gadamer, language depends on the world because language represents the world, and the world can only be true because of this representation. Gadamer linked language and ideology and, thanks to Heidegger, turned his attention away from the

epistemological method of knowing that had hitherto dominated philosophy and toward a mode of being (Rapport, in Holloway, 2005).

Van Manen has recently been refining the hermeneutic method of phenomenology. His methodology is consistent with Gadamer's because he holds that language discloses being within specific ancient and cultural contexts, understood by participant and researcher, and through language, such as the language of the interview (Langdridge, 2007). In a practical way, phenomena in the disciplines of psychology and nursing, for example, can be clarified using Van Manen's hermeneutic phenomenology. He claimed that the relationship between being and practice is formed in a number of ways by phenomenology, including how it informs, reforms, transforms, performs, and pre-forms it (van Manen, 2007). In light of this, it can be seen that hermeneutic phenomenology has evolved from a philosophy to a methodology. The key verb in phenomenological inquiry, in Giorgi's opinion, is "describe." The researcher's goal is to describe the phenomenon without making any assumptions before to doing so and while still being accurate.

The history of phenomenology is intriguing. Phenomenology has provided ways of thinking about the phenomena of human experience to the means of expressing them, starting with Husserl's philosophy of the objects of human experience at the turn of the 20th century (Barnacle, as cited in Barnacle, 2001) and continuing through van Manen's hermeneutic phenomenology as a research methodology of the latter part of the 20th century (van Manen, 2007). Husserl viewed phenomenology as a philosophical strategy for discovering true meaning by delving ever-increasing depths into reality (Laverty, 2003). With a focus on the objects—the actual things—phenomenology Husserl's was on the interaction between consciousness and the objects of knowledge (Barnacle, as cited in Barnacle, 2001). Husserl wanted to create a science of phenomena that would explain how things are perceived and how they appear to consciousness (Spinelli, 2005). Husserl's identification of the life world was one of the main features of his work (Smith et al., 2009).

Husserl's phenomenology is descriptive, according to Solomon and Higgins (1996), by which individuals are taken as the vehicle through which the fundamental structure or

essence of the thing of interest may be accessible and then described. One may eventually get at the truth if it were feasible to define how fundamental structures appear. Descriptive phenomenology specifically aims to ascertain the shape and character of reality as mediated by a person's experience of it.

4.3.6.2 Phenomenology as a Methodology

Phenomenology is an approach that is useful for portraying initiatives and research in human science because it is related to that field of study. It appears that phenomenology underwent a significant transformation over many years as it went from being a philosophy to a scientific research methodology. Only the discipline of psychology accepted Husserl's methodology to enable psychologists to grasp particular aspects of our human experience of the world. Husserl wanted to establish lived experiences in all domains of research (Langdridge, 2007).

As there have been many variations in the application of the phenomenology philosophy and methodologies, as well as the varied forms of those methodologies (Finlay, 2009), this may be seen as one example of how phenomenology has expanded from philosophy to methodology. According to Langdridge (2007), the philosophical viewpoints that phenomenology offers have been adopted as a methodology or family of methodologies, so phenomenological psychology can be seen as a family of approaches that are all familiar with phenomenology but with different emphasises, depending on the particular string of phenomenological philosophy that most informs the methodology.

In summary, phenomenology is an approach to understanding knowledge from a philosophical and theoretical standpoint (Bozzi, 1990). To understand lived experiences, it is a methodological area in social science study to examine human occurrences at a higher level of consciousness. Discussions, interviews, participant observations, and action research are common methods used in this field to obtain research data. However, in order to get a greater level of insight regarding the personal knowledge of the research participant, the researcher's skill is vital. In the present study, a phenomenological research design was adopted because it assisted the researcher to understand the lived experience of the professional nurses, their challenges, coping

mechanisms, and the support programmes and structures available to help them with their caring burden.

4.3.6.3 Different Types of Phenomenology

There are two main types of phenomenological enquiry in qualitative research, namely descriptive and interpretive phenomenology. Husserl pioneered descriptive phenomenology, while Heidegger pioneered interpretive phenomenology (Connelly, 2010). Strengths and weaknesses of each type will be outlined below as well as the reason for using one of them.

4.3.6.3.1 Interpretive Phenomenology

According to Langdridge (2007) Hermeneutic phenomenology and existential phenomenology are other names for interpretive phenomenology (Spinelli, 2005). Hermeneutics is the process by which an observer interprets language or content; it can be used as a methodology or to advance phenomenology (Webb & Pollard, 2006); hence, the substitute narration of interpretive phenomenology. Van Manen has been refining the phenomenological hermeneutic approach. Gadamer's philosophy, which is that language, including the language of the interview, provides the means for data, informs his method (Langdridge, 2007). A branch of human science called hermeneutic phenomenology examines people (van Manen, 1997). Reflexivity of a person during the evaluation of a scenario or experience can help in interpreting the meanings uncovered or give value to those types of interpretations when employing hermeneutic (interpretive) phenomenology as a methodology. Reflexivity is the process by which researchers become conscious of and reflective about the ways in which their procedures, questions, methodologies, and subject states may have an impact on the data or psychological knowledge compiled in a study (Langdridge, 2007).

According to Sloan and Bowe (2014), the following are the strengths and weaknesses of interpretive phenomenology:

Strengths of interpretive phenomenology:

- It emphasises the need of having faith in the value and strength of subjective consciousness.

• From the perspective of hermeneutic phenomenology, awareness is seen as having vital, living structures, of which we might receive explicit knowledge through a process of reflection.

• It includes of suggestions made to the researcher regarding how to interpret meanings related to phenomena.

• Finding themes and connecting with the facts analytically are key to comprehending the meaning of experience.

Weaknesses of interpretive phenomenology:

- • It downplays the significance of the phenomenon's core elements.
- It is more complex, and time is a factor.

The researcher did not use interpretive phenomenology because it is complex and does not put more emphasis on the phenomenon. Consequently, this phenomenology was not considered.

4.3.6.3.2 Descriptive Phenomenology

Qualitative research is descriptive in nature in that the researcher is concerned in interpretation, procedures, and knowledge is obtained using pictures or words. As stated earlier, descriptive phenomenology was established by Husserl (Connelly, 2010). Descriptive phenomenology by Husserls is also called transcendental phenomenology. Here the researcher explores the meanings that insiders' attribute to an experience and describes their findings in accurate words without any intention of interpretation (Husserl, 1962). According to Sloan and Bowe (2014), correlating the noema of experience (the "what") and the noesis of experience (the "how it is experienced") is the goal of descriptive phenomenology. This notion of descriptive phenomenology is further amplified by Creswell (2015), who points out that phenomenology describes the 'what' and 'how' of individuals' experienced phenomena.

Since the observer can step back from the events and meanings being investigated to take on a broad perspective on the essences discovered, Husserl's descriptive or transcendental phenomenology was given this name, indicating that the meanings of

human experiences have been objectified (Smith et al., 2009). It is important to note that, despite the fact that Heidegger's hermeneutic phenomenology followed Husserl's descriptive phenomenology, it did not displace or supersede the earlier method or take away from the value of descriptive phenomenology as a tool for identifying the essences of human experience. Choosing which of these ideologies or techniques is appropriate for a certain subject requires judgment, which is important.

There are some similarities are found in Husserlian phenomenology, Heidegger and Gadamer's hermeneutic phenomenology. Both of these traditions have their roots in German philosophy; their creators collaborated and had mutual impact. Each of these phenomenologists sought to understand the real world or genuine human experience. Both Husserl and Heidegger demanded an examination of the reality of our world and ourselves as responsive beings since they believed that the world is just one life world among many others (Laverty, 2003). The focus of the Husserlian approach to phenomenology is on the idea of describing the continuous elements of occurrences as they come into awareness. As a result, through such a description, the researcher interacts with the phenomenon's structure (Crotty, 1998).

Like all different types of research, descriptive research has both advantages and disadvantages, some of the most important of which are listed below (Fox & Bayat, 2008).

Strengths of descriptive phenomenology

- Researchers can employ both quantitative and qualitative data in descriptive research,
- This data collecting enables descriptive research to offer an understanding of human events.
- It is quick to perform and inexpensive.
- It enables the collection of both quantitative and qualitative data.
- It allows the formulation of hypotheses, as well as giving a large amount of valuable data for the development of future investigations.

- By using descriptive research, data is gathered in the environment where it happens, without any form of alteration, ensuring high quality and integrity.

Weaknesses of descriptive phenomenology

- One significant disadvantage of descriptive research is the lack of confidentiality.
- Subjectivity and mistake are detrimental in descriptive research.
- Reliability issues, which makes it difficult to carry out a credible investigation.

The researcher used descriptive phenomenology in the present study because it gave professional nurses an opportunity to share and describe in detail their lived experiences to develop an effective and visible support programme. Specifically, the researcher used the descriptive phenomenological method to capture the experiences of nurses. Descriptive phenomenology was used because it allows the researcher to give a relevant and authentic description of the PNs' phenomenological experiences. This method has assisted the researcher to find relevance and correlation between the lived experiences of the nurses and how those experiences affect them. In the current study, the researcher received deeper and a wealth of knowledge from trained nurses who spend the majority of their hours with patients and experience many challenges on a daily basis. Moreover, the participants described their feelings and thoughts about their caring burden, which enabled the researcher to gain understanding. Furthermore, they were asked about the methods and mechanisms that they used to cope with the caring burden; and about support structures and programmes available to assist with their caring role. Ultimately, the feedback and responses from the PNs were employed in developing a suitable support programme for nurses.

4.4 Study Site

The three MHCUs that were chosen for the study were located in the South African province of Limpopo. There are five districts in the northern region of South Africa, which is home to the Limpopo Province. There are just three specialised mental institutions in this province that offer care to MHCUs. These chosen mental health facilities offer services to MHCUs with forensic patients, intellectually disabled individuals, and chronic mental illness. There are 219 MHCUs and 65 licensed nurses

working in these mental hospitals together. The workers of these institutions include multi-professional members such as social workers, psychologists, and occupational therapists. Because the mental health facility is open 24 hours a day and has doctors on call, most nurses work in shifts.

The study was conducted in Limpopo Province at three mental health institutions. With a total size of 125 755 square kilometers, or 10.3% of South Africa's total land area, Limpopo Province is the fifth-largest of South Africa's nine provinces. It is made up of twenty-five local municipalities and has a population of 5.6 million. It is divided into five districts. The province has 30 district hospitals, 5 regional hospitals, 2 tertiary hospitals, 3 specialized hospitals, and 15 private health institutions in terms of healthcare services (South Africa, 2016, as cited in Matlala et al., 2017). The three mental health facilities are the hospitals in Evuxakani, Hayani, and Thabamoopo. Three districts, Mopani, Vhembe, and Capricorn, are served by their complete mental health care services. All of these institutions are predominately based in rural areas and offer 24-hour mental health care services. Each mental health institution is discussed below.

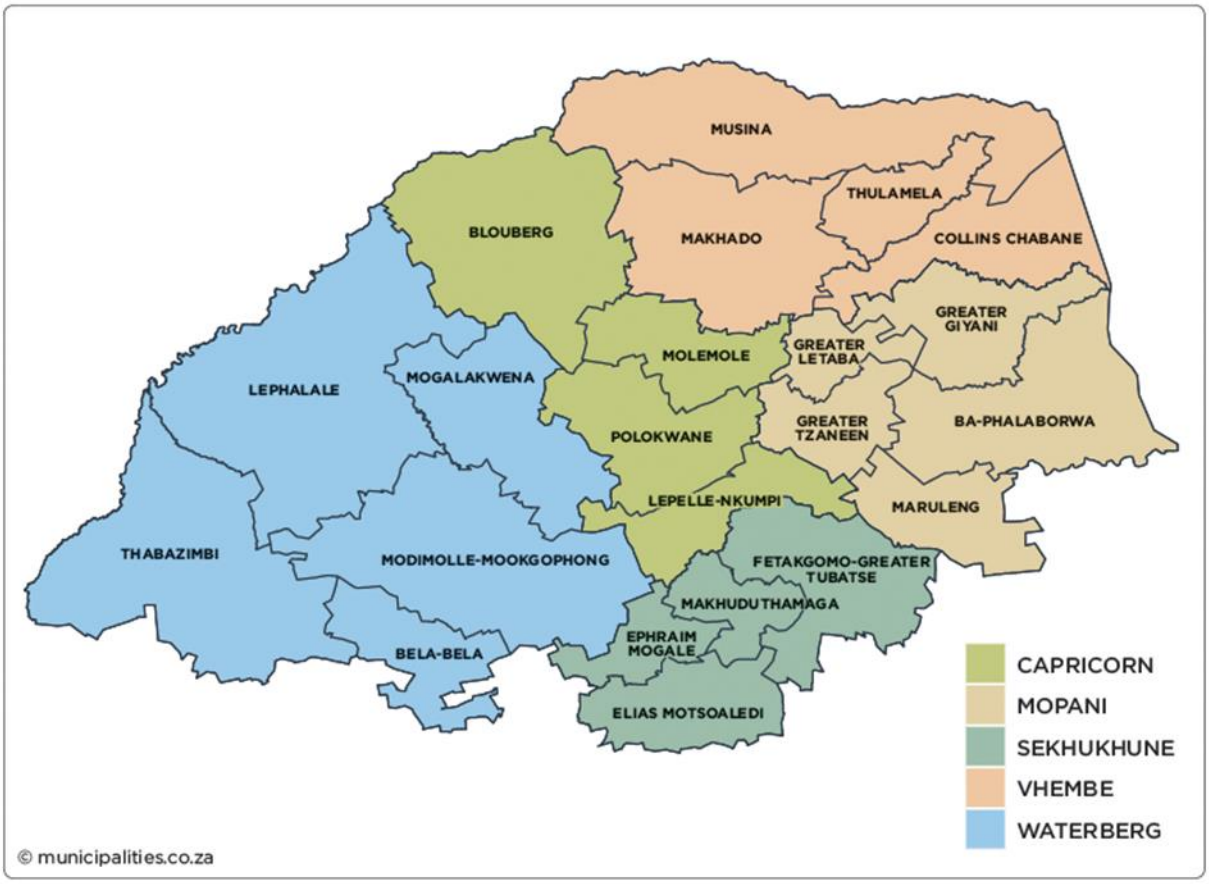

Figure 2: *Map of Limpopo Province and its Districts (www.municipalities.co.za)*

4.4.1 Evuxakeni Mental Health Institution

Evuxakani Hospital is a mental health institution situated in the Mopani district, around five km from Giyani CBD. This hospital was built in 1984. As a Category C municipality, Mopani district is located within the north-eastern part of the Limpopo Province. The district is made up of five local municipalities: Greater Giyani, Greater Letaba, Greater Tzaneen, Ba-Phalaborwa, and Maruleng. The district municipal offices are in Giyani. Evuxakani mental health institution is the only psychiatric facility in the whole of Mopani district. This hospital receives patients from Letaba, CN Phathudu, Maphuta Malatjie, Sekororo, and Nkhesani Hospital.

Figure 3: *Map of Mopani District and Local Municipalities (www.municipalities.co.za)*

4.4.2 Hayani Mental Health Institution

Hayani mental health institution is located in Vhembe district. It is situated in Sibasa Mutale Road, about four km from Thohoyandou. This hospital was built in 1969Musina, Thulamela, Makhado, and Collins Chabane are the four local municipalities that make up the Vhembe district. Thohoyandou is where the district municipal offices are located. Hayani Hospital renders service to Tshilidzini, Malamulele, Donald Fraser, Siloam, Elim, Botlokwa, and Messina Hospital. Hayani has three forensic wards: a maximum-security-, a semi-closed- and an open ward. Hayani Hospital appears to be at an advantage with a secure ward and an enforced no-smoking policy, reducing the risk of substance abuse significantly, which does allow patients to move faster through the system and back home.

Figure 4: *Map of Vhembe District and Local Municipalities (www.municipalities.co.za)*

4.4.3 Thabamoopo Mental Health Institution

Thabamoopo, which means 'mountain of the rock' is one of the mental health institutions situated in Lebowakgomo, around 55 km from the town of Polokwane. It gets its name from the Tropic of Capricorn, which runs through Polokwane, the county seat of Limpopo. Thabamoopo Hospital was built in 1972. It falls under the Capricorn District in Limpopo Province. Polokwane, Molemole, Blouberg, and Lepelle-Nkumpi are the four local municipalities that make up this district. The seat of this district is in Polokwane town. Thabamoopo Hospital serves the following local hospitasl: Makweng, Polokwane, Lebowakgomo, Seshego, and Groblersdal Hospital. Three areas, namely Capricorn, Waterberg, and Sekhukhune, are served by the complete mental health care services offered by Thabamoopo Hospital. The facility provides rehabilitation services and reintegrates those who have received mental health treatment into their societies. Additionally, it provides clinical training to students from Limpopo College of Nursing, University of Limpopo, University of Venda, Tshwane University of Technology, and other South African universities. Thabamoopo Hospital is a general psychiatric hospital

with open forensic facilities and a closed ward for forensic patients. Acute care, sub-acute services, chronic services, forensic services, and intellectual disability services are the main services offered by Thabomoopo mental health institution. In South Africa, forensic patients include the accused referred for forensic psychiatric observation while still awaiting trial (Observandi), and state patients. This hospital renders assessment to patients referred to the unit by the courts through multidisciplinary approach.

This hospital provides detainees with forensic psychiatric observation as well as care, treatment, and rehabilitation for state patients and mentally ill prisoners. Gender and age groups separate forensic patients. These patients are housed in extremely secure observation units until the justice system deems them fit for trial, at which point they are either returned to the hospital for re-admission as state patients for a specified period of time. It offers up to 30 days of forensic psychiatric observations to patients. There is a cannabis problem in Thabamoopo and it will only be solved once the hospital is secured and the no-smoking policy is enforced for both staff and patients.

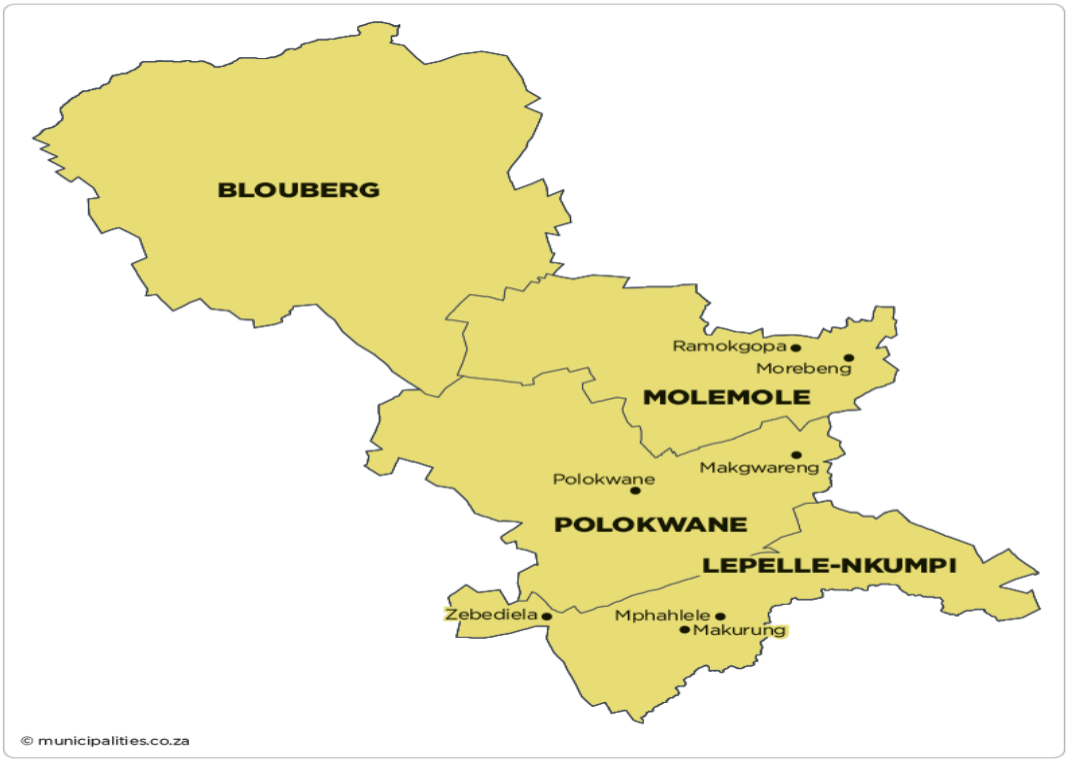

Figure 5: *Map of Capricorn District and Local Municipalities (www.municipalities.co.za)*

4.5 Population and Sampling

4.5.1 Population

A population is any collection of cases in which a researcher is interested (Polit & Beck, 2012). The study's target population included all professional nurses providing patient care at Limpopo Province's Hayani, Evuxakeni, and Thabamoopo mental health institutions. The sample comprised 30 professional nurses (10 from each hospital). In quantitative research, subjects are the people who are examined, while in qualitative research, the people who are investigated are referred to as participants. A sample is a subset of a population that is selected for a specific study (Burns & Grove, 2011). They all worked in male and female acute wards and chronic wards at some point of their career. It is the policy of these three mental health institutions for nurses to rotate and work in different wards. This policy gives the nurses a chance to care for patients with a variant of mental illnesses. The current study contained a sample of thirty (30) PNs when a point of saturation was reached, as recommended by Mays and Pope (2000). According to Morse (1995), saturation has become widely recognised as a guide or

indicator in qualitative research that sufficient data collection has been achieved. After interviewing 39 PNs, the researcher realised that sufficient data has been obtained, and then further interviews were discontinued.

4.5.2 Sampling

Sampling according to LoBiondo-Wood and Haber (2010) is the process of picking a subset of the target group to serve as the representative of the entire population. Below, the sampling method and participants will be discussed. Purposive homogenous sampling was used in the present study. Palinkas et al. (2015) define a homogenous purposive sample as one that was chosen because it possesses a shared trait or traits. Participants in purposive homogenous sampling, for instance, are comparable in terms of their ages, cultures, occupations, or life experiences. In this study, participants were professional nurses caring for chronic mental ill patients in the three identified facilities. The researcher chose this sampling method because it allows the researcher to use participants who have common characteristic and phenomenological experiences. As a result, the researcher asked PNs who work in the three mental health facilities in Limpopo Province and care for patients with chronic mental illness to volunteer to take part in the study. These three facilities are mental health institutions offering comprehensive 24-hour mental care services. The nurse manager granted approval for the study to be conducted with PNs who met the following inclusion criteria after consulting with the researcher, as guided by Polit and Beck (2012):

- Both male and female registered professional nurses.
- Registered professional nurses working in Hayani, Evuxakeni, and Thabamoopo mental health institutions in Limpopo Province.
- • The participants could speak and understand English.
- Participants who were interviewed in the present study were over 18 years of age.

4.5.3 Participants

This study comprised PNs caring for patients with chronic mental illness. These nurses were working in one of the three mental health institutions in Limpopo Province. They had either a diploma or a degree in nursing. Apparently, they are the same, the

difference is the institution at which they studied. The ones with a diploma in nursing acquired their qualification at a college while the ones with a degree in nursing obtained their qualification at a university. The participants were between the ages of 27 and 64. The majority of the participants were in their mid-thirties. Of the PNs, 89 per cent were females and 11 per cent were male PNs. In the present study, the participants were coming from three ethnicity groupings. At Evuxakeni Hospital, 96 per cent were Tsonga. At Hayani Hospital, the predominant language was Venda. At Thabamoopo Hospital, 95 per cent of the PNs were Pedi. In addition, all PNs participating in the current study were Limpopo Province residents.

4.6 Data Collection

Data collection includes the method and instrument used to collect the data. Below is a detailed discussion of the data gathering procedure and the data collection tool for this project.

4.6.1 Data Collection Process

For the current study to be conducted, permission and approval had to be obtained prior to the study. The following institutions were approached to obtain permission: Turfloop Research Ethical Committee (TREC), Department of Health, provincial and district level, the Chief Executive Officers (CEOs) of Evuxakeni, Hayani, and Thabamoopo mental health institutions, respectively, the Nurse Manager of the MHIs, and participants (see ethical consideration section for details).

After receiving permission from the above-mentioned, the researcher contacted the nursing managers of each hospital via phone to schedule an appointment for interview. To avoid interfering with patient care procedures and impeding on service delivery, the researcher scheduled appropriate dates and times to conduct interviews. Data was collected between October 2020 and December 2020. On arrival, the researcher reported at the nursing manager’s office for a brief meeting. Then the researcher was oriented by a nurse at each institution. The orientation entailed visiting almost all of the wards except the maximum ward at Hayani Hospital prior to conducting the interviews. These wards included male and female acute and chronic wards, and the intellectual disability wards. After orientation, the researcher went to each ward by herself to

conduct the interviews. In most wards the researcher was received and directed to the PNs by a senior person in that particular ward. Only day-shift PNs were interviewed in the study.

The researcher asked nurses to volunteer to participate in the study before starting it, outlining the study's goals in the process. The title, purpose of the study, potential benefits of the study, potential dangers of the study, the role of participants, and ethical concerns were all explained verbally by the researcher in addition to other information that was included in the consent form. Participants were given the chance to ask questions, and the researcher answered them. Following that, participants had the opportunity to read the entire consent form, ask questions, and provide approval if they wished to take part in the study. The researcher provided clarification where necessary and ensured that all participants understood the process of data collection before signing and dating the form.

4.6.2 Data Collection Instrument

Semi-structured interviews were employed in this study as a method of gathering data. The tool used to collect data using structured questions is known as a data collection instrument (Polit & Beck, 2012). Semi-structured one-on-one interviews are advantageous when the researcher is primarily interested in a complex process, when a subject is contentious or personal, according to de Vos et al. (2005). They also allow the researcher and the participants to be flexible. Semi-structured interviews were used because they are partially structured and allow both parties to engage and probe when necessary. The researcher established rapport with the participants prior to the interview to have a positive effect on the interview. Professional nurses were addressed and interviewed in one of the following areas: nurses' station, doctor's room, nurses' duty rooms, and patients' ward. The reason for using different venues was to accommodate all PNs and to avoid hampering patient care. Between 30 and 60 minutes were spent on each interview.

Participants were interviewed in English. With the participants' permission, the researcher used an audio-recorder to record the interviews for later analysis and also to provide permanent evidence of the data collection process. Field notes were also taken

during the interview. Participants' nonverbal gestures were captured and recorded using field notes. The interviews recorded were transcribed verbatim. Interviews were conducted until data saturation was reached, as revealed by repeating themes with no new insights arising and not by the number of interviews conducted. The researcher made sure that the transcripts, field notes, and audio recordings were safely kept in a locked cabinet where only the researcher had access to them. There are therapeutic communication skills that the researcher utilised during the interview, as outlined by Jack-Ide et al. (2013), as follows: listening, reflection of feelings, timing, depth, language and terminology, paraphrasing, clarifying, focusing, using of silence, confrontation, and probing. The researcher appears to be rather passive around the PNs based on their listening therapy skills. Listening is divided into two categories: verbal, and non-verbal messages. The researcher listened actively to what nurses were saying both verbally and non-verbally. The researcher listened to the factual information that the PNs were conveying, and the researcher also listened to the feelings conveyed by the PNs. The researcher constantly observed the nurses' body movements, facial expressions, quality and tone of voice, and gestures to see whether non-verbal messages contradicted or confirmed what the participants were saying.

Regarding reflection of feelings, the researcher regularly reflected on the feelings of the participants. This was accomplished by paraphrasing their sentiments and relaying them to the PNs in the researcher's own words. In terms of timing, the researcher was cautious and calculative before reflecting on the participant's feelings and emotions. Moreover, before asking the individual to express her feelings, the researcher assessed her readiness. The researcher gave the PNs enough time to hear her reflection since she waited for the nurse to finish speaking and for a respectable amount of time to pass. The depth of the study focused on the nurse's capacity to receive reflections before expressing feelings to them. The researcher's use of language and vocabulary was suitable given the individuals' backgrounds, educational levels, and intellectual prowess. The researcher limited the use of psychological terms; instead, she used clear and simple language suitable for the participants. By restating the participant's main points in a similar manner but with fewer words, paraphrasing was accomplished. Without introducing any fresh concepts, the researcher provided the nurses with a more

exact translation of the raw data they were expressing. If something is clarified, it means that the researcher made sure the nurses explained what she had understood correctly, where she had trouble understanding what they were saying, or where they may have provided the researcher with a lot of information that needed to be explained. Consequently, clarity-seeking questions were asked by the researcher. The researcher employed a focusing approach to focus the PNs' questions and the researcher's dialogue on a crucial point or detail. The use of focusing techniques helped the nurses connect with their emotions. The researcher ensured that participants did not derail and lose focus during the interview.

Silence was used to give both the researcher and the PNs time to think, collect their thoughts, and further explore issues. It encouraged the nurses to communicate and share their thoughts and feelings. The researcher brought discrepancies to the nurses' attention during the confrontation process. This was done empathically in order to allow for moderately regulated exploration of issues. To better understand the PNs and their responses, the researcher used probing during the interview. To elicit information from the nurses, the researcher asked open-ended questions.

Ultimately, the data collected was analysed and used to develop specific strategies that speak to the identified needs of nurses. In other words, a support programme was extracted from the participants' responses and needs. Since the goal of qualitative research is to comprehend phenomena in depth and complexity, the researcher needs techniques for identifying key themes and analyzing pressing issues. The participant's informed consent form and letter, any field notes taken during the interview, any notes made during the 'data analysis' process, such as grouping meaning-making units into themes, the draft transcription and analysis of the interview, and any additional or subsequent correspondence between the researcher and the participant were all filed in a file that the researcher created with sections for each of the different interviews. Audio recordings, field notes, and the filing of paper records are all examples of data storage. The field notes and interview transcriptions were also kept electronically on various hard disks. The next section explains data analysis, or more precisely, data explicitation.

4.7 Data Analysis

Data analysis from a qualitative research study is unquestionably one of the most important stages of the research process (Leech & Onwuegbuzie, 2007). Data analysis in qualitative research, according to Ary et al. (2007), comprises attempting to analyse the phenomenon being examined and grasping an understanding of the connection between all of the information received from the many sources of data. Similarly, Bogdan and Biklen (2007) define data analysis as "working with data, arranging it, dividing it into manageable units, coding it, making sense of ideas it, and looking for trends. Polit and Beck (2012) define data analysis as the process of organizing, structuring, and retrieving meanings from research data. Matthews and Ross (2010), the primary aim of analysing data involves describing, examining and explaining the characteristics and content of the data that have been collected in the research project.

The first step in phenomenological analysis, according to Brinkmann and Friesen (2018), is description. The methodological rule of phenomenological description is to be unconcerned with interpretations and to stick to what appears, no matter how inadequate it may be (Heidegger, 1985). In the current study, verbatim transcription of semi-structured interviews was used to create an introductory descriptive account of the concept. Data verbatim transcription necessitates listening to the voices of the participants repeatedly, which can aid in early analysis (Tracy, 2013). When transcribing, it is critical to use the appropriate symbols so that another researcher can understand the data. Furthermore, fact-checking, which entails listening to recordings and reading transcripts, can help researchers fix any transcription problems that may have occurred. The transcripts are then coded, either manually or with computer software, with the goal of detecting recurring themes from the phenomenon under study. It is crucial for qualitative researchers to comprehend phenomenological study in terms of interviews, transcription, and manual coding since it provides a basis for the procedures required to conduct high-quality research (Tracy, 2013).

According to Tracy (2013), in a phenomenological investigation, the primary goal of the data analysis stage is to derive meaning from the themes discovered through the initial manual coding. The six steps necessary for any phenomenological approach are

included in this method. Transcribing semi-structured interviews, journals, or other qualitative datasets comes first after data collection. The second step post transcription is the process of data organization. In this case, the researcher must focus on organizing the data to make sense of the numbers of rich text. To put it another way, the researcher is making an effort to create the plot by attentively reading and comprehending the transcripts (Saldaa, 2013).

Coding is the name of the third stage. Using tangible copies of the data or digital versions, coding is a method of systematically organizing and comprehending the data (Tracy, 2013). Manual coding entails annotating the transcripts with comments and highlights to find recurring topics. Researchers can establish first- and second-level codes by making corrections between themes using this method. Deducing categories is the fourth step in phenomenological data analysis. The researcher must begin classifying the codes once they have been detected (Saldaa, 2013). The topics that participants discuss and the brief comments that are made while reading the transcript are sometimes used by the researcher to code and categorize data. In this case, the researcher might group things together not only because they are similar but also because they might belong to certain communities. Finding recurring motifs and providing interpretations is the fifth phase. This is a crucial stage in the analysis of phenomenological data because it allows the researcher to draw conclusions from the discovered common patterns or themes and relate them to the overall goal of the study.

The final step is to keep a reflective journal. This is an important step in the qualitative data analysis process, particularly when conducting a phenomenological study, because it addresses researcher bias as well as establishing appropriate transferability and credibility measures. According to Chenail (2011), keeping a reflective journal or diary not only examines the researcher's choices and decision-making process throughout the qualitative study process, but also helps to re-evaluate the options made or themes identified for review.

Groenewald's (2004) adapted version of Hycner's data explication process was used to analyse the data. Because the process requires continuous bracketing and phenomenological reduction, Hycner's (1999, as cited by Groenewald, 2004) simplified

explicitation process was used for data analysis, which is consistent with the philosophical underpinnings of descriptive phenomenology. Groenewald outlines five critical steps in the process of phenomenological explicitation. The five steps are as follows: bracketing and phenomenological reduction, delineating units of meaning, clustering units of meaning to form themes, summarizing each interview, validating and modifying it as needed, and extracting general and unique themes from all interviews and creating a composite summary. During the data analysis process, the researcher in this study decided to follow the five steps suggested by Groenewald. Below is a description of each of Groenewald's five steps, as well as a brief presentation of how the researcher in the current study followed the steps:

4.7.1 Bracketing and Phenomenological Reduction

According to Husserl, the usage of bracketing is important for the researcher to obtain knowledge into lived experiences. Husserl is supported by Streubert and Carpenter (2007), who define bracketing as a productive way of ensuring the validity of data collection and analysis in phenomenological research. Gearing (2004) noted similarities to Husserl's (1939) outline of two negative procedures: (a) the epoché of the natural sciences returning to the things themselves and; (b) the epoché of the natural attitude, the phenomenological reduction becoming oblivious of the presumptions and presuppositions that researchers had in mind and focusing on initial phenomena in the way it presents itself rather than getting involved in it. These two elements enable researchers to focus on lived experiences as they emerge. Phenomenological reduction needs the researcher to stay open and unattached to the descriptions being shared by participants regarding their experience of transition, from their natural perspective. Hycner (1999) considers Husserl's invention of the term reduction to be disastrous because it doesn't have anything to do with reductionist natural science methodology.

The researcher started data analysis by specifying her thoughts about the findings, such as ‘the chronic mentally ill patient is humble and harmless’. These expectations were put aside in order to hear what emerged from the data. Basically, the researcher’s presuppositions and personal bias or theoretical views were suspended. The recording was played back numerous times to increase accuracy as the researcher sought to

accurately capture the language, and then read the transcripts several times with openness to any meanings appeared. Furthermore, the researcher tried by all means to suspend her own meanings and interpretations and getting into the participant world. This assisted the researcher to extract the genuine phenomena from the perspective of the participants (see Results chapter).

4.7.2 Delineating Units of Meaning

Delineating is the process through which meaning elements that are considered to be relevant in relation to the topic being examined are identified (Groenewald, 2004). According to Hycner (1985), at this point, transcription of the interview has been completed, she has tried to keep as true to the data as possible while bracketing her presuppositions, and she has an understanding of the context of the entire interview. This stage of the data explication process is critical because the statements that appear to illuminate the topic under study are extracted or ignored (Hycner, 1999). Each interview's list of relevant meaning units is carefully examined, and any units that are obviously redundant are eliminated (Moustakas, 1994). The researcher does this by taking into account the literal content, the frequency of a meaning, and the manner (non-verbal clues) in which it was presented. The underlying significance of two seemingly comparable units of meaning could vary in terms of worth or the order of events (Hycner, 1999).The researcher then started the onerous process of data explication by taking those statements that illuminated the research phenomenon (Hycner, 1985).

During this stage, the researcher started by investigating the data carefully, looking at one transcript at a time and analysing it. Statements related to the thought and feelings of participants about their caring burden towards chronic mentally ill patients were underlined. The researcher scrutinized each word, phrase, sentence, and paragraph in addition to taking note of crucial non-verbal clues. Additionally, the researcher created a list of meaningful units that were pertinently retrieved from each interview and carefully examined them, eliminating unnecessary units. This was achieved by considering the number of times something was mentioned as well as how it was stated. Themes and

units that appeared frequently were noted and given attention. At the end the entire transcript was coded (see Results chapter).

4.7.3 Clustering of Units of Meaning from Each Theme

At this stage the list of relevant units of meaning is carefully analysed as a way of eliciting the importance of meaning of units within the holistic framework (Groenewald, 2004),. The codes were put together to form the themes. Hycner (1999) states that this stage requires the researcher to be extra judgmental and skilled. Generally, clusters of themes are created by combining units of meaning, and the researcher picks crucial subjects, also known as units of relevance (Sadala & Adorno, 2001). The importance of the researcher returning to the recorded interview and then to the list of meaning units that are superfluous in order to extract clusters of appropriate meaning is stressed by both Holloway (1997) and Hycner (1999). Clusters frequently overlap, which is expected given the makeup of human phenomena. The researcher controls basic themes that convey the significance of these clusters of the distinct clusters by closely examining the meaning.

During this step, the researcher used her creative sight to form clusters of themes by categorising units of meaning together. The researcher repeated listening to the recorded interviews to enhance clustering of the appropriate units, leading to the identification of central themes (see Results chapter). Significant topics were identified by the researcher after critically scrutinising the meaning of the several clusters and central themes. In the results chapter, using some illustratative extracts from one of the transcripts, the researcher explains how she compiled notes based on numerous readings and replays of the audio tapes. Furthermore, the researcher used pschological language to convey emerging themes and sub-themes. The researcher again brackets her presuppositions after compiling a list of meaningless units as a means of staying true to the phenomenon. The researcher thoroughly examines the list of meaning units in an effort to ascertain the essence of each unit's meaning in a broad context.

4.7.4 Summarising,Validating and Modifying Each Interview

At this stage, Hycner (1999) emphasises the need of returning to the participants allows the researcher to do a validity check to ensure that the interview's significance has been

accurately captured (Hycner, 1999). This validity check is the result, and any necessary update is made now. The researcher used each interview as a starting point for a narrative that included all the themes identified from the data, creating a comprehensive context. By asking the participants if the significance of the interviews had been adequately captured, the researcher in the current study performed a validity check. Modifications were made where necessary to ensure a validity check. A comprehensive context for the current study was supplied via a summary that incorporates every theme identified from the data.

4.7.5 Extracting General and Unique Themes from Interviews to make a Composite Summary

Hycner (1999) indicates that after the completion of the above mentioned processes, the researcher must look for both individual variations and the themes that are familiar to most or all of the interviews. Here similar themes were noted, and the researcher also brought out the unique or minority voices as imperative counterpoints of the study. At this stage, the researcher converts everyday expressions of the participants into proper expressions to the scientific communication supporting the research (Sadala and Adorno, 2001). To conclude the explication, the reseacher wrote a compound summary reflecting the background from which the themes emerged.

4.8 Quality Criteria

According to Anney (2014), qualitative research projects often use four quality criteria, namely dependability, credibility, confirmability, and transferability. The above-mentioned quality criteria guided the researcher in the present study:

4.8.1 Credibility

The degree of assurance that can be placed in the veracity of the research findings determines the research's credibility (Macnee & McCabe, 2008). The researcher can establish the study's analysis by using credibility techniques including extensive and varied field experience, reflexivity time-sampling, triangulation, member checking, peer evaluation, interview skills, and consistency of structure (Anney, 2014).The duration of the interviews conducted were between 30 and minutes, the shortest being 30 minutes while the longest around 60 minutes. The data collection duration was three months.

Prior to the official submission of the finished project, the researcher used her supervisors and peers in the academic community to examine the present study at various stages. As a result, these procedures are thought to give the study more legitimacy.

4.8.2 Transferability

Transferability concerns the aspects of applicability. According to Kyngäs et al. (2020) transferability is the ability to administer the results to other participants or contexts. For the purpose of ensuring transferability, a full description of the research context, sample, setting, sample size, demographics, qualifications features, inclusion and exclusion criteria, interview approach and process, and underlying hypotheses was used in this study. In addition, the researcher plainly indicated the theoretical spheres of the study and the extent to which the results could be utilised in other environments and with other participants (Babbie & Mouton, 2007). In order to help accomplish this, comprehensive descriptions, purposive homogenous sampling and direct quotes from the participants were used. Transferability needs the researcher to give adequate data and background to allow the viewers to determine whether the results can be practiced to other environments and contexts.

The research findings in the present study are reported in narrative form to obtain broad description of participants' lived experience of role transition as impossible to generalise. (Kleiman, 2004), suitable to the phenomenology of Husserlian. An attempt was done to accurately describe participants' experiences to permit others to evaluate the transferability of the research findings to their own settings. The extent to which the outcomes can be applied or conveyed in various atmospheres makes the findings meaningful to others by describing them and their context in detail by means of explaining the sampling method.

4.8.3 Dependability

Dependability focuses on aspects of consistency, meaning if the study were to be repeated, would the results remain the same or would they be similar? (Babbie & Mouton, 2007). According to Brink et al. (2012), dependability is the providing of

evidence such that its results would be identical if it were repeated with the same or similar individuals in the same or similar context. In this case, the researcher tries to take into account any changes in the environment that can affect the conditions or the design. Furthermore, the researcher clearly outlined the research steps followed at the beginning of the research endeavors to the development of the support programme and reporting of the findings. Dependability mean having adequate details and documentation of the methods used for the study can be analysed and duplicated.

Here the researcher tried to give a crystal description of the research process from the onset of the inquiry to the finalisation of the research report. Furthermore, dependability was ensured through the use of digitally recorded interviews, the researcher being the only transcriber as well as being the only data analyser (Streubert & Carpenter, 2002). A persistent approach was adhered to during data collection and interview data analysis (Graneheim & Lundman, 2004)

4.8.4 Confirmability

The elements of neutrality are addressed through confirmability. This simply means that the study's findings can be validated by a third party, and that the researcher's data collection will serve as the sole basis for all evaluations (de Vos et al., 2005). The approach for this investigation was meticulously documented, and the data was checked and checked again. This was done to make sure that the data represented the participants' voice rather than the researcher's biases and opinions. The researcher ensured confirmability by keeping all research records such as documentations, recordings, field notes, transcriptions and information collected during the study. The above-mentioned research documents and materials were stored and kept safe for a period of five years, so that they could be reviewed if needed. The researcher also described her predispositions in the research report. Confirmability is described as a method of ensuring that the study's findings are the informants' experiences, not the preferences of the researcher(s), and it can be attained using an audit trail of the raw data, memos, notes, data reduction, and analysis. This definition is supported by a study by Streubert & Carpenter (2002). All data can be linked back to their original

source, and a chronological structure was employed to group the analysed data into logically distinct and well-supported periods.

4.9 Ethical Considerations

According to Polit and Beck (2012), ethics is viewed as a system of moral principles that is concerned with how closely research processes abide by their commitments to the study participants on a professional, legal, and societal level. The protection of human subjects through the usage of accurate ethical principles is essential in all research study. In a qualitative study, ethical considerations have a distinct resonance relating to the comprehensive type of the study process. The researcher must make sure that participants won't be in risk during the research. The researcher must also avoid questions that are heartless and invasive and that may impair the autonomy of participant (Botma et al., 2010). The following ethical considerations were followed:

4.9.1. Permission for the Study

Before commencing with data collection, the researcher sought and obtained permission from Turfloop Research Ethical Committee (TREC). The permission was obtained on 4 July 2019 at the University of Limpopo Province, project number: TREC/127/2019. The researcher also received permission from Limpopo Province Department of Health to conduct the study at Evuxakeni, Hayani, and Thabamoopo mental health institutions. The permission was received in March 2020. The researcher also sought permission from Mopani, Vhembe, and Capricorn Departments of Health. Permission was granted from Mopani, Vhembe, and Capricorn Departments of Health in September and October 2020. Permission was also received from the Chief Executive Officers (CEOs) of Evuxakeni, Hayani, and Thabamoopo mental health institutions, respectively before data collection. Permission was also obtained from nurse managers of these MHIs to conduct a study, and informed permission was also received from the participants (professional nurses).

4.9.2. Informed Consent

Prior to commencing with collection of data, participants were asked to give written informed consent. The potential participants were given an explanation regarding the

aim of the study and data gathering procedure. They had enough time to ask questions and voice their concerns. It was made very clear that their participation was voluntary and that it would not in any way affect their employment if they declined to take part or withdrew from the study while it was still ongoing. Informed consent forms and letters were handed over to participants to further explain the study. They each had adequate time to read the letter and informed consent before deciding whether or not they wanted to participate in the study. Before the interview, they had to sign an informed consent form granting permission to participate in the study. The participants' informed consent forms and letters were written in English. Permission was also asked to record the interview.

4.9.3. Anonymity

By keeping the participants' names and identities a secret during the data collection, analysis, and reporting of the study results, the subjects' anonymity was maintained. There was no mention of their names, the hospitals at which they are based, or other forms of identification in the research report as a way of protecting their identity. The researcher is the only one with the ability to match the identity of the participants and voice recordings. This was done to put participants at ease and to promote their speaking without any form of fear.

4.9.4. Confidentiality

The participants' information was kept confidential. Personal information given by the participants during the interviews was not divulged in order to avoid the possibility of linking participants' information or responses to their identity. Encrypted devices, password protected were used to store data. The two supervisors of the researcher received access to the transcripts using email as a way of ensuring cross-checking in data analysis. All data stored in hard disk, personal laptop, and memory sticks was secured by using passwords that were only known by the researcher. Information from the present study, both digital and written, will be kept on file for five years. However, once they are no longer needed, the interview tapes will be deleted.

4.9.5. Privacy

The researcher ensured privacy by respecting participants' dignity, autonomy and rights to self-determination as well as their general welfare. The researcher ensured privacy by managing the interview environment during interview sessions, data processing and diffusion of the results. Each interview was conducted independently, majority in a private and appropriate room, few in the ward in the respective hospitals minimal access by other nurses. To reduce the possibility of recordings being heard by others, data transcription was performed in a private space while wearing earbuds. Participants' identification were not included during data transcription, including their names or any important component of identity. In the presentation of results chapter of the study, the participants were called to by their participant number in the verbatim quotes. However, participants were made aware that their real age would be used. The access of the supervisors to the data was also outlined to the participants and their permission was received.

4.9.6. Aftercare for Participants

The researcher regarded providing and referring participants to counselling in the event that they needed it as fulfilling her moral obligation. All PNs were advised to consult their residential psychology practitioner for further assistance. For this study, only one participant was emotional when talking about the death of a colleague. The colleague was stabbed to death by a patient with chronic mental illness at work. Consequently, the participant was verbally referred to the local psychologist for counselling.

4.10 Reflective Summary

Developing a support programme for professional nurses caring for patients with chronic mental illness is challenging and demanding. This is a new study, and the researcher is not aware of any support programme that has been developed in the three Limpopo mental health institutions; hence, it comes with numerous challenges. The first challenge that the researcher encountered was getting access to the three mental health institutions and the professional nurses. As a prerequisite, the researcher had to obtain permission from Department of Health at the provincial level. This process took about seven months to be completed. The researcher sought permission

in August 2019 and permission was only granted in March 2020. Upon making follow-up calls, the researcher was told that the delay was due to logistical problems that the Provincial Department of Health was experiencing.

After receiving consent from the Provincial Department of Health, the researcher had to request permission from the Department of Health at the district level (Vhembe, Mopani, and Capricorn districts). This process was also not easy; instead, it was financially costly and strenuous. Sometimes, the researcher had to drive to the respective districts to deliver the letters personally. The other factor that exacerbated the matter was the COVID-19 pandemic. From late March 2020, when the COVID-19 restrictions started, the researcher could not do much because of the protocols and regulations in place. The researcher was granted permission from different districts only in September 2020, after most of the restrictions had been lifted. After obtaining permission from district level, the researcher had to get permission from the three mental health institutions, respectively. The CEOs of Evuxakani, Hayani, and Thabamoopo mental health institutions were contacted to ask for authorisation to carry out the study. At least that process was not long, nor was it difficult.

The researcher also contacted nursing managers to arrange appointments to interview the professional nurses. From late September to mid-December, the researcher travelled around these three MHIs to gather data by interviewing the professional nurses. Semi-structured interviews were utilised to have a conversation with the nurses with the aim of developing a support programme for them. Another challenge that the researcher faced was the lack of conducive and quiet space to conduct the interviews. In some wards, there was no private and quiet place to conduct the interviews. Ultimately, the interviews were conducted inside the ward. This was not ideal in that other staff members and patients would disturb by talking in the background. Although the place in some wards was not conductive, it enabled the researcher to get extra abreast with the sites where the participants provided health services.

Conducting an interview on site, where professional nurses offer care, helped the researcher to be empathic. This process assisted the researcher in understanding some of the challenges that PNs experience, for instance, the shortage of resources

like consultation rooms. The researcher experienced this first-hand by conducting some interviews in the ward owing to the shortage of consulting rooms. The researcher also witnessed a fight between MHCUs, which was traumatic. After each interview, the researcher had a chance to conduct member check through paraphrasing and summarising the information shared and to check whether there was any information that the professional nurses forgot to share, and that they thought would be essential to add to the existing information.

The researcher was able to commence with data analysis using Groenewald's (2004) adapted version of Hycner's data explication process. The research process was shared with the supervisors who continuously provided the support and guidance necessary to advance with summarising and compiling of results. Having to observe COVID-19 rules and regulations was also a challenge, for example, having to conduct an interview wearing a mask was a challenge in that the researcher had to listen attentively to capture what the particpants were saying. Before and after each interview, the researcher had to sanitise her hands and the participants' hands as well as the chair where participants had been siting. This study was not only beneficial to professional nurses, but it was also eye opening and a lesson to the researcher.

4.11 Concluding Remarks

In this chapter, an account is given of how the study was conducted. The following headings were discussed: study site, research methodology, research design, population and sampling, data collection, data analysis, quality criteria, and ethical considerations. It is imperative to note that research methodology is critical for the success of any study; hence, it must be conducted properly. The findings of the study will be discussed in detail in the following chapter.

CHAPTER FIVE

RESULTS

5.1 Introduction

In this chapter, the research design of the study is outlined. In addition, the findings of the data collected from professional nurses (PNs) who nurture and care for chronic mental ill patients in three Limpopo Province mental health institutions (LMHIs) is presented. The results of the study are outlined and categorised in three sections. The first section presents the demographical profile of the participants who care for patients with chronic mental illness. The demographic information of the participants includes illustrative notes, tables, and graphics. The second section consists of the primary themes and sub-themes that emerged during phenomenological data explicitation. The themes and sub-themes gathered from the study are explained in the form of illustrative notes and direct quotes and extracts. The last section highlights the summary of the results.

5.2 Demographic Profile of the Participants

One hundred per cent of the participants were professional nurses who care for psychiatric patients. Approximately 50 per cent of the PNs were in their late thirties. The age group of these nurses ranged in from 27 to 64 years. The majority of the participants were females, contributing 70 per cent of the sample. The study consisted of many married participants, a few single participants and only one separated participant. The highest level of education of the PNs was either a degree or a diploma in nursing. The PNs worked full-time in one of the following mental health institutions: Evuxani, Hayani, and Thabamoopo Hospital. The greatest number of these nurses were staying in rural areas; 20 per cent were based in the township and 7 per cent were based in town. From the feedback of the nurses, the common diagnoses of patients were schizophrenia, substance-induced psychosis, schizo-affective disorder, bipolar disorder, mood disorder, ADHD, and intellectual disability. Table 1 shows the characteristics of the PNs in details.

Table 1: ***Characteristics of Participants***

Characteristic	Number
Professional nurses	**30**
Age	**27–64 years**
Gender: **Male** **Female**	**30** **7** **23**
Marital status: **Married** **Single** **Separated**	**30** **17** **12** **1**
Qualifications	**All of the participants are professional nurses.** **Diploma= 20** **Degree = 10**
Mental health institutions: **Evuxakeni Hospital** **Hayani Hospital** **Thabamoopo Hospital**	 **10** **10** **10**
Place of residence: **Town** **Township** **Rural**	**30** **5** **9** **16**
Common diagnoses:	**Schizophrenia** **Substance-induced psychosis** **Schizo-affective disorder** **Bipolar disorder** **Mood disorder** **ADHD** **Intellectual disability**

5.2.1 Professional Nurses

The targeted participants for the study were registered professional nurses from three mental health institutions (MHIs) in Limpopo Province. The total number of PNs who were interviewed at three LPMHIs were 39. Of the 39 interviews, 30 were selected owing to their relevance and depth of content. An equal number of 10 PNs were interviewed from each mental health institution. All of the PNs who form part of the study are currently registered with the South African Nursing Council (SANC). The years of experience of the participants ranged from 2 years to 28 years of service. Amongst them, there were two operational managers who are responsible for all nurses and the daily functioning of the ward.

There were nurses who started working at these psychiatric hospitals as auxiliary nurses, then progress to becoming enrolled nurses and later qualified as PNs. This study consisted of day-shift PNs; 28 PNs were working from 07:00 to 19:00 while two were working from 07:00 to 16:30. Even though these PNs were working day shift at that time, they had previously worked nights and they were able to share some of their night-shift experiences. It is the nature and procedure of most hospitals in South Africa for nurses to work day and night shift because they provide a 24-hour service. All the nurses were permanent employees and worked on a full-time basis. Almost all of the nurses worked seven-day shifts, except two nurses who were operational managers. A large number of nurses were affiliated with some religion; with the majority (90 per cent) being Christians and 10 per cent practising the traditional African belief system. All the nurses who took part in the study were black.

5.2.2 Age

The age of the PNs who were interviewed at the three mental health institutions is between 27 and 64 years. The majority of the participants were young and still under 40 years of age. Two of the PNs were close to retirement; they were over 60 years. They decided to extend their service by five years because of their love for nursing and caring for patients. The results revealed that age did not contribute in understanding the

challenges and using healthy coping mechanisms. The understanding was the same across all age groups. Figure 6 Illustrates the age group of the participants.

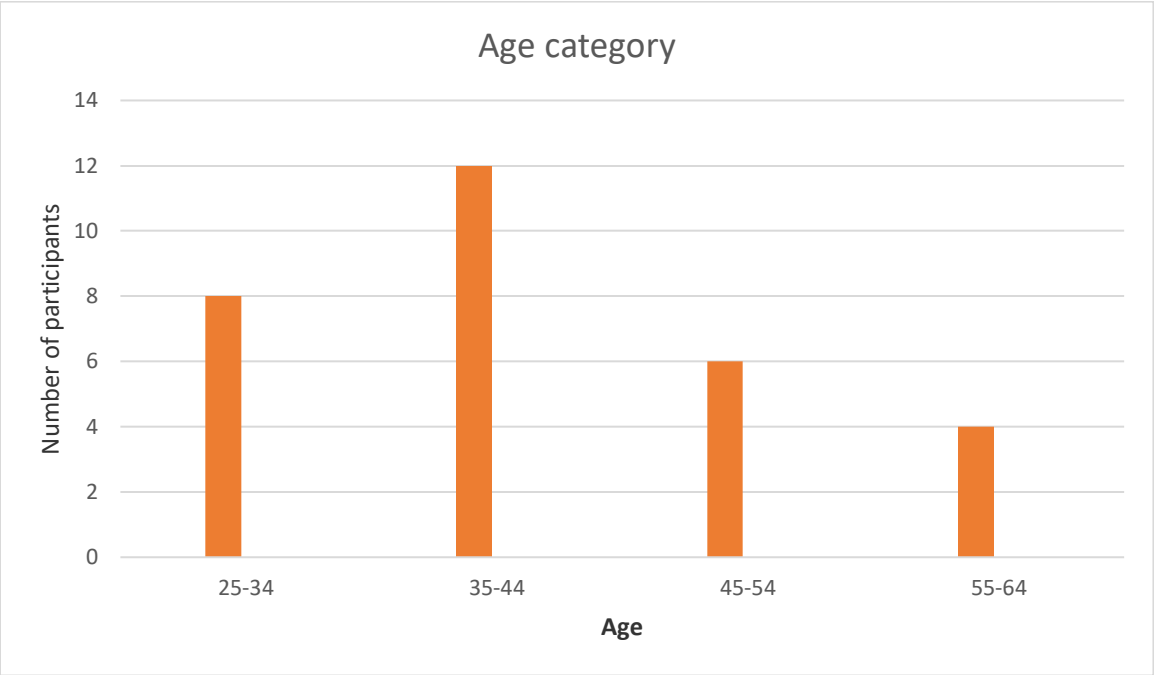

Figure 6**:** *Age Group of Participants*

5.2.3 Gender

The gender of the participants was included under demographical information with the intention to receive feedback and lived experience from both genders. The current study consisted of both males and females. However, females were the predominant gender. This is due to the fact that the population of the PNs at the three hospitals are predominately female. The study comprised 23 females and 7 males. Evuxakeni hospital had the highest number of male participants; coincidentally, Hayani and Thabamoopo hospitals had the same number of male participants. The number of female PNs at Evuxakeni was seven, at Hayani there were eight, and at Thabamoopo there were also eight. The study showed that men find the caring burden easier than women. For example, when patients become violent and aggressive, male PNs are able to handle the situation better than women. Table 2 explains in detail the gender of the participants in the study.

Table *2*: *Gender of the Participants*

Gender	Evuxakeni	Hayani	Thabamoopo	Total
Male	**3**	**2**	**2**	**7**
Female	**7**	**8**	**8**	**23**
Total	**10**	**10**	**10**	**30**

5.2.4 Marital Status

The current study included the marital status of participants under demographical information with the intention to see whether it contributes to social support systems. This study comprised the following marital status: single, married and separated. Married PNs contributed 57 per cent, single 40 per cent, and separated 3 per cent of the sample. A large number of participants had more than one child. This study results have revealed that marital status had no influence in the caring duties of the PNs.

Table *3*: *Marital Status of the Participants*

Marital status	Evuxakeni	Hayani	Thabamoopo	
	No.	**No.**	**No.**	**Total in %**
Single	**1**	**4**	**7**	**40**
Married	**9**	**4**	**4**	**57**
Separated	**1**	**0**	**0**	**3**
Total	**11**	**8**	**11**	**100**

5.2.5 Qualifications

All nurses were fully qualified professional nurses and registered with the South African Nursing Council. These PNs have a tertiary qualification. They either have a nursing diploma or a nursing bachelor's degree. General nursing, mental nursing, and community health nursing are all included in the curriculum for both degrees. In Limpopo, there are a few colleges and two universities that offer these qualifications in the field of nursing. Eleven PNs have a bachelor's degree in nursing, and 19 of the PNs graduated from Limpopo Nursing College with nursing diplomas, which they obtained at the University of Venda and the other two PNs hold a bachelor’s degree in nursing,

which was acquired at the University of Limpopo. Four PNs had extra qualifications related to the nursing field. One hundred per cent of the PNs who participated in this study were academically qualified to work and care for patients with chronic mental illness.

5.2.6 Mental Health Institutions

As alluded to earlier, there are three mental health institutions in Limpopo Province, namely Evuxakeni, Hayani, and Thabamoopo Hospital. Evuxakani Hospital is situated in the Mopani district under the Giyani municipality. Hayani Hospital is located in the Vhembe district under the Thulamela municipality. Lastly, Thabamoopo Hospital is based in Capricorn municipality under Capricorn district. Evuxakeni Hospital has five referral hospitals, which are Nkhensani, Lebata, CN Phatudu, Sekororo and Maphuta Malatjie Hospital. Tshilidzini, Malamulele, Donald Fraser, Siloam, Elim, Botlokwa and Messina Hospital refer all patients with chronic mental illness to Hayani Hospital. Thabamoopo Hospital receives patients from Makweng, Polokwane, Lebowakgomo, Seshego and Groblersdal Hospital.

These mental health facilities' main goal is to offer specialised interdisciplinary care to those with chronic mental illness who are admitted, either voluntarily or involuntarily. By recognizing mental health difficulties, preventing mental health issues, and providing care and treatment to those who have psychiatric disorders, nurses in the field of psychiatric nursing promote mental health and wellness (Standards and Scope 2006 Draft Revision). In these institutions, there are various wards that are utilised to admit patients. These wards included the forensic ward, chronic ward, acute ward, intellectual disability and ADHD ward, and the maximum-security ward. These MHIs provide users of mental health care with specialized interventions, such as care, treatment, and rehabilitation. Registered psychiatrists or medical professionals, psychiatric nurses, psychologists, social workers, and occupational therapists deliver the interventions utilizing a multidisciplinary approach.

5.2.7 Place of Residence

The three mental health institutions are located in townships in Limpopo Province. However, their service is not limited to the residents of the place where the institution is located. The majority of the PNs participating in this study were not staying far from their place of work. This study found that 78 per cent of the PNs were staying in townships, 20 per cent were staying in rural areas and 2 per cent were based in town. The majority of the nurses stay close to their workplace, within 30 kilometers. As a result, they travel to and from work every day.

5.2.8 Common Diagnoses

All the PNs were caring for patients with chronic mental illness in one of the three mental health institutions. The patients who are admitted in these hospitals have been diagnosed with one or more chronic mental illness by either a medical doctor or a psychiatrist. From the feedback and responses given by PNs, the common diagnoses, in no particular order, were schizophrenia, substance-induced psychosis, schizo-affective disorder, bipolar disorder, mood disorder, ADHD and intellectual disability previously known as mental retardation. From this study, schizophrenia was found to be the leading admission diagnostic illness. Some of the patients also had medical conditions like hypertension, diabetes, and epilepsy.

5.3 Themes and Sub-Themes

In the methodology section, the researcher applied Hycner's streamlined data explication procedure in five steps to analyze the data, as cited by Groenewald (2004), to derive main and unique themes. As a way of demonstrating what the researcher did in the first two steps of data analysis, an illustrative example is outlined (in Table 5), indicating the following: a) how bracketing and phenomenological reduction was made by the researcher (e.g., Step 1: the researchers' presuppositions and personal bias or theoretical views were suspended and she listened to all recordings of the interviews and then read the transcripts over and over again with openness to whatever meanings emerged); and b) how to delineate units of meaning (e.g., Step 2: the researcher made a list of meaningful units from each interview that are relevant and thoroughly analysed

them, discarding redundant units). For all the thirty transcripts, the researcher followed

Original transcripts	**Explanatory comment**	**Emerging themes**

this process.

Researcher: Kindly share with me your experience of taking care of a person who is diagnosed with chronic mental illness. **Participant 4**: Ayi, it's difficult. Is actually not safe, they these people are not predictable. Anything is possible with this people; they can kill you if they are angry. Our patients are smart and dangerous, and they are strong phela, you can see them. We see their bad side when they relapse. Haaa, if they relapse, you will see things, it's hard, you will sweat to stabilise them. That's why in my opinion, women should not work in this ward. Only men must work here, not in a bad way, I'm not undermining women, but this place is like hell, is not good for them. All these patients that you see here, have committed crime, all of them, that's why they are here. So, this place is not safe, we just work because we have to. You must have a heart to work here.	Unpredictable and dangerous behaviour of patients Bad behaviour because of relapse Working in psychiatric wards is not good for female nurses Patients have committed criminal offences	Indication of safety issues Challenges when patients relapse Ill treatment from patients Forensic patients

Table 4: *Data Analysis – An Illustrative Example*

After going through steps one and two of data analysis, the researcher then interrogated all of the emerging themes to look for relationships that could be established. Findings from clear data explication process (Hycner, 1999) result in six primary themes and

twenty-four sub-themes. The units of pertinent meanings that were isolated during the explanation of each interview will be integrated into the themes and sub-themes that are given. The following main themes were identified: a) the nature of chronic mental illness, b) professional nurses' phenomenological experiences, c) challenges experienced by PNs, d) coping mechanisms used by PNs, e) support structures and programmes for PNs, and f) suggested support programmes for nurses.

One theme is associated with theme 1: common diagnoses. Eight sub-themes were further associated with theme 2: a) general experiences of the PNs, b) receiving and giving reports, c) personal hygiene, d) morning devotions, e) health education, f) giving patients medication, g) physical assessment, h) administration tasks. Six sub-themes are attached to theme 3: a) shortage of staff, b) lack of support, c) safety and security problems, d) lack of incentives, e) shortage of resources, and f) shortage of treatment. Sub-themes were further associated with theme 4: prayer, b) belief in God, c) teamwork, d) self-counselling, and e) absenteeism. Four sub-themes are attached to theme 5: a) family support, b) support by colleagues and supervisors, c) psychological support, and d) general social support. Steps1–5 in the data analysis, methodology chapter guided this process. All these themes and sub-themes are tabulated in Table 5.

Table *5*: *Themes and Sub-Themes*

Themes	**Sub-Themes**
1. Nature of chronic mental illness	Common diagnoses
2. Professional nurses phenomenological experiences	2.1. General experiences of the PNs 2.2. Receiving and giving feedback or reports 2.3. Personal hygiene 2.4. Morning devotions 2.5. Health education 2.6. Giving patients medication 2.7. Physical assessment 2.8. Administration task

3. Challenges experienced by PNs	3.1 Shortage of staff 3.2. Lack of support 3.3. Safety and security problems 3.4. Lack of incentives 3.5. Shortage of resources 3.6. Shortage of treatment
4.Coping mechanisms used by PNs	4.1. Prayer 4.2. Belief in God 4.3. Teamwork 4.4. Self-counselling 4.5. Absenteeism
5.Support structures and programmes for PNs	No formal support structures and programmes available except union forums, monthly meetings, and nurses' day
6. Suggested support programmes for PNs	6.1. Family support 6.2.Support by colleagues and supervisors 6.3. Psychological support 6.4. General social support

5.3.1 Theme 1: Nature of Chronic Mental Illness

In the present study, it was found that all the patients admitted in the three mental health institutions have been diagnosed with one or more chronic mental illnesses. Hence, PNs who care for patients with some of the above-mentioned disorders were interviewed.

5.3.1.1 Sub-Theme: Common Diagnoses

Although the three mental health institutions are situated in different districts, the results indicated that they share common admission diagnoses. These diagnoses include schizophrenia, substance-induced psychosis, schizo- affective disorder, bipolar

disorder, mood disorder, intellectual disability and ADHD, as reflected in the extracts below:

> *It's mix up; we have substance induce, schizophrenia and mood disorders, so is mix up.* (Participant 4, age 36, male).

> *In female acute; we are having schizophrenia, bipolar disorders, and then some major depression.* (Participant 22, age 27, female).

> *We have schizophrenia, we have bipolar mood disorder, we have depression.* (Participant 21, age 64, female).

> *Schizophrenia, bipolar, mood disorder, substance-induced psychosis, yes, and schizo-affective.* (Participant 28, age 30, female).

As outlined above, all of the patients admitted in these three mental health institutions have some kind of chronic mental illness. However, the most common admission diagnosis was reported to be schizophrenia.

> *It ranges from schizophrenia, schizo-affective disorder. We also have BMD; we have two or three of them but mostly is schizophrenia. We also have mental retarded patients; these ones can't bathe themselves totally.* (Participant 2, age 47, female).

> *Most of them is schizo, schizo plus diabetes. Others is caused by abuse I mean this what do you call drug abuse; but most of them is schizophrenia.* (Participant 12, age 46, female).

> *Most of them; they are schizophrenic, some are bipolar.* (Participant 30, age 30, female).

Some are diagnosed with a schizophrenia, some usually we have schizo-affective, but majority have schizophrenia. And others because of age, they have hypertension and diabetics. (Participant 25, age 30, male).

As if caring for patients with mental illness is not enough, the findings of this study discovered that PNs also care for patients with dual diagnoses. Some of the patients have extra diagnoses on top of the chronic mentally ill diagnosis. PNs stated that some patients suffer from medical conditions, which put more pressure and additional work on the nurses. These medical conditions include hypertension, diabetes, and epilepsy. Now they have to give patients medication for mental illness and for other medical conditions. Patients with dual diagnoses would take more drugs than the ones with only one diagnosis and require the presence of a nurse.

Some of these patients have medical conditions like hypertension and epilepsy. (Participant 10, age 55, female).

Some of them have this schizophrenia patients but they also have medical cases like diabetes and blood pressure. (Participant 11, age 56, female).

Schizophrenia, mental retardation and other medical conditions like hypertension, diabetics, epilepsy. (Participant 16, age 29, female).

Nurses who participated in the study revealed that almost all patients are not ordinary mentally ill patients; they have committed some form of offence. After committing an offence, the patients were evaluated, then declared mentally ill by a panel of health professionals. The fact that these patients committed criminal offences indicate that they are dangerous to the nurses and to fellow patients. The nature of offences that most patients committed are as follows: murder, rape, destroying of property and stealing, to mention a few.

Others, you find that maybe they burn the houses; others they even killed people. Others, they killed their parents, mothers whatever. (Participant 12, age 46, female).

That's all we have; in state patient, some of them committed murder, attempted rape and then destruction of properties. And some are those who used to steal and assault. (Participant 11, age 56, female).

Any state patients are those patients who did maybe killed people; ja, they commit this huge crime. But Invo maybe they have committed this malicious damage. (Participant 12, age 46, female).

But this ward is not the same as other wards because patients who are in here are only males and they have committed lots of things. Like dangerous things, that's why they say it's a closed forensic ward. In other words, is a maximum ward, where they keep people who have murdered people, raped. They did a lot of things like house robbery, a lot of things, many. Everyone you see here; they have been charged. They were supposed to be doing time in prison, that's why they have classified them as state's patients. They are the property of the state, ya. They are not fit to stand trial. (Participant 27, age 32, male).

The three MHIs in Limpopo admit patients on a voluntary and an involuntary basis. These patients are divided into various categories or wards depending on their diagnoses.

It's forensic ward, it falls under maximum. These patients that are here; they are transferred from maximum most of them. We have state patients and involuntary patients. (Participant 12, age 46, female).

We admit others from the holding cells; like those who are maybe declared involuntary mental health care user or those who are aah the forensic, state's patients, yes. And then again, we are seeing also the observations patients. We just used to say observations patients, but we know they are patients, they are observatics. (Participant 24, age 60, female).

Yes, it's a forensic ward, is like that one of maximum and the semi-closed. (Participant 11, age 56, female).

They are only divided in home, according to their diagnoses. (Participant 21, age 64, female).

In the above-mentioned excerpts PNs reveal that all patients admitted in these MHIs have been diagnosed with one or more mental disorders, schizophrenia being the more prevalent diagnosis. In addition to the psychological diagnosis that the patients have, they suffer from other medical conditions. Some patients are admitted on a voluntary basis while others on an involuntary basis. One other notable factor is that the majority of the patients have committed criminal offences. As a result, these nurses are afraid.

5.3.2 Theme 2: Professional Nurse's Phenomenological Experiences

The second theme that emerged from the PNs' responses is the phenomenological experiences of PNs.

5.3.2.1 Sub-theme 1: General Experiences of the Professional Nurses

Generally, it is not easy to care and look after a sick person. More often than not, nurses are the primarily caregivers of institutionalised mentally ill patients and are in contact with these patients on a daily basis. The results of this study highlight that caregiving for chronically mental ill patients is an emotionally intense and physically demanding experience, which is characterised by constant stressful demands. The majority of the PNs expressed the caring burden to be challenging and difficult. This is captured by the extracts below:

Heyiiii (takes a deep breath) is so difficult; those patients are difficult, mara but we are trying by all means to handle them. Just because some of them are stable on treatment, ya but them are difficult, so difficult. (Participant 11, age 56, female).

So, giving the care like I was saying is difficult; you are thinking for a person who is not thinking straight for themselves. Giving him care, who doesn't need it, who seems like he doesn't need care much. (Participant 15, age 34, female).

It's very challenging and what can I say? I can say it's very challenging cause most people have stigmatised these patients. (Participant 20, age 28, male).

Initially, the PNs found the caring duty to be hard and draining. Some of them were scared and even terrified by chronic mentally ill patients. But as time went by, they began to adjust and enjoy caring for these patients. Numerous PNs started to know and understand the patients; and developed a good nurse–patient relationship. Moreover, they found ways of dealing with and handling them in cases where they relapse and become violent or aggressive.

At first it was not easy because if it's you first time being exposed to psychiatric patient and then with the stigma that they come with being psychotic, you will develop fear. But at the same time, you will laugh when they do those crazy things. But as time goes on, you know you start to develop a feeling of settlement. (Participant 25, age 30, male).

Aaaah, we no longer fear anything. But at first, you will have some fear ku yhoo; what if they become aggression but for now, we are used of working with them. And we have the strategies, we know if the patient is relapsing, we know the anti-psychotic drugs that we can give them to be stable, to sedate them, yes. (Participant 29, age 44, female).

Well, at first it was tough, but you end up getting used to it. (Participant 17, age 28, female).

She laughs, at first you will be like scared, but you get used to them. You get used to them and develop that love and take them like your own children. (Participant 29, age 44, female).

In addition, caring and nurturing chronic mentally ill patients is demanding and one must have passion and love for it. Professional nurses interviewed in this study outlined that it takes a lot of courage to look after patients with chronic mental illness. They further stated that one must be passionate and have a heart for it, considering the fact that it is challenging. This is supported by the following extracts:

Hiiiiii, is not nice, it's hard. Yho, you must have a heart for it. (Participant 1, age 38, female).

*Is not easy, you need to have a heart for it or else you will not make it. (*Participant 2, age 47, female).

Haaa, is not easy, it's tough. These people, you don't know them, they can be difficult sometimes. Not every day but is not easy to nurse them. (Participant 6, age 35, male).

The findings of this study revealed that nursing and caring for chronic mentally ill patients is not safe. In recent years, we have seen an increase in violence towards nurses over the news and social media. Currently, the caring and nursing of psychiatric patients has become dangerous and risky. The fact that they are unpredictable and unstable makes the nurses anxious. See excerpts from participants below:

It's difficult. Is actually not safe, these people are not predictable. Anything is possible with this people; they can kill you if they are angry. Our patients are smart and dangerous, and they are strong phela, you can see them. We see their bad side when they relapse. (Participant 4, age 36, male).

… dangerous. We are always closing and locking the door. They are not predictable these people. (Participant 18, age 56, female).

Few PNs find caring for chronic mental ill patients not challenging. They prefer caring for chronic mentally ill patients than for ordinary patients that are less complicated. For some it is because they naturally love taking care of ill people while for others is having the right education that makes the caring burden easy. This is captured by the following extracts:

It's good (she laughs), it's good. Is just that you need the skill; ja, you need the skill. Especially if you know the patients, haaaa, is not a problem. (Participant 12, age 46, female).

I'm enjoying it because from the beginning, from the age of five, I loved to help those who couldn't help themselves. I loved to even feed olderly people, I liked to bath them. When I was at primary and high school level; I used to fetch wood for the cripples and old people, even if they had children. (Participant 21, age 64, female).

This one is nice. Taking care of mental is good because these ones are patient, you see. They don't know too much; they depend on you. The other patients is very difficult to nurse a normal patient than mental ill patient. They don't have problems, it's nice. But the normal patient, you can treat them and they say you didn't treat them nicely (she laughs). Then they take you to court and you lose your licence. So, this one is nice, you work freely. (Participant 23, age 45, female).

In the same study, some PNs expressed mixed emotions about the caring burden. The feelings of these nurses are subjective and depend on many things such as wards, patients, days. Depending on the days and patients, some find the caring burden hard while others find it easy. The following extracts are examples of this point:

Depends on days (she laughs). Other days is quiet is fine. But some days is tough cause this people, aaaa they change like weather. Basically, some days is fine but some days you might find that some of them have relapsed, so it's hard. (Participant 16, age 29, female).

No, is quite challenging, but since well I like psych, I don't have a problem with it. We will always be up for challenges because their thinking is not normally as compared to ours. So, sometimes is very challenging, ya. You encounter different thing, like every patient has a different personality, behave is different. So, you have to be always up for challenges. (Participant 22, age 27, female).

Is not that bad. It depends on days, some days are better, other days are worse. Some days, they will be fighting each other, not listening and just behaving bad. But likeIi said, it depend but is not easy, it's hard sometimes". (Participant 3, age 37, male).

A notable number of PNs find the caring burden to be physically strenuous. The nursing profession and the duties of nurses are strenuous and demanding in nature. The working hours and types of duties involved in nursing are physical demanding and require a lot of energy. Some of them experience physical pain as a result of caring for the chronic mentally ill patients. They suffer from backache from carrying and turning bedridden patients. The backache might also have emanated from long working hours and from standing for most of those hours. This is what participants had to say:

Every day when we go home, we are tired, we work very hard in this ward. (Participant 30, age 30, female).

This job is strenuous, some of the nurses they complain of backache. I think it is because of standing the whole day and turning patients. (Participant 2, age 47, female).

We don't sit down here, there is a lot of things that we have to do. So, when our off days comes we are tired, we just want to go home and rest. Here you can't rest, when is time to feed, you have to feed, when a patient has a problem, you have to solve it, even if you are tired. (Participant 18, age 56, female).

While caring for patients, PNs experience psychological trauma. The psychological trauma involves both patients and nurses. These psychological traumas include the relapsing of patients, the death of patients and nurses, and the attack of a nurse by patients while rendering care. The nature of death plays a vital role in the healing and recovery process. See the following statements to support this notion:

And when we saw him, we could tell he is not fine, then the following day he passed away. (Participant 10, age 55, female).

Yes, we got in and we forgot to lock. Then she came in, about to hit me with that steel. That's when I put my head in the fridge as a way of protecting myself (both laugh). But they managed to stop her and give her treatment. So, we are at high risk. We are at higher risk of getting injuries. (Participant 9, age 50, female).

Unfortunately, when they were not aware; nurses and securities, he comes and hit that woman three times. And that woman falls and died at the same time. (Participant 11, age 56, female).

Here in the ward, he just hanged himself in the toilet, we don't know why. (Participant 6, age 35, male).

Since the nature of the jobs of these PNs involves trauma, psychological services like counselling and debriefings are essential and beneficial to victims after a traumatic event. It is often offered to victims of trauma, meaning the people who were directly involved and affected. These psychological services are often facilitated by psychologists. This is captured by the excerpts below:

We only saw a psychologist in 2018, after that patient that committed suicide here in the ward. So, management organised counselling for us. A psychologist

from Letaba came to see us, aniri we didn't have a psychologist here. Ende it really helped but support we don't have. (Participant 3, age 37, male)

… but there was a time where one of the nurses was contaminated with COVID virus; the psychologists came to see nurses. (Participant 12, age 46, female).

I remember only once, after the death of the staff that was beaten by a patient. The only time that we were invited to the main hall, and they briefed us. That was about it, never again. (Participant 11, age 56, female).

But that debriefing, they only conduct debriefing when a staff has passed away, you see. If someone just pass away, they call us and do it. (Participant 19, age 45 male).

As stated earlier, the caring burden is demanding and strenuous on PNs. More so, owing to extra nursing and non-nursing duties that they have to do on a daily basis. On a daily basis, there are tasks over and above their regular duties that PNs do to offer holistic treatment to patients. Some of these duties are nursing related; others are not. The ones that are not in their scope of practice like bathing, calling and tracing families and so on are due to challenges like shortage of staff and family rejection. The current study discovered that the daily routine or duties of PNs in the three psychiatric hospitals includes giving and receiving reports from and to night staff, personal hygiene of the patients, administration of medication, morning prayer, health education, and administrative tasks. The above-mentioned daily routine or duties of PNs will be discussed below.

5.3.2.2 Sub-theme 2: Receiving and Giving Reports

The first and foremost thing that participants do every morning is to receive reports from the night staff. This report comprises the patients' physical and mental state. The night staff outline the challenges experienced at night and the overall well-being of the mentally ill patients. The purpose of this process is to offer and promote holistic treatment to patients during the day. In the evening, before these PNs knock off, they also give feedback to the night staff on how the patients were doing during the day. This

feedback involves incidents that happened, any complaints from the patients, doctors' feedback and so on. This is seen in the following extracts:

> *We start by getting report from night shift, how everyone slept. If ever there is something we need to carry out.* (Participant 20, age 28, male).

> *Our daily routine, in the morning, we receive report from night staff.* (Participant 19, age 45 male).

> *After that, like I will write the progress report. How the patient is doing, if they slept well, if they are having any problem.* (Participant 17, age 28, female).

5.3.2.3 Sub-Theme 3: Personal Hygiene of Patients

The current study discovered that PNs are involved in maintaining self-care and hygiene of mental health patients. This study found that some patients cannot maintain their self-care and personal hygiene. As a result, the nurses have to help them with basic personal hygiene like making up their beds, bathing and dressing, applying lotion, dishing up food and feeding them. According to the professional nurses participating in this study, their scope of practice does not include personal hygiene of patients, but they find themselves doing it. This is due to logistical challenges like the shortage of nurses. For them it is an over-and-above task for which they are not even compensated. According to them, personal hygiene of patients is not the responsibility of PNs. However, the present study discovered that 90 per cent of the PNs take care of patients' personal hygiene. The following excerpts support this statement:

> *In the morning, they do personal hygiene, some of them need assistance. Some of them they do by themselves, aaaaa. After that, is then that we give them clean hospital attire. We make sure they don't wear their own clothes.* (Participant 11, age 56, female).

> *We when arrive in the morning, we take report from night staff, and then, we undress them so that they can bathe. Some of them are clean, they have wash,*

so we bathe the ones that are bedridden. So, we bathe then, apply lotion, we do that whole bathing process. (Participant 10, age 55, female).

You know these patients don't know how to do anything, so we start by bathing them. Totally, personal hygiene. After that, we making the beds, but there is that one who can't get out of the bed. She is helpless, she don't know how to do anything, she just stay in the bed. Then the others after bathing, we give them clothes to wear. (Participant 23, age 45, female).

5.3.2.4 Sub-Theme 4: Morning Devotions

In this study, the researcher discovered that PNs do not only cater for the patients' mental well-being but that they also nurture their spiritual well-being. This study found that PNs conduct morning devotions for patients every single day. Nurses indicated that they conduct morning devotions every morning in various wards. Both the nurses and patients form part of the morning devotions. The report from PNs mentions that the morning devotions can take about 15 to 30 minutes or longer, depending on wards and patients, but the patients really enjoy every moment of it and benefit from it. This is captured by the following extracts:

Our daily routine is in the morning, we take report. After taking report, then we go for morning prayer, a short morning prayer. (Participant 30, age 30, female).

After taking report, we have a morning prayer. (Participant 4, age 36, male).

When we get to the assembly area, we have prayer, every day. We read the Bible, then we prayer, all of us. (Participant 8, age 35, female).

The morning devotions comprise prayer, singing of gospel songs and preaching of the word of God. In these prayer meetings, more often than not, the patients lead the prayer while nurses listen and supervise. In many MHIs, patients are given an opportunity to pray and preach to the nurses and fellow mentally ill patients. The PNs in the present

study revealed that the patients understand better when one of them is preaching. They actually prefer to hear their mates preach. This point is in line with the following excerpts:

> *We read the word of God and explain it. They also enjoy singing, they will sing. Because they are slow, they are the chronic, we take longer time than the other wards. In the other wards, they only last for 15 minutes but we take up to 30 minutes. Because sometimes when you say it's over, someone, she will pitch a song and u cannot say I said is over. We would just have to sing with her.* (Participant 21, age 64, female).

> *Is a full service; eee. Then we have someone to preach for us and we pray. Like our patients can preach because most of them have this Christian background. They do know some Bible verses, so we give them an opportunity to teach everyone. As patients themselves, they do understand better when they are being taught by other patient.* (Participant 15, age 34, female).

5.3.2.5 Sub-Theme 5: Health Education

As part of their work allocations, PNs conduct health education on a daily basis. PNs conduct health education where they teach chronic mentally ill patients about health-related matters. The health education offered by PNs involves basic topics like anger management, conflict management, how to behave in the ward, COVID-19 and many more topics. The health education is aimed at empowering patients, preparing them for life after discharge, to help them connect with the world, and to know what is happening outside the mental health institutions. The health education also focuses on basic or general topics and illnesses that are current and trending. This is captured by the extracts below:

> *Then we give them mini education of which nowadays is about COVID. It might happen that we have another one but that one will be to add the first one is COVID-19. Just to make them know what is going around.* (Participant 15, age 34, female).

After a morning prayer, hmmmm, we have a meeting with the mental health care users. So, in that meeting, we teach them. In our ward, we have a programme that we must follow, so everyday there is a topic, we call it 'topic of the day'. So, we follow the programme, we teach what is in the programme. (Participant 4, age 36, male).

In some wards of the MHIs, nurses help patients to cultivate their personal development, skills and growth. With the help of the nurses, patients do the following for personal development:

They do gardening, some are busy cutting those old sponge. They clean them, and then cut them into pieces and make pillows" (Participant 13, age 47, female).

Some patients also plough mealies, vegetables and plant the seeds of the fruits they ate. (Participant 13, age 47, female).

I think they are teaching them how to do gardening. Akiri, OT is all about independence, kuri when you leave here, will you be able to work on our own, nah. They teach them about gardening, they make sure that is fine and is watered. (Participant 17, age 28, female).

5.3.2.6 Sub-Theme 6: Giving Patients Medication

Furthermore, part of the PNs' daily routine also involves administering treatment to patients. The treatment can be in a form of tablets or injections. Every day, PNs give patients medication at a specific time prescribed by the doctor. The timing of the treatment differs: some get it in the morning, others during the day, and others at night. This treatment is not only psychiatric treatment since some patients also have medical conditions. This is supported by the following excerpts:

We didn't have afternoon medication nowadays, we give them 9h00 and 21h00. If there is medication in the afternoon, maybe is antibiotics, 6 am, 14h00 and then in the evening. (Participant 18, age 56, female).

And then, from 9 o'clock, is time for medication, we administer medication. After medication, immediately after medication, we give them breakfast. (Participant 19, age 45 male).

Mostly patients here they only get medication in the morning. They only get medication two times a day, it's BD. We give them 9 in the morning and 9 later on. (Participant 16, age 29, female).

While administering medication, PNs encounter challenges like patients refusing medication. In this study, PNs revealed that patients hide medication under their tongue, some put it under their pillows and others vomit it into the toilet. However, the PNs initiated a strategy for dealing with this problem. They monitor and supervise the patients, and physically check whether the patients have indeed taken their treatment. As a way of dealing with this problem, the PNs double check with patients whether they have swallowed their medication. Apparently, this method is working and reduces the chance of patients relapsing. This is congruent with the following extracts:

Other challenge is when we give medication; we must make sure they swallow the medication because some of the patients hide the medication under their tongue. (Participant 11, age 56, female).

Sometimes you find that we can give them, they can put it inside the mouth but hide it somewhere (both laugh). We have to make sure that there are others who are monitoring them. We they have finished to drink medication; we force them, order them to open their mouth in order to make sure they have swallowed the medication. Sometimes if you can't observe them taking the medication; you can find other tablets, other medication under the pillows. So sometimes you can mind why they are relapsing, whereas they are not taking the medication. So, we have to make sure we are observing them; so, we order them to open their mouth, ja. This people, they are ill, but they are clever (both laughing). (Participant 12, age 46, female)

After that we give them treatment one by one. Then we make sure that whoever we are giving medication to he must open the mouth, play around with his tongue so that we can see they didn't hide any treatment. It's a tendency of mental health care users to hide some medication. After taking it, after they would say can I go to the bathroom so that he can vomit it, he can split it out. (Participant 15, age 34, female).

5.3.2.7 Sub-Theme 7: Physical Assessment

Physical assessment forms part of the duties that PNs do as a daily routine. PNs who participated in this study revealed that they do physical assessments for patients. The physical assessments are done during the week, not on weekends. Owing to the high number of patients, physical assessments are done throughout the week. Every day, new patients are seen by the doctor. The PNs, with the help of other nurses, divide patients into an equal number of groups and allocate dates and times for physical assessments. By the end of the week, all of the chronic mentally ill patients have been physically assessed. The following extracts capture this statement:

I will write what need to be written and also physical assessments. We don't do physical assessment in one day, we do it throughout the whole week, Monday to Friday. We divide them into groups, by the end of the week everyone must have done physical assessments. (Participant 2, age 47, female).

We do weekly assessment. We divide our patients according to the week, so we know who is doing assessments when. The patients also know when is their assessment. Like now, we have 27 patients, so we schedule them according to the days of the week, just like that. But weekends we don't do weekly assessment. (Participant 10, age 55, female).

We do weekly assessment, at the same time I have to order medication, drugs, surgical or general. I also have to check in the notice board what is due for that day. (Participant 1, age 38, female).

5.3.2.8 Sub-Theme 8: Administrative Duties

Lastly, on a daily basis, the PNs participating in this study are expected to do administrative duties. PNs highlighted that they have to do a variety of administrative tasks in the ward. These administrative tasks are both nursing related and non-nursing related tasks. Nursing-related administrative tasks include writing reports, ordering medication, attending meetings, compiling statistics, ordering drugs, writing patients reports and leave of absence reports, and many more. Calling and tracing the relatives of the patients and buying stuff for patients are some of the non-nursing related administrative tasks. This is supported by the following excerpts:

Daily, I do general management of the ward. As a unit manager, I make sure that all the duties are delegated and acknowledged by subordinates, the people under me. And I also do my duties according to my delegation" (Participant 7, age 29, female).

So, during the day is basically just paperwork; asking them, checking whether they are fine, any relaptic behaviours and record everything. And there are those days where you deal with ordering drugs and other stuff. (Participant 16, age 29, female).

I see to it that patient care is going well, all the nurses who are on duty are all here and we have all the stock in place. Actually, my work is here in the office, admin and those things. (Participant 9, age 50, female).

... I do administration. I do all the administration of this ward, I mean records of the ward, submission of leave and claims of the nurses. And I also do stats, after and submit it. (Participant 5, age 51, female).

Some of the PNs do administrative tasks over and above their duties owing to the shortage of staff. On a daily basis, PNs do administrative tasks that were supposed to be done by ward managers. In addition to patient care, these nurses are also expected to do ward manager duties. The ward manager's administrative tasks include attending meetings, making rosters for all the nurses,and submitting claims and overtime for nurses. See the extracts below:

> *Usually, we take report from night staff. After taking report, I sign the register, I sign the report book, I sign for it and write delegations.* (Participant 8, age 35, female).

> *Like in this ward, we don't have nursing operational manager. Like the other wards have operational manager who is doing the paperwork. I'm doing patient care but now I'm doing paperwork and patient care. You know, is difficult. Now I have to write reports and send to nursing manager. And if the patient is complicating, they call you 'sister come, there is a problem'.* (Participant 23, age 45, female).

> *By that time, we will be busy in the ward with admin, reports or stats that needs to be done.* (Participant 6, age 35, male).

From the deductions drawn from extracts on lived experiences shared by PNs, it is clear that people are different and do not react the same way even in similar environments. The current study was able to capture various feelings and emotions about the experiences of PNs. Although they had different experiences, it was notable that the large number of these nurses have challenges while caring for patients.

5.3.3 Theme 3: Challenges Experienced by Professional Nurses

Challenges faced by PNs was seen as a third theme. The caring burden is stressful and demanding for the nurses. In the present study, PNs encountered a variety of

challenges while caring for patients with chronic mental illness. These challenges are related to patients, their families, staff members, supervisors, and the hospital at large. Challenges that PNs experience in mental health institutions are shortage of staff, rejection, shortage of resources, shortage of treatment for patients, physical and verbal abuse, safety and security problems, and a lack of incentives. The above-mentioned challenges will be discussed in detail below.

5.3.3.1 Sub-Theme 1: Shortage of Staff

PNs interviewed in this study also reported shortage of staff. Of PNs, 95 per cent highlighted experiencing shortage of personnel in the three mental health institutions. The ratio between patients and nurses is not proportional, which makes the caring burden very strenuous and overwhelming. In addition, some nurses have to be at work earlier in order to cover and assist the other nurses. The following excerpts exemplify this particular sub-theme:

> *Shortage of staff obviously. Like in our shifts, there is a day, ani we come back on Wednesday. Then from Wednesday to Saturday, each person has to go home by 11, normally we work 7 to 7. There is just that day where you have to knock off at 11. Because of shortage of staff, you find that some of us are not knocking off. They will go and we will remain. So, shortage is a problem. Myself I have to sacrifice almost every shift.* (Participant 16, age 29, female).

> *Another challenge is, aah, shortage of staff, which is a national problem, I don't even want to talk about it. For example, in this ward we have 5 nurses and 40 patients, so it's hard. How are five nurses supposed to take care of 40 patients? Is not possible, but it's happening here. The government is not hiring nurses.* (Participant 3, age 37, male).

> *Our challenges is shortage. We don't have enough staff and that's our biggest challenge. Like now we are 7, i mean nurses and the patient are 27. Those numbers don't match.* (Participant 10, age 55, female).

Shortage of male staff has been found to be a continuing factor for these PNs. As indicated earlier, the population of nurses in the three MHIs is predominately female. Consequently, male PNs are fewer and in high demand. According to female participants, male nurses are needed and play a vital role in assuring their safety. The following behaviours have been observed by female nurses when a male nurse is present: patients are cooperative, less aggressive and violent, and behave well. Even though it is the policy of some psychiatric wards for female nurses to work with female patients and males with males, the majority of the nurses do not agree in that they see the need to have both females and male nurses in one ward. This policy was established after a few cases of sexual assault, where male nurses were accused of sexually assaulting female patients. Considering the shortage of personnel, this policy can only be theoretical but not practical. For safety and security reasons, female PNs in male wards prefers to work with male nurses. This is supported by the following extracts:

> *Challenges is the time when they fight each other; sometimes as a woman you find that i…(laughs) it needs males and even manpower. Because I can't go inside them and try to help. it's difficult. They know that we ladies don't have much power than them; even if he is trying to do something, maybe you are trying to speak with and say don't do that, he can be harsh.* (Participant 12, age 46, female).

> *So, if we have more males and few females, it will be better because males are needed in this ward because they are patients who did crime like murder, rape. So, if there are more male, we are afraid as females.* (Participant 13, age 47, female).

> *Our problems as nurses, but is a general problem, shortage of staff. Especially males' staff. Because these people, they are mental health users, you can't predict them.* (Participant 15, age 34, female).

PNs caring for patients with chronic mental illness at the three mental health institutions are not only experiencing a shortage of nurses but also a shortage of other multidisciplinary staff members. Like in any other hospital setting, multidisciplinary professional team members play a significant part in ensuring patients' holistic treatment. However, this often not so in many public and rural hospitals. In these MHIs, the multidisciplinary staff that are not available or that are insufficient are psychiatrists, social workers, and psychologists. And general staff members are also not enough. This is captured by the excerpts below:

> *We don't have a psychiatrist also; we only have GPs.* (Participant 4, age 36, male).
>
> *Another challenge, when we do doctor's rounds, all MDT members are supposed to be there but is not like that here. Doctor's rounds are for nurses and doctors.* (Participant 6, age 35, male).
>
> *Another challenge is for cleaners; here in the ward if you can see today the patients themselves, they only cleaned around the corrido. There is no cleaner; the one that cleans she is sick.* (Participant 13, age 47, female).

In addition, the results of this study indicated that shortage of PNs is a serious problem, which causes a lot of stress and strain on these PNs. Owing to personnel shortages, nurses are forced to do tasks over and above their duties. Out of sympathy for patients and their colleagues (staff and auxiliary nurses), PNs end up bathing patients, feeding them and carrying some of the bedridden patients and those who are unable take care of their basic needs. This is in line with the following excerpts:

> *And we also have shortage of staff, I mean nurse, we are not enough. As a professional nurse, I also bathe patients which I was not supposed to, but I do it because we don't have enough staff. Normally a professional nurse does not bathe patients, but here we do.* (Participant 1, age 38, female).

Another challenge is that one of shortage of staff. We also bathe patients as professional nurses because we don't have enough nurses. We are not enough at all. Aniri, some of our patients are bedridden, we have to turn them time and again, so the other nurses cannot do it alone, we help them. (Participant 2, age 27, female).

The above extracts suggest that professional nurses encounter enormous challenges while providing care to patients with chronic mental illness. They provide care for patients. Nurses are expected to do more nursing, and non-related nursing duties because of the shortage of staff. They are expected to provide optimal care to patients with a low number of staff, which increases their stress levels and makes the caring duties not easy. Consequently, these nurses feel overwhelmed and tired, which ultimately has a negative impact on patient care. Based on the above extracts, it is clear that the shortage of staff is a massive problem in nursing practice.

5.3.3.2 Sub-Theme 2: Lack of Social Support

Lack of social support systems directly affects patients and indirectly affects PNs. The reason for this is that these nurses are the primary caregivers of these patients and are responsible for their entire well-being. Rejection has been found to be one of the social supports that patients have, and it is a common challenge in these three mental health institutions. The kind of rejection that patients encounter is classified into two categories, namely family rejection and community rejection. These two categories will be discussed below.

5.3.3.2.1 Family Rejection

This study discovered family rejection as a second common challenge amongst the three MHIs. There are many chronic mentally ill patients who face rejection from their families and relatives and who have not seen their family members for many years. The family members do not contact them, either by calling them or visiting them. The PNs feel that the families have cut off these patients and they do not exist to them. When families reject or abandon patients that automatically puts more strain on the nurses. They feel that mental health institutions have lost their original purpose and have become a dumping area for chronic mentally ill patients. The PNs treat the patients and

they become stable, ready to go home but there is no custodian to receive them. The following excerpts exemplify this specific sub-theme:

> *Because in most cases we are not only dealing with the patient alone. We are also dealing with family rejections, ja, most of them are rejected by their families. So, now is the thing of, a patient has been here and have not seen the family for a long time. Wena, you will do your part and give medication and stuff but at the end of the day they need support and be reunited with their families.* (Participant 4, age 36, male).

> *Relatives, family of these patients are a problem. They don't want to visit them; they don't care about them.* (Participant 5, age 51, female).

> *The family is the one that gives us challenge because most of them they don't want these patients. Some of them they qualify to get LOA, but they don't want them.* (Participant 14, age 40, female).

In addition, there are many patients in institutions who have being admitted for many years. They are mentally stable but there is no family member willing to take them home, which results in a shortage of space in the ward. These patients are occupying a space of someone who is mentally ill and needs assistance. This is supported by the following comments from participants:

> *Some over 30 years; some of them were here before I was even born (she laughs).* (Participant 16, age 29, female).

> *We have many patients here who have not seen their relatives in many years. Others maybe over 10 years. We call them but they don't come.* (Participant 5, age 51, female).

You may find that the patient has been admitted in the 1990s or vho 2000 and they didn't even have a visitor. (Participant 11, age 56, female).

Most of these families reject the patients because of what they did prior to admission. The PNs think the rejection emanates from the kind of offences the patients have committed. Maybe the families are afraid of their loved ones. See the extracts below:

Cases like murder, rape all those kinds of cases. So, if ever he has murdered his own father or someone within the family, they are scared of him. So is very difficult to accept him back. (Participant 20, age 28, male).

The challenges here that we have is the problem of relatives sometimes. Some of the relatives reject those patients. I think they are afraid of what they have done, eeee. They reject them; even if we do home visits, some of them don't want to be with the patients. (Participant 11, age 56, female).

Some patients are rejected by their families. We will want to discharge the patient, the patient is fine and he can go home but when we call the family, they don't want him. Others can even tell us that they don't want him. (Participant 6, age 35, male).

5.3.3.2.2 Community Rejection

The findings of this study indicate community rejection as another challenge for PNs. PNs interviewed in this study stated that most community members tend to reject patients with chronic mental illness. Like family rejection, community rejection is sometimes caused by fear and anger towards patients with chronic mental illness. The community display fear and anger towards these patients owing to the crimes they committed before their admission to a mental health institution. Consciously or subconsciously, these community members still think these patients are capable of committing the same offence and even worse offences. This is congruent with the excerpts below:

Some have been here for 20 years, others 15 years or 10 years. It all depends on the families if they want them or not. Remember our communities don't accept that they have mental illness.
(Participant 8, age 35, female).

There are those the community no longer wants; so, they just have to remain here; they will not be going home. (Participant 7, age 29, female).

And some we can see that these are stable but due to family rejection and community rejection, some are rejected by the community, they don't want them back based on what they did prior coming here. (Participant 20, age 28, male).

Looking at the above extracts, lack of social support is a serious challenge for nurses. Most families and relatives are not supporting patients. They often distance themselves from them and expect the nurses to be the only ones rendering social support to patients. Family and community health awareness projects should be made a priority to alleviate the stigma around mental illness.

5.3.3.3 Sub-Theme 3: Safety and Security Problems

Safety and security were reported by PNs to be a challenge in these three mental health institutions. They reported being afraid of the chronic mentally ill patients. The fear comes from the offences and crimes that the patients have committed and also from the aggressive behaviour that patients display in the ward. The feedback from the PNs revealed that patients with chronic mental illness tend to be aggressive towards each other or to staff members for no apparent reason. Some of these patients portray aggressive behaviour towards nurses when they have relapsed. The PNs experience aggressive behaviour from patients in two forms, physical or verbal. Patients are violent towards the nurses by swearing at them, intimidating them and physically attacking them. Some patients go to the extent of vandalising the property of the nurses. The following excerpts exemplify this particular sub-theme:

That's why all the securities are male. Because if they can target you, there was this patient and he is an old man. He is suffering from diabetes, so his diet is different to others. When he drinks tea, he always demands the sugar one. Recently, one of my colleagues said today you are not getting one, we are following orders. The dietician said no what what and you also know the kind of illness you are facing. So, he targeted his car and smashed the windows. (Participant 27, age 32, male).

They can take a chair and throw at you and say I'm seeing a snake. (Participant 18, age 56, female).

I remember I was working night shift and there was a patient who was very aggressive. He was beating other patients, wanting to gwaza us. The patient had relapsed because there was no treatment. So, I ran to ask for help. (Participant 7, age 29, female).

It's so risky, yho is very risky akeri they are not stable. That's why you need a lot of manpower in here, especial when you are a woman, you must not stay alone in the ward. Because some are rapists in here even murders, is dangerous in here. (Participant 27, age 32, male).

This study found that patients with chronic mental illness are also physically violent towards each other. They would usually fight in the ward for small things. The fight starts from minor things like food, chairs and so on. This is a serious challenge in that PNs have to stop the fight, mediate and make them reconcile. The other challenge about these fights is that nurses tend to be blamed for all the fights that happen in the ward. The management often blames the nurses for every fight that happens between patients or between a nurse and a patient. This increases strain on PNs and makes them feel unsupported by management. This is supported by the following extracts:

Here they fight, they fight all the time. Ende, they are fighting for small things. Maybe someone looked at someone and that one beat him and say why are you looking at me. (Participant 8, age 35, female).

They are always fighting. You will find one patient would take a chair and hit the other patient for no apparent reason. (Participant 9, age 50, female).

And when these cases are discussed in the meetings, they always ask 'where was the nurse?' And some of these things you would not know because the patient didn't tell you that they are going to beat this patient. (Participant 25, age 30, male).

There is fear amongst PNs owing to the aggressive behaviour portrayed by patients. PNs experience fear when caring for chronic mental ill patients. They are anxious and feel that their lives are in danger. Social media reports and news contribute negatively to the anxiety that nurses have. More often than not, the media would report on a nurse that was killed or attacked by a patient in a certain hospital. Consequently, such reports increase the existing fear among nurses. See the excerpts below:

We are afraid, we are too afraid working in this ward.(Participant 4, age 36, male).

The challenge is self-fear because every day, even if is not every day, when you read on the media 'a psych patient has attacked a nurse somewhere. A nurse has lost his or her life, so you are always conscious'. (Participant 28, age 30, female).

If you check, there have been cases of nurses been attacked and killed by them. So, you work in fear sometimes, you won't know what's happening or what the patient is thinking about. Anything can just happen anytime. So, there is fear obviously, especially akiri there are those you know this patient is rough, if he relapses, he just gonna mess up everything, so it's hard. (Participant 16, age 29, female).

Based on the extracts above, nurses are not safe in their workplace. They experience a range of physical and emotional abuse while caring for patients. Generally, a good and conducive working environment plays a vital role and makes employees feel safe, which then enhances their performance. The government really needs to improve the safety and security of these mental health institutions to benefit both patients and nurses.

5.3.3.4 Sub-Theme 4: Lack of Incentives

Another challenge that PNs face is lack of incentives. More often than not, PNs experience financial problems at work. Participants interviewed in this study express their dissatisfaction with the money they receive. Recently, a portion of the money of PNs working at these institutions was reduced owing to budget constraints. Their overtime money and Sunday lunch money, to be precise, was reduced without their knowledge or consent. No one, not even the management, informed or warned them of these sudden changes. They were surprised to see their claims not processed and were told to reduce the number of hours for the claims to be approved. Some nurses saw and received these changes on social media and through word of mouth from their colleagues. This is captured by the following excerpts:

> *What can I say except money, we want money, but the government does not want to give us. We wake up in the morning, come to work, we take care of these patients, but they give us little money. Honestly, is not enough. Now they cut our money for lunch on Sunday and night shift. So that's a challenge and a big stress.* (Participant 3, age 37, male).

> *Ok, let's talk about money. I don't go to church on Sunday because I'm working and I want money right. Mara now they cutted our money for Sunday, lunch money. There is no lunch money on Sunday, ende vhele here in our ward we don't go for lunch. Who will stay with 27 patients if we go to lunch? But the government don't care.* (Participant 10, age 55, female).

> *And on top of that they are not paying for overtime, and we are no longer claiming.* (Participant 16, age 29, female).

Regarding incentives and financial renumeration, nurses are not satisfied. They feel less appreciated financially by the government. And this has a negative impact on their morale and performance. Financial support in the form of an increment or bonus would really boost and lift the morale of these professional nurses.

5.3.3.5 Sub-Theme 5: Shortage of Resources

The shortage of resources was also highlighted as a concern by the PNs in the current study. The majority of PNs working in these institutions indicated struggling with basic resources to care for patients. The shortage of resources for patients that they face are essential and basic things such as linen, clothes, body lotion, and hot water. These are small, basic resources yet essential for patients' personal hygiene. Nurses reported all these challenges to the authorities, but nothing was done. The following excerpts exemplify this particular sub-theme:

> *The main challenge is that of lack of resources. We don't have resources.* (Participant 21, age 64, female).

> *Haaa, there are many challenges here, because there is no equipment.* (Participant 18, age 56, female).

> *Another challenge is of linen. It's a challenge because they don't work over the weekend because of our government. They do want to pay them over the weekend but, aaaa, is a provincial thing, we are not the only ones.* (Participant 5, age 51, female).

> *And sometimes, you find that we don't have equipments like clothes. You find that it is a weekend, there are no clothes, no lotions for the patients. So, it's kinda hard, we have to improvise to ensure that our patients are well and still be there for them.* (Participant 7, age 29, female).

General but imperative materials like toilets, toys, TV, air conditioners and blood pressure (BP) machines are amongst the resources that are lacking in these institutions. The present study found that in one of the institutions, there are no toilets for staff members. Those staff members have to use the toilet in another ward, which means they have to leave their post unattended. A basic item like a BP machine was reported to be missing or unserviceable in most wards, which again hinders patient care. Consultations rooms and nurses' rooms appeared to be also a challenge to these

PNs. The researcher experienced the shortage of consultation rooms for nurses in that some of the interviews were conducted in the nurses' duty room and in the ward. This is supported by the extracts below:

> *There is no staff toilet, if you are working night what do you do? During the day, we go to other wards. Here, there is no staff toilet and we can't use the patients one. Ifli come here with diarrhea, I fill the annual leave and go home.* (Participant 18, age 56, female).

> *Like the lights, these lights are not working, both of them. Then the aircons are not working, TV is not working.* (Participant 22, age 27, female).

> *But we don't have BP machine. The problem is BP machine in this hospital. And then the other challenge is that our consultation rooms are not enough. (Participant* 23, age 45, female).

Rehabilitation equipment for patients was also reported as an obstacle to patient care by PNs. PNs in the current study revealed that they do not have rehabilitation resources, which have a huge impact on patients care. They end up utilising their own equipment in order to keep the chronic mentally ill patients busy and entertained. These PNs are expected to have group activities to enhance patient care but there is no equipment provided for that. This is captured by the following excerpts:

> *Group activities sometimes we involve them in playing dice, cards, dancing and we play music with our phones because we don't have any music system and the TVs are not working.* (Participant 22, age 27, female).

> *We don't have much of rehabilitating games. The games that we have they are just playing ludo and cards.* (Participant 25, age 30, male).

We do aaa; some of them will be playing chess and play these cards is called casino. We play this game; we call it ludo; we play with two dices and a box written four squares. (Participants 15, age 34, female).

Soemething like the infrastructure of the wards is also a problem in these three mental health institutions. According to these PNs, the structure of these hospitals is not appropriate for psychiatric patients. They feel that the wards were not initially built for psychiatric patients; hence, they are not fit to accommodate patients with chronic mental illness. There were rooms that were supposed to be included in a proper psychiatric hospital, which are not in place at these mental institutions. For example, there is an absence of seclusion rooms. The following extracts are in line with this point:

The main challenge here, in this ward is this ward does not qualify to be acute ward, ni vula structure. In a proper, good acute ward, the windows are high. The windows must be high, the patients should not be able to touch up, the ceiling. (Participant 6, age 35, male).

In this ward the challenges that we come across are beyond our control. Number 1, structure. Our ward was supposed to have seclusion rooms, but we don't have. We don't have, now when we seclude a patient, we have to take them to the other wards where they have seclusion. (Participant 8, age 35, female).

Some of the patient use to abscond. As you can see the structure in this hospital is not suitable for psych patients. They used to abscond. We do have this windows neh; but in the dining hall, we don't have bacillary proof. They used to loosen the screws and escape through the window and get out. (Participant 6, age 35, male).

Based on the above-mentioned extracts, it is evident that shortages of essential resources affect both nurses and patients. For instance, the shortage of BP machines directly affects patients, while the shortage of consulting rooms affects nurses and

hampers service delivery. Shortage of resources results in-patient care being compromised.

5.3.3.6 Sub-Theme 6: Shortage of Treatment

The final challenge that the PNs illustrated was a shortage of treatment for patients. The feedback from the participants shows that sometimes patients do not receive their prescribed medications owing to a shortage of drugs. Shortage of treatment is a serious concern for PNs because patients relapse when they have not taken their medication. The majority of patients display aggressive and violent behaviour when they have relapsed. The other concern that the PNs have is that patients take long to recover from the relapse, which delays their entire recovery journey. The following excerpts exemplify this particular sub-theme:

> *In the ward, well, you find that there is shortage of treatment.* (Participant 6, age 35, female).

> *Another thing is treatment. Sometimes, we work without treatment, and if patients do have treatment, they relapse. And we are the ones, us nurses who suffer. They become aggressive, others beat us, it not nice. Like today we had a problem, lucky doctor was here. One of the patients had a fit and we don't have treatment.* (Participant 10, age 55, female).

> *Sometimes you find that no medication at pharmacy, they say the medication are out of stock.* (Participant 13, age 47, female).

It is evident that the above-mentioned challenges affect both PNs and patients negatively. It is crucial to note that the challenges that nurses encounter in these three MHIs significantly affect the PNs' psychological, emotional, and physical health. These PNs use numerous strategies to cope with the caring burden.

5.3.4 Theme 4: Coping Mechanisms Used by Professional Nurses

Another theme that the current study identified is the strategies that PNs use to cope with the caring burden. This study discovered that PNs apply both maladaptive (negative) and adaptive (positive) coping mechanisms to manage the caring burden. The coping mechanisms that these PNs use are prayer, faith or belief in God, teamwork, self-counselling, and absenteeism. The results of this investigation showed that the majority of PNs seem to use positive coping mechanisms to deal with the caring burden. These positive coping mechanisms are prayer, faith or belief in God, teamwork and self-counselling. Absenteeism was the only negative coping mechanism that a few PNs reported using to cope with the caring burden. All the coping mechanisms that the PNs presented with are discussed below.

5.3.4.1 Sub-Theme 1: Prayer

The PNs participating in this study reported using prayer as a way of coping with the caring burden and their problems. Most of PNs use prayer to cope with the challenges that they come across because they are Christian. Prayer has been found to be a commonly used coping mechanism in most Christian PNs. Others even go to the extent of praying with their family members to manage and solve their problems. The following excerpts exemplify this particular point:

> *For me because I am a Christian, I pray. What can we do because the hospital don't help us, is everybody for himself la sesi.* (Participant 6, age 35, male).

> *Myself, I am a Christian. Ni mhani mfudhisi, so is just scriptures and praying. Nothing else. You know we take everything to the one that is above. You go home, you read the word. You pray and rest, then you come to work. There is nothing greater than prayer, prayer gives you peace.* (Participant 16, age 29, female).

> *I pray, that's my only hope. I only pray, I don't drink, I don't smoke ever since I was born. I believe in prayer; all my life and it helps. I just tell my wife and kids*

that there is this problem, and we kneel down and pray. (Participant 19, age 45 male).

5.3.4.2 Sub-Theme 2: Faith in God

Faith in God was also found to be one of the coping mechanisms that are utilised by PNs interviewed in this study. These nurses strongly believe that their faith in God assists them to cope well with the caring burden. The PNs revealed that they get their strength to care for patients with chronic mental illness from God. This is captured by the following excerpts:

But I cope because I have God. God helps me a lot. Otherwise, I was not going to care but now when someone does not have a shirt, I go to the other wards to ask for a shirt. That's the way Christian do, we help others. (Participant 1, age 38, female).

I go to church. I pray, when I pray and talk to God, I feel good. I tell Him all my problems because I cannot hide anything from Him. And remember, God will not tell anyone that you came and complain of 123, no is between us. So, I feel better when I speak to God. (Participant 2, age 47, female).

Like as we came in this ward every morning, we ourselves we put our trust to God. That God will protect us. (Participant 24, age 60, female).

5.3.4.3 Sub-Theme 3: Teamwork

One of the other adaptive coping strategies that PNs in these three mental health institutions use is teamwork. Nearly all employees emphasized the importance of working as a team to support them in making patient-centered decisions and in reducing their stress. These PNs are of the opinion that working together, or unity, is power. Furthermore, they indicated that having a good working relationship with their colleagues helps them to offer good care to patients. Since they have a good working relationship with each other, they are able to cover and stand in for each other when a need arises. This is congruent with the extracts below:

Here we use, we have a good relationship with each other; so that when they wake up in the morning, they don't say heyi I am going to that place. And that is helping us cope; we work good together (Participant 13, age 47, female).

And if someone don't have food, we share and eat together with our colleagues. We are there for each other. (Participant 13, age 47, female).

When we are short of staff, we just improvise. One takes lunch; I will take lunch this time. We work together. (Participant 7, age 29, female).

5.3.4.4 Sub-Theme 4: Self-Counselling

Self-counselling was highlighted to be another adaptive coping mechanism used by PNs at these three mental health institutions. Since they have studied basic counselling as part of their modules, they decided to use it and to counsel themselves when they have problems. These PNs also mentioned that the other reason for self-counselling is that the psychological services in these hospitals are mainly for patients. See the excerpts below:

The coping mechanisms, aaah, we just counsel ourselves. (Participant 22, age 27, female).

No, there is no such. No psychologist, social worker who have come here to counsel us, not even one day. we end up counselling ourselves. (Participant 12, age 46, female).

We counsel ourselves here, there is not support structures for nurses here. We have people like social workers and psychologist who can talk to us about our problem but is not happening. (Participant 3, age 37, male).

5.3.4.5 Sub-Theme 5: Adaptation

Adaptation has been discovered as one of the methods that PNs use to cope with the caring burden. From the feedback given by nurses interviewed in this study, some nurses adapt to the situation, in this case the caring burden, as a coping mechanism.

This coping mechanism is often used after acceptance of the situation. The following extracts capture this sub-theme:

> *So, getting used to them, having a bond with them helps us cope. I think we just get used to them se hi dzidzivala. You just tell yourself that I'm here to work, help this people. So that our coping skills that we use.* (Participant 5, age 51, female).

> *Aaah, we just adapt to the environment and go on like that.* (Participant 3, age 37, male).

> *Sometimes there is nothing you can do; you just have to comfort yourself in order to cope. Thi, we are working.* (Participant 14, age 40, female).

5.3.4.6 Sub-Theme 6: Absenteeism

The results of the current investigation also showed that shortage of staff leads to absenteeism and fatigue. Absenteeism has been seen to predominate among PNs working with chronic mentally ill patients. Nurses use absenteeism as a way of coping with work demands. PNs reported being tired because they are working too much, which results in absenteeism. Many of them mentioned that they take sick leave and do not go to work as a way of coping with the caring burden. According to the nurses, this negative coping mechanism is perpetuated by the shortage of staff and financial problems that are prevalent in these institutions. The following excerpts exemplify this particular sub-theme:

> *Shortage of staff is our main problem; you can also see that we are short staff, we are not enough. And when there is shortage, the nurses work too hard, actually too much and they get tired. And when they are tired, they don't come to work.* (Participant 22, age 27, female).

> *But sometimes we experience burnout. And when we are burnout, we take sick leave so that we can rest. We will check how many leave days we have, then take two days. We go home and rest. What can we do? We are burnout.* (Participant 20 age 28, male).

Nurses get more frustrated and start not coming to work. And when there are lot of absenteeism, the work suffers, patients also suffer. (Participant 4, age 36, male).

The above extracts give a clear indication that PNs utilise different coping mechanisms while caring for patients. Seemingly, most of these coping mechanisms are adaptive and a few are maladaptive. Support structures and programmes are also essential for coping with the caring burden.

5.3.5 Theme 5: Support Structure and Programmes Available to Professional Nurses

Another theme of the current study is support structures and programmes available to assist the nurses with the caring burden. The researcher found it deem to determine the support structures for nurses in order to develop a support programme for them. The reason for this inclusion is to check whether nurses have support structures and how effective those structures are before developing a support programme. The responses gathered in this study revealed that not all institutions and wards have support structures and programmes. The majority of the PNs from the three MHIs indicated that they do not have formal and functional support structures and programmes. The support structures and programmes available in these institutions are mostly for patients, not for nurses. This is captured by the following excerpts:

For us staff, aaa, I don't want to lie, we don't have. We just work nje, there is support for us and we, all the nurses need it. We don't have shame. Let me be honest sesi, the focus is on patients in this hospital not staff. (Participant 5, age 51, female).

As I said I don't know any support structure in this hospital, I don't know where to go if I have a problem, maybe when have stress, who can I talk to because I can't just talk to anybody. (Participant 21, age 64, female).

No, we don't have. No one supports us, no one. (Participant 24, age 60, female).

In addition, PNs indicated that they do not have support from most of the multidisciplinary team members (MDT). Procedurally, patients with chronic mental illness were supposed to consult with 90 per cent of the MDT members but in these institutions is not like that. In these institutions, nurses and doctors are the ones that are consistently consulting with patients and caring for them. Consequently, patients end up not receiving holistic treatment. PNs stated that the involvement of other MDT personnel is crucial to optimal patient care and overall treatment. This is congruent with the following extracts:

> *When we do doctor's rounds, all MDT members are supposed to be there but is not like that here. Doctor's rounds are for nurses and doctors. We will refer patients to professionals, but they will take forever to see the patient.* (Participant 6, age 35, male).

> *We have a challenge with the physio also, I can't remember the last time they were here.* (Participant 7, age 29, female).

> *The thing is, these patients don't need a nurse alone, they need OTs, psychologists, physio.* (Participant 3, age 37, male).

However, aminority of PNs reported having some form of support structures in place for nurses. These support structures include union forums, support visits and other nursing-related meetings. All these support structures are aimed at addressing the challenges that PNs experience while caring for patients with chronic mental illness. It is like a venting session of some sort. The meeting is usually held once a month. The target group is all the nurses with operational managers and matrons. See the following excerpts:

> *We have our own ward meeting with our matron once a month. In that meeting, we talk about our problems and challenges. They also tell us their problems, but still there is nothing they will do.* (Participant 1, age 38, female).

> *The programmes that we have I don't know if they are related to what you are saying. We do have nurses' day.* (Participant 15, age 34, female).

We used to. I think this thing of corona has changed a lot of things. We used to at least monthly or two monthly meeting, where we used to talk about everything that is affecting us and together with the patients. Like anyone can come up with an agenda of what we need to talk about, everything that's happening in the ward that concerns us and patients. (Participant 20, age 28, male).

Sadly, the result of this study revealed that a large number of PNs participating in the present study do not have functional formal support structures and programmes. Functional support structures and programmes are a must-have and are critical in that they will allow the nurses to share their experiences and to find healthy ways of coping with the caring burden. The PNs recommended the following support programme to assist with the caring burden.

5.3.6 Theme 6: Suggested Support Programmes for Nurses

The primary purpose of this study is to develop a support programme for (PNs) who care for patients with chronic mental illness. Considering the phenomenological experiences shared by the PNs and the challenges that they face, it is essential to have a support programme for these professional nurses. Emotional and psychological difficulties can cause stress and burnout in nurses if there is no assistance. As a result, this may have a negative effect on the well-being of nurses as well as how well they perform at work and provide care. Considering the results from the previous theme, it is evident that the developing of a support programme is needed and will be beneficial to all nurses and patients. When asked about a suitable support programme to help with the caring burden, PNs' suggestions fell under five categories, namely family support, support by colleagues and supervisors, financial support, psychological, and general social support. All these suggestions and recommendations are discussed as follows:

5.3.6.1 Sub-Theme 1: Family Support

In the current study, PNs emphasised the need for continuous support from families of the chronic mental health patients. They indicated that they would be delighted to have the family members getting involved in the patients' lives. The kind of support that is needed is social and financial support. The social support can be achieved when family

members of the mental ill patients contribute by maintaining continuous contact with the patients. They can call the patients, visit them, take them home for leave of absence and home visits. Here is what they had to say about the social support needed:

> *The relatives of these patients should support us. Shame, we know is not easy to care for these patients, but they can just come nje, visit them. They become happy after a visit. We have noticed also that we have less relapses.* (Participant 5, age 51, female).

> *These people are mentally ill, but they know who is their mother. I wish relatives and families can be positive and support us.* (Participant 29, age 44, female).

> *Maybe that one is for social worker. Maybe they contact the family of these patients to come and see them.* (Participant 4, age 36, male).

Still in terms of family support, PNs think financial support from the families can be beneficial to patients. This financial support can be in the form of money and presents. For instance, the family members can bring good food for patients at every visit. These PNs are optimistic and believe that some teamwork between nurses and the family members is crucial and will definitely be beneficial to patients. Here is what they had to say about financial support needed:

> *They can come, bring a danone. They sell danone in the tuckshop outside, is R20 is not expensive.* (Participant 5, 51, female).

> *By procedure, I mean the way things are supposed to be, patients who are here, hospitalised should get half of their grant and the family get the other half.* (Participant 7, age 29, female).

5.3.6.2 Sub-Theme 2: Support by Colleagues and Supervisors

As stated earlier, PNs alluded to having insufficient support from MDT members and from the management of the institutions. As a result, they appealed to their colleagues and supervisors to support them and to be more active regarding in-patient care. The PNs indicated that their colleagues can offer support by doing ward rounds with them, seeing patients when they refer them, counsel them and many more. This is captured by the following extracts:

> *We would like the social workers, OT and other professional to help us with caring for these patients. They are not our patients only.* (Participant 6, age 35, male).

> *I feel when we do the ward rounds, all the MDT members should come because if they don't come, we don't give the holistically treatment to our patients, which is not right.* (Participant 25, age 30, male).

> *So, I feel like we also need to involve other nurses and other multidisciplinary team members in decision-making. Yes, if there are meeting or anything that needs anyone's input.* (Participant 7, age 29, female).

The PNs participating stated that their managers do not consider their well-being. These nurses long for and need support from their managers. It can be in the form of words or hiring more staff. The managers can also portray gratitude and support by showing interest in the well-being of nurses, not only of patients. The following excerpts exemplify this particular sub-theme:

> *The management can employ more nurses, that's what we want from them. They should also employ male nurses; we need male nurses in this ward so that they help us with the turning of the patients.* (Participant 2, age 47, female).

So, I think they need to focus on the occupational health of the nurses as well. Because you know for me to be able to care for patients I have to be okay, financially, physically, emotionally and otherwise. (Participant 7, age 29, female).

I think it will be good if they can increase staff so that we the professional nurse can also rest. We do many things; we also need to rest. And also, the laundry staff should work over the weekend, they must give them overtime. (Participant 1, age 38, female).

Nurses would be ecstatic to receive attention and hear from the management of these hospitals. Actually, these PNs would like to see an improvement at the level of communication. According to these PNs, the management should listen to them and consult with them before making major changes and decisions. This is captured by the following excerpts:

Yes, it's boring and painful, sesi. Now they are cutting money, they don't even tell us, we just hear from media. Management take decisions without consulting us, they don't care about us. (Participant 20, age 28, male).

Think we should start with improving our communication; communication is the best. I know there are things we cannot change but talk to the people about it, then we will not have a problem. (Participant 25, age 29, female).

Management where not there at all, what they care about is work, they want to see the work done. When they receive circulars, they don't discuss anything with staff members, maybe ask what we think, no, they just implement. (Participant 6, age 35, male).

5.3.6.3 Sub-Theme 3: FinancialSsupport

The other kind of support that PNs recommend is financial support. From the responses of these nurses, they would appreciate financial support in the form of money or incentives. This is congruent with the following extracts:

I think if we had financial support, it will be better. Money answers everything, money solves a lot of problems (both laugh). Money is not evil, if is evil bring it to me I will use it for you (he laughs louder). (Participant 3, age 37, male).

And support from management, we also want money. (Participant 19, age 45, male).

We also want money. I think if we had financial support, it will be better. Money answers everything, money solves a lot of problems. (Participant 14, age 40, female).

5.3.6.4 Sub-Theme 4: Psychological Support

The PNs participating in this study recommended psychological support as a support programme that will help them cope better with their caring burden. According to these nurses, talking about one's challenges to an expert is vital and beneficial. Since they advocate for the mental well-being of patients; they also need to take care of their mental health. This psychological support programme can be in the form of counselling, debriefing and therapy. See the excerpts below:

Psychological support is needed in life and also in this ward. In this ward, patients sometimes threaten nurses especially women. (Participant 27, age 32, male).

Support programme? I think counselling will help us, phela we have many problems, patients, relatives and our own problems. I remember when that psychologist from Letaba came, it was good to talk about how we feel. There was a change, she really helped us. So, counselling will be alright. (Participant 6, age 35, male).

I think counselling will help us. We need counselling, we have many problems. Is really not easy to take care of these patients. The social worker should come counsel us; I think that will be good. (Participant 5, age 51, female).

The PNs indicated that the counselling sessions can be done, preferably in a group; and personal sessions can be done individually. Venting and talking about their work-related

problems should be the main focus of the psychological support programme. The following excerpts capture this sub-theme:

> *I think debriefing sessions will help us, for sure. And also have support groups where people will ventilate and talk about their problems.* (Participant 9, age 50, female).
>
> *Even if in a group; it can be alright. They can teach us how to cope with patients because you can find that a patient can talk something traumatising to you. So, they can come with the solution of how to handle this patient if is like this.* (Participant 13, age 47, female).
>
> *They should come for staff. They can do individual therapy and maybe group therapy, inside or outside. We will relive our stresses.* (Participant 18, age 56, female).
>
> *Unless when I have a specific problem maybe I can go to the psychologist, one-on-one but for us together will be good.* (Participant 8, age 35, female).

According to these nurses, this psychological support programme can be held once a month or bimonthly. It will depend on the therapist's schedule and can be conducted in the ward or the hall of the respective hospitals. This is supported by the following extracts:

> *And then you guys, psychologist can give us counselling, maybe once a month or once in two months.* (Participant 5, age 51, female).
>
> *Maybe once a month, to get someone who can come talk to us. I think it can be better. Aniri, we are staying here most of the time, we are taking care of the patient.* (Participant 12, age 46, female).
>
> *I don't know how to put but they can talk to us just to uplift our morals something like. Maybe once in a month or quarterly.* (Participant 14, age 40, female).

5.3.6.5 Sub-Theme 5: General Social Support

Besides the above-mentioned support programmes, PNs require the need for consistent general social support to deal with their challenges and to ease their caring burden. In this study, the general social support needed includes having staff outings, exercising and playing sports. These nurses strongly believe that the examples stated above of general social support will help to improve their mood and will ultimately enhance their mental well-being. The following excerpts exemplify this specific sub-theme:

> *To support us, maybe we can have activities like playing netball and tennis court. You find that some of our nurses are obese because of sitting the whole day and writing. We are always writing and spend the whole day here and go home.* (Participant 13, age 47, female).

> *Even going out; we do it as colleagues, I know it boosts. So, the organisation can do that for us.* (Participant 20, age 28, female).

> *It will be nice just to go on an outing as nurses. They should plan an outing for us, just for us to relax. Even if, we don't go far, there are a lot of places around like Kruger even Nandoni. We can play games or sports and forget about patients for two hours only.* (Participant 3, age 37, male*).*

PNs interviewed in this study articulated their deep need for having a functional support programme that will help them with the duty of caring for their patients. Looking at the suggestions they have made, a holistic support programme will be helpful and beneficial to these nurses.

5.3.7 Summary of the Results

Based on the themes and sub-themes presented in this study, it is clear that the nursing profession really needs to be given extra attention. The first theme in this study focused on the nature of chronic mental illness that was found in the three MHIs. PNs were caring for patients with different types of mental illness ranging from common ones such

as schizophrenia, bipolar disorder, schizo-affective disorder, and depression, to substance abuse, ADHD and intellectual disability. Some of the patients were found to have dual diagnoses, which put more strain on the nurses because patients with dual diagnoses require more attention. The second theme focused on the phenomenological experience of professional nurses. From the PNs' perceptions, the caring duty has both negative and positive aspects. Many PNs find the caring duty physically, emotionally, and psychologically draining. They expressed feelings of being overwhelmed, anxiety, fatigue and sadness while providing patient care. A positive aspect was that some PNs found the caring duty to be fulfilling. This feeling of fulfilment comes because they believe that caring for patients with psychiatric conditions is a calling for them.

In the third theme, the findings demonstrated that PNs are faced with tremendous and disheartening challenges. Challenges that these PNs experience are local and international challenges. These challenges are the shortage of staff, resources, medication, safety and security problems, lack of social support and lack of incentives. The present study discovered that the provision of high-quality patient care is affected by various things, like inadequate staff, medication, and many more. The findings also demonstrated that the above-mentioned challenges affect both nurses and patients negatively. For example, shortage of medication makes it hard for nurses to deliver care and may delay or disrupt a patient's journey to recovery. Patients certainly suffer when medications are not available.

Another disheartening challenge that is prevalent recently is the safety of nurses working in mental health institutions. Nurses are abused and assaulted physically and psychologically on a daily basis in MHIs. The abused is usually in the form of swearing, and name calling while others go further by destroying the nurses' property. For instance, a nurse's car was vandalised and damaged by a patient in Thabamoopo Hospital. Another example is that a nurse was assaulted and killed by a mental patient in Hayani Hospital, Limpopo Province. What is sad about the whole safety issue is that nothing is done; hence, nurses feel unsupported by the management of the hospital. Many PNs experience psychological trauma after being attacked or after witnessing other nurses being abused. Direct or indirect psychological trauma often affects nurses

and some end up developing resentment issues towards patients. Some PNs experience psychological symptoms such as intense fear, helplessness, withdrawal, and hypervigilance. As a way of coping some nurses request to be move to another ward to avoid being in contact with the patient who abused them. Although psychological support in the form of a debriefing session does occur after a traumatic experience, nurses feel it is not enough because is only done once; there are no follow-up sessions.

The fourth theme revealed that PNs in the current study use a variety of strategies to cope with stress and trauma in the work place. In this study a large number of nurses used adaptive coping strategies to manage their challenges. Another heartbreaking problem associated with the fifth theme is the lack of formal and effective support structures and programmes in these three MHIs. Considering personal and work-related challenges that PNs encounter every day, it is only fair and appropriate for these nurses to have a formal and structured support programme. In the last theme, the PNs came up with different suggestion regarding support programme which would be suitable for them. The suggested support programmes that these nurses recommended basically entails their social, emotional and psychological needs. Based on the nurses' suggested support programme, a support programme was developed by the researcher (see Chapter 7).

5.4 Concluding Remarks

The primary conclusions of the study were outlined in this chapter. Nurses, patients, patients' relatives, other professionals, and the hospital as a whole are all affected by these results. From the current investigation, six major themes have been identified. Each of these topics was described in full above, along with an explanation of its significance. The nurses' comments and reactions will be carefully considered as we construct our support program (see Chapter 6 for details). This assistance program's main goal is to relieve the nurses' load of caring for patients.

CHAPTER SIX

DISCUSSION OF RESULTS

6.1 Introduction

The findings from Chapter 5 will be explored in this chapter. Based on the topics, the findings are examined in reference to the literature that is either available to support or to present a different perspective. The concepts and sub-themes that were provided in the previous chapter will serve as the discussion's framework. The concluding remarks will be included in the chapter's last section.

6.2 The Nature of Chronic Mental Illness

Only three specialised mental health institutions in Limpopo Province provide patients with mental illness with care, treatment, and rehabilitation, as was noted in the methods chapter. The results of this study revealed that all PNs offer care to patients who are chronically ill in the three MHIs. According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), any mental problem that persists for a long time and impairs one's ability to function physically, emotionally, intellectually, socially, or spiritually is referred to as chronic mental illness (APA, 2013). There are numerous different types of mental diseases, according to the DSM-5. The more prevalent varieties include eating disorders, personality disorders, obsessive-compulsive disorders, post-traumatic stress disorders, psychotic disorders, psychotic impulse control, and addiction disorders. In line with DSM-5, all patients admitted to the three mental health institutions have been diagnosed with one or more mental illnesses. Before patients are admitted to MHI, an assessment must have been made to declare them mentally ill.

According to Bhandari (2018), a mental health assessment occurs when professionals such as medical doctors, a psychologists, or a psychiatrists asses the availability mental problem and the type of treatment needed. In these MHIs, a qualified psychiatrist with reports from other professionals is the one to have diagnosed most of these patients. Prior to a patient being diagnosed, various assessments and evaluations have been

conducted. These assessments and evaluations usually come from other multi-professional team members such as psychologists, medical doctors, etc. After the assessment, each professional compiles a report that will assist the psychiatrist to make a diagnosis.

Although the three mental health institutions are situated in different districts, the results indicated that they share common admission diagnoses. These diagnoses are schizophrenia, substance-induced psychosis, schizo-affective disorders, bipolar disorders, mood disorders, intellectual disability, and ADHD. Schizophrenia seems to be a leading common diagnosis in the three MHIs. The results of this study discovered that the majority of patients admitted are suffering from schizophrenia. Still on diagnoses, the findings outlined that some patients are diagnosed with dual diagnoses (psychiatric and medical). According to Dikobe et al. (2016), caring for psychiatric patients with dual diagnoses is a severe global concern.

In agreement, Fortinash and Holoday-Worret (2012) also note that treating patients with dual illnesses can be challenging. In this study, the term "dual diagnosis" refers to a psychiatric patient who also has a medical problem. These medical conditions include hypertension, diabetes, and epilepsy. The dual diagnoses can be both psychiatric and medical diagnosis. For instance, a patient with schizophrenia and diabetics. According to these nurses, the psychiatric diagnosis is the primary reason for admission and the medical condition is the secondary diagnosis. When there is a patient with dual diagnoses, the PNs have to treat patients and give medication for both diagnoses, which can be tiring at times. Patients with dual diagnoses would take more drugs than the ones with only one diagnosis and would require the presence of a nurse to ensure treatment adherence.

These specialised mental health institutions also admit state patients and prisoners with mentally illness in accordance with Sections 41 and 49 of the Mental Health Care Act (Act no 17 of 2002). Patients are admitted to these MHIs on a voluntary basis or an involuntary basis. Upon admission, patients are kept in different wards relevant to their diagnosis. Nurses who participated in the study revealed that some patients, except the ones suffering from ADHD and intellectual disability, not only have mental illness but

have also committed criminal offences prior to their admission. The nature of the offences most patients committed are as follows: murder, rape, destroying of property and theft, to mention few. Most of them found themselves in a psychiatric hospital after undergoing assessments and evaluations, then were declared mental ill or unfit by a panel of health professionals. The fact that these patients committed criminal offences indicate that they can be dangerous to the nurses and fellow patients. Hence, some of the professional nurses express anxiety while caring for these particular patients.

6.3 Professional Nurse's Phenomenological Experiences

The second recurring feature in the PNs' comments was the phenomenological experiences of PNs. Generally, it is not easy to care and look after a sick person. More often than not, nurses are the primary caregivers of institutionalised mentally ill patients and are in contact with these patients on a daily basis. This may imply that nurses, in contrast to other healthcare workers, frequently work set hours and deal with unforeseen circumstances (Cleary et al., 2012). According to Joubert and Bhagwan (2018), nurses make up the largest group of medical professionals providing care to those utilizing mental health services in the field of psychiatric services. In addition, nursing is one of the few caring professions that provides hands-on care 24 hours a day, seven days a week, making it a frustrating and difficult line of work (Hamaideh & Ammouri, 2011). (Cleary, et al., 2012). Congruently, the PNs in the present study also provide healthcare seven days a week and work on day shifts, which makes the caring burden hard. Even though all the PNs were working day shift at the time of the interview, they had experience of working night shift, and some were able to share with the researcher some of their night duty experiences. Professional nurses reported that, although they provide care to patients through treatment, health education, and trying using all means, it remains hard to care for mentally chronic ill patients.

The study findings highlight that caregiving for chronic mentally ill patients is an extreme emotionally and physically demanding experience, which is characterised by constant stressful demands. Furthermore, this study revealed that PNs have different experiences in caring for chronic mentally ill patients. The overall lived experiences of the participants with regard to caring duties were generally positive, with only few

expressing negative feelings on the phenomenon. Professional nurses experience caring duties and responsibilities differently. As a negative experience, the majority of the PNs expressed the caring duties and responsibilities to be challenging and difficult.

In the beginning of their caring duties, these PNs found the caring duty to be filled with emotions such as anxiety, fear and timidity. A large number of PNs reported being overwhelmed and drained by providing care to these patients. Initially, some of the PNs were scared and even terrified by chronic mentally ill patients. But as time went by, their feelings changed as they began to adjust, adapt, and enjoy caring for these patients. For numerous PNs, the difficulty in caring went away the moment they started to know and understand the patients; and then they developed a good nurse–patient relationship. Moreover, they found ways of dealing with and handling them when they relapsed and become violent or aggressive. Professional nurses interviewed in this study also outlined that it takes a lot of courage to look after patients with chronic mental illness. According to these nurses, what keeps them going is their love and passion for sick patients. Apparently, they find joy and fulfilment when caring for a sick person.

As unique and uncommon excerpts (negative experiences), few PNs find caring for chronic mental ill patients not challenging, instead they find it easy. They prefer caring for chronic mental ill patients than ordinary patients in that they are less complicated. For some it is because they naturally love taking care of ill people while for others it is having the right education that makes the caring burden easier. In the same study, some PNs expressed mixed emotions about their caring burden. The feelings of these nurses are subjective and depend on many things such as the wards they work in, the kinds of patients, and days. These nurses experience both challenging and non-challenging emotions on different days. Their feelings about their caring duties change relatively on different days.

The results of this study reveal that PNs suffered extensive psychological setbacks while providing care because of several of reasons. The psychological challenges experienced by these professional nurses included fatigue, frustration, feeling overwhelmed and not being valued by authorities. Participants also mentioned that the tremendous workload and inability to handle the professional responsibilities are the

main causes of all these emotions. According to the study participants, they felt less important because their superiors and even other multidisciplinary team members took them for granted. Participants also highlighted the lack of psychologically support while offering care to patients.

A notable number of PNs find the caring burden to be physically strenuous. The nursing profession and duties of nurses are strenuous and demanding in nature. The working hours and types of duties involved in nursing are physical demanding and require a lot of energy. Some of the PNs experience physical pain because of caring for the chronic mentally ill patients. They suffer from backache from carrying and turning bedridden patients. The backaches might also have emanated from long working hours and from standing for most of those hours. Another lived experience of the PNs is psychological trauma. While caring for patients, PNs experience psychological trauma. These psychological traumas include the relapsing of patients, the death of patients and nurses, and the attack of a nurse by patients while rendering care.

Unfortunately, in recent years, there has been an increase in violence towards nurses reported over the news and social media. The findings of this study discovered that nursing and caring for chronic mentally ill patients has become unsafe. These nurses state that dealing with psychiatric patients can be dangerous since they occasionally act violently and aggressively. The unpredictable and unstable nature of the patients makes the nurses anxious. Since the nature of the jobs of these PNs involves trauma, psychological services like counselling and debriefings are essential and beneficial to victims after a traumatic event. Consequently, counselling and debriefings are conducted after a traumatic event in these institutions. It is often offered to victims of the trauma, meaning the people who were directly involved and affected. These psychological services are often facilitated by psychologists.

The current study discovered that PNs have duties over and above rendering care to mental ill patients. The PNs have extra nursing and non-nursing duties that they have to do on a daily basis. This is in line with a study by Gunasekara et al. (2014). On a daily basis, there are tasks over and above their regular duties that PNs do to offer holistic treatment to patients. These PNs found themselves doing duties that are not in their

scope of practice owing to challenges like the shortage of staff, and family rejection. They find themselves maintaining the personal hygiene of patients, calling and tracing their family members, and so on. This study revealed that the daily routine of PNs in the three psychiatric hospitals involves giving and receiving reports from and to night staff, personal hygiene of the patients, administration of medication, morning prayers, physical assessment, health education, and administrative tasks.

6.3.1 Receiving and Giving Feedback or Reports

The first and foremost thing that participants do every morning is to receive reports from the night staff. This report comprises the patients' physical and mental state. The night staff outline the challenges experienced at night and the overall well-being of the mentally ill patients. The purpose of this process is to offer and promote holistic treatment to patients during the day. In the evening, before these PNs go home, they also give feedback to the night staff on how the patients were doing during the day. This feedback involves incidents that happened, any complaints from the patients, doctors' feedback and so on. Eivergrd et al. (2016) agree that patient handover is critical to psychiatric nursing practice and care. Verbal handovers and ward rounds are reporting modes of communication used to shape the ability of psychiatric staff to construct, recognize, and understand patients, as well as the ability of patients to construct themselves.

6.3.2 Personal Hygiene of Patients

The current study discovered that PNs are involved in maintaining the self-care and hygiene of mental health patients. The majority of mentally ill individuals disregard their personal cleanliness, which ultimately need the assistance of a nurse in maintaining adequate hygiene. This is consistent with a research by Hsu et al. (2017) that found patients with schizophrenia typically had subpar self-care abilities. This study found that some patients cannot maintain their self-care and personal hygiene. As a result, the nurses have to assist them with basic personal hygiene like making up their beds, bathing and dressing themselves, applying lotion, dishing up food, and feeding them. The patients who usually need assistance are the ones with ADHD and intellectual disability. This is usually due to their condition. According to the professional nurses

who participated this study, their scope of practice does not include providing personal hygiene for patients, but they find themselves doing it. This is caused by logistical challenges like the shortage of nurses. For them it is an over-and-above task for which they are not even compensated. According to them, personal hygiene of patients is not the responsibility of PNs. However, the present study discovered that 90 per cent of the PNs take care of patients' personal hygiene.

6.3.3 Morning Devotions

In this study, the researcher discovered that PNs not only cater for the patients' mental well-being but they also nurture their spiritual well-being. Prayer has been found in this study to be a crucial daily routine for patients Similarly, Hefti (2011) states that religious ways of coping are exceedingly common among patients with psychiatric disorders. This study found that PNs conduct morning devotions for patients every day. Nurses outlined that they conduct morning devotions every morning in various wards. Both the nurses and patients form part of the morning devotions. The reports from PNs mention that the morning devotions can take about 15 to 30 minutes or longer, depending on wards and patients, but the patients really enjoy every moment of it and benefit from it. The morning devotions comprises prayer, singing of gospel songs and preaching of the word of God. In the prayer meetings, more often than not, the patients lead the prayer while the nurses listen and supervise the whole session. In all these MHIs, patients are given an opportunity to pray and preach to the nurses and fellow mentally ill patients. The PNs in the present study realised that these patients understand better when one of them is preaching; hence, the entire prayer meeting is patient oriented.

6.3.4 Health Education

As part of their work allocations, PNs conduct health education on a daily basis. Dastan and Kilic (2014) claim that given the length of these patients' treatment periods, they have substantial informational demands when they are admitted to the hospital. All mental institutions should include patient education programs as a part of their inpatient and outpatient treatments. PNs conduct health education regularly, where they teach chronic mentally ill patients about health-related matters. According to Gümüs (2008) health education and programs are important consequently educational programs must

be planned and Implemented and also because the patients have expressed their interests for information. He continued by stating that patient education aims to provide accurate and pertinent clinical information to patients in order to improve their understanding of their sickness state, promote health, and improve behavior. According to Chien et al. (2001), mental patients have a strong hunger for practical counsel on how to manage their condition' symptoms. According to Hätönen et al. (2008), understanding the benefits of medication on psychiatric symptoms helps people with mental health issues stick to their treatment plans more effectively and understand the root of their illness. Additionally, improvements in lifestyle consistency, healthy behavior, social functioning, and employment have all been associated with patient education (Dogan & Sabanciogullari, 2003).

In the current study, the health education offered by PNs involves basic topics like anger management, conflict management, how to behave in the ward, COVID-19, and many more topics. The health education is aimed at empowering and equipping patients with knowledge that will help them to function well after discharge, at helping them connect with the world, and know what is happening in the real world (outside the mental health institutions). The health education also focuses on basic or general topics, diseases and illnesses that are current and trending. In some wards of the MHIs, nurses help patients to cultivate and develop their personal skills and growth. With the help of the nurses, patients do the following for personal development skills: gardening, washing cars, helping in the tuckshop and sewing clothes, scarves and pillowcases.

6.3.5 Giving Patients Medication

As part of the PNs' daily routine, they are required to administer treatment to patients. Every day, PNs give patients medication at a specific time prescribed by the medical doctor. The timing of the treatment differs: some get it in the morning, others during the day and a few at night, depending on their diagnoses. This treatment is not only psychiatric treatment since some patients also have medical conditions. The treatment can be in the form of tablets or injections. While administering medication, PNs encounter challenges such as non-adherence. More often than not, psychiatric patients have a tendency to refuse treatment. This is supported by Taj et al. (2008) and Hlongwa

and Sibiya (2019) who state patients suffering from chronic psychiatric disorders are commonly not adhering to their medication. In this study, PNs revealed that patients hide medication under their tongues, some put it under their pillows, and others vomit it out into the toilet. However, the PNs initiated a strategy to deal with this problem. They monitor and supervise the patients, and check physically whether the patients have indeed taken their treatment. As a way of dealing with this problem, the PNs double check with patients whether they have swallowed their medication. Seemingly, this method is working and reduces the chance of patients relapsing.

6.3.6 Physical Assessment

Physical assessments form part of the duties that PNs do daily. According to Al-Huseini et al (2016) physical examination is an essential tool used to identify medical condition that can cause or aggravate an underlining condition and to identify conditions that cannot be handled in the psychiatric ward. Generally, a physical examination should be conducted on all patients presenting to the emergence department (Al-Huseini et al, 2016). This is supported by Szpakowicz and Herd (2008) who highlight that physical examinations are vital features of a comprehensive evaluation of psychiatric patients. An article published in the Journal of Emergency Medicine, in 2012 arrived at the conclusion that a physical examination is an effective screening instrument to determine if a patient requires further medical evaluation (Shah et al, 2012). Al-Huseini et. al (2016) share the same sentiments. PNs who participated in this study revealed that they conduct physical assessments for patients. The physical assessments are done once a month, during the week; not on weekends. Owing to the high number of patients, physical assessments are done throughout the week. Every day, new patients are seen by the doctor. The PNs, with the help of other nurses, divide patients into an equal number of groups and allocate dates and times for physical assessments. By the end of the month, all of the chronic mentally ill patients have been physically assessed.

6.3.7 Administrative Duties

According to Gunasekara et al. (2014), nurses have a responsibility to care for and support patients who have been admitted for the treatment of mental diseases. They are also expected to undertake various administrative tasks for the ward. This includes

admission of patients, meeting attendance, dispensing of medication and communication with patients and / or relatives. These administrative roles are often time-consuming and tiring for nurses. Lastly, on a daily basis, the PNs who participated in this study are expected to do administrative duties. PNs highlighted that they have to do a variety of administrative tasks in the ward. These administrative tasks are both nursing related and non-nursing related tasks. Nursing-related administrative tasks include writing reports, ordering medication, attending meeting, complying statistics, ordering drugs, writing patient reports and leave of absence reports, and many more. Calling and tracing the relatives of the patients, and buying stuff for patients are some of the non-nursing related administrative tasks that these PNs do.

6.4 Challenges Experienced by PNs

According to Udod et al. (2017), the caring role can be stressful and challenging in nature. Psychiatric nurses have a significant mandate in the process of caring for patients with mental illness and often encountered enormous challenges and diverse issues associated to this environment (Zarea et.al, 2012). This is congruent to the findings of the current study. The challenges faced by PNs was seen as a third theme in the present study. The caring duties and responsibilities are genuinely stressful and demanding for the nurses. In the present study, PNs encounter a variety of challenges while caring for patients with chronic mental illness. These challenges are related to patients, their families, staff members, supervisors, and the hospital at large. Challenges that PNs experience in mental health institutions are staff shortage, a lack of social support, a shortage of resources, a shortage of treatment for patients, safety and security problems and a lack of incentives. The above-mentioned challenges will be discussed below in detail.

6.4.1 Shortage of Staff

In line with the literature provided in chapter 2, PNs interviewed in this study outlined lack of staff as a huge concern. A study conducted by Marie et al. (2017) concur and state that healthcare professionals experience insufficient staffing of personnel in psychiatric units, which cause nurses to overworked . Additionally, a Nigerian study found that the scarcity of nurses in mental health care facilities has a depressing effect

on the delivery of high-quality medical care (Jack-Ide et al., 2018). The current research highlighted 95 percent of PNs experienced a shortage of personnel in the three mental health institutions. The ratio between patients and nurses is not proportional, which makes the caring duties very strenuous and overwhelming. In some instances, some nurses are unable to take vacation and overtime leave owing to the personnel shortage. According to Sobekwa and Arumachallam (2015), who concur, an inadequate number of professional nurses are required to manage and provide treatment for large numbers of mental health care consumers as a result of a rise in admission volumes. As a result, nurses end up with an unacceptable burden.

High workloads and stress associated with work were expressed as a huge problem to professional nurses who are available. Due to a lack of professional nurses, professional nurses working in these mental health institutions are overworked, according to the nurses, who added that they were unable to take vacation or overtime leave. Owing to the personnel shortage, nurses are forced to do over-and-above tasks, and experience backache. Out of sympathy for patients and their colleagues (enrolled and auxiliary nurses), PNs end up bathing patients, feeding them, and carrying some of the bedridden patients and those who are unable take care of their basic needs. Others must come to work early in order to cover and assist the other nurses. Moreover, limited male staff has been found to be a serious challenge for these PNs.

As highlighted in Chapter 4, the population of nurses in the three MHIs is predominantly female. Consequently, male PNs are fewer and in high demand. Joyner et al. (2014) agree, saying that South African nursing remains a predominately feminised profession. According to female participants, male nurses are needed and play a vital role in assuring their safety. This is supported by Mulaudzi et al. (2020). The following behaviour has been observed by female nurses when a male nurse is present in the ward: patients are cooperative, less aggressive and violent, and behave well. Even though it is the policy of some psychiatric wards for female nurses to work with female patients and males with males, the majority of the nurses do not agree with this policy in that they see the need to have both female and male nurses in one ward. This policy was established after a few cases of sexual assault, where male nurses were accused

of sexually assaulting female patients. Considering the shortage of personnel, this policy can only be theoretical but not practical in that, in the three MHIs, female nurses were more in number than male nurses. For safety and security reasons, female PNs in male wards prefer to work with male nurses. Other nursing specialties, including staff nurses and auxiliary nurses, are also suffering from a lack of workers.

PNs who care for patients with chronic mental illness at the three mental health institutions not only experience a shortage of nurses but also a shortage of other multidisciplinary staff members. Like in any other hospital setting, multi-professional team members play a significant part in ensuring patients' holistic treatment. However, it is often not so in many public and rural hospitals. Participants in the present study revealed that a multidisciplinary team plays a vital role when caring for patients with mental illness. From the feedback given by the professional nurses, the different expertise of a professional multidisciplinary team inclusive of social workers, counsellors, psychologists, medical practitioners, and psychiatrists would be helpful in creating a mentally stable society. A study by Jack-Ide et al (2012) is in support of this notion. In his study, participants outlined the essence of having professionals such as psychologists, social workers, doctors, psychiatrists, and nurses working together in rendering appropriate services to patients with mental conditions. Makgato (2020) concurs by indicating that a multidisciplinary team is imperative in dealing with mentally ill people. In one of these MHIs, multidisciplinary staff members that are not available or are insufficient are psychiatrists and psychologists.

In this study, nurses described how the lack of essential personnel, such as psychiatrists, hinders the delivery of mental health care. The same thoughts are expressed in a research by de Kock and Pillay (2017), which alludes to a serious dearth of psychiatrists in South African rural mental health facilities. Additionally, a different study conducted in South African public hospitals revealed that there are incredibly few psychiatrists in rural healthcare facilities—only 0.03 per 100,000 people (de Kock & Pillay, 2017). De Kock and Pillay (2017) claim that South Africa faces a problem with the lack of human resources for mental health care due to the fact that many psychiatrists work in private facilities. The lack of psychiatrists has a direct impact on

mentally ill patients and stalls their recovery process. General staff members such as cleaners are also a challenge in Hayani and Evuxakani MHIs.

6.4.2 Lack of Social Support

According to Chronister et al. (2021), family members are the primary source of social support, which is crucial for the health and wellbeing of people with persistent mental illnesses. According to the research discussed in the second chapter, Takalo (2015) cites Johns et al. (2007) who found that patients receiving mental health care who did not receive family visits or social support while in the hospital were more likely to be readmitted. Similar to this, Smith et al. (2014) assert that a strong support network will hasten rehabilitation. Lack of social support has been found to be a second challenge in the present study. Lack of social support system directly affects patients and indirectly affects PNs. The reason for this is that these nurses are the primary caregivers of these patients and are responsible for their entire well-being. Rejection has been pointed out to be one of the lacking social supports that patients have and is a common challenge in these three mental health institutions. The kind of rejection that patients encounter is classified into two categories, namely family rejection and community rejection. These two categories of rejection will be presented below.

6.4.2.1 Family Rejection

The results of this study indicate family rejection as a second common challenge amongst the three MHIs. There are many chronic mentally ill patients who face rejection from their families and relatives, some of whom have not seen their family members for many years. This is in line with research by Johns et al. (2007) who discovered that the MHUCs who do not have social support and visits from their family while hospitalised are prone to be re-admitted to the hospital. The family members do not contact them, either by calling them or visiting them. The PNs feel that the families have detached themselves from these patients and they do not exist to them. When families reject or abandon patients that automatically puts more strain on the nurses. The PNs treat the patients and they become stable, ready to go home but there is no custodian to receive them. They feel that mental health institutions have lost their original purpose and have become a dumping area for chronic mentally ill patients.

There are many patients in these institutions who have being admitted for a number of years. Some of them are mentally stable but there is no family member willing to take them home, which results in a shortage of space in the ward. These patients are occupying the space of someone who is seriously mentally ill and needs assistance. Moreover, Family gatherings and additional contacts may be helpful in offering social support (Perreault et.al, 2005). Most of these families reject the patients because of the offence they committed prior to admission. The PNs strongly believe that rejection emanates from the kind of offences the patients have committed, which create fear and anxiety.

6.4.2.2 Community Rejection

The findings of this study indicate community rejection as another form of lack of social support for PNs. PNs interviewed in this study disclosed that most community members tend to reject patients with chronic mental illness. A study by Makgato (2020) concurs by revealing that some participants experience feelings of discomfort every time they happened to interact with patients with mental illness. The instability of the mentally ill patients was reported as the primary source of anxiety. Like family rejection, community rejection is sometimes caused by fear and anger towards patients with chronic mental illness. The community displays fear and anger towards these patients owing to the criminal offences that they committed before their admission to a mental health institution. Consciously or subconsciously, these community members are of the opinion that these patients are capable of committing the same and even worse offences.

6.4.3 Safety and Security Problems

According to the study's findings, PNs at specialized mental health facilities are quite concerned about safety and security risks. Because they are constantly dealing with aggressive, violent, and unpredictable patients, psychiatric nurses in acute psychiatric units operate in stressful settings, according to a study done in the KwaZulu-Natal Province of South Africa (Joubert & Bhagwan, 2018). PNs expressed their safety concerns during interview, they viewed their workplace risky and dangerous, and other participants talked about violent encounters they had with patients with chronic mentally ill patients. This is emphasised by Duncan et al. (2016), who confirmed in their findings

that professional nurses in Canada experience emotional and physical abuse from MHCUs. Aggressive behavior is one of the key traits of many psychiatric disorders, including personality disorders (antisocial personality disorder, borderline personality disorder), schizophrenia, intermittent explosive disorder, post-traumatic stress disorder, bipolar disorder, depression, and alcohol/substance-induced psychiatric disorders, according to Trifu et al. (2020). The majority of participants in the current study were women, who also voiced their fear of being attacked by male mentally ill patients, who make up the majority of the patient population.

This is in line with a study by Niu et al. (2019), which found that nurses were subjected to physical and psychological abuse induced by their MHCUs in psychiatric institutions in Northern Taiwan. Additionally, a South African study by Maluleke and van Wyk (2017) found that female psychiatric nurses experienced sexual harassment and unsafe working conditions while working weekend shifts. Even while both male and female nurses were subject to violence, intimidation, and assaults from MHCUs under their care, it was discovered in a different study by Jack-Ide et al. (2018) that female nurses were rarely helpless in the ward and needed protection from the male nurses.

Participants expressed concern about being attacked by chronically sick people who are able to roam the ward. They continued by saying that the courts had sent some of the patients to their facility for surveillance. The challenges that nurses face at work might leave them feeling demotivated, irate, and unsatisfied (Buchan, 2006). Safety and security problems were reported by PNs as a challenge in these three mental health institutions. The PNs present with anxiety and excessive fear of the chronic mentally ill patients. The fear also comes from the offences and crimes that the patients have committed as well as the aggressive behaviour that patients display in the ward. The feedback from the PNs revealed that patients with chronic mental illness tend to be aggressive towards each other and to staff members for no apparent reason. Some of these patients portray aggressive behaviour towards nurses when they have relapsed. The PNs experience aggressive behaviour from patients in two forms, physical or verbal. Patients would be constantly violent towards nurses by swearing at them, intimidating them, and physically attacking them. Other patients go to the extent of

vandalising the property of the nurses. For example, a patient in Hayani Hospital killed a nurse and one patient in Thabamoopo hospital smashed the windows of the car of a PN.

This study found that patients with chronic mental illness are also physically violent towards each other. They usually fight in the ward for small things. The fight starts from minor things like food, a chair, and so on. This is a serious challenge in that PNs have to stop the fight, mediate, and make them reconcile. The other challenge about these fights is that nurses tend to be blamed for all the fights that happen in the ward. The management often blames the nurses for every fight that happens between patients or between a nurse and a patient. This increases strain on PNs and makes them feel unsupported by the management.

6.4.4 Lack of Incentives

Incentives should be provided, and initiative rewarded. Another challenge that PNs face in the current study is lack of incentives. More often than not, PNs experience financial problems at work. Chikudu (2016) shares the same sentiments. Participants interviewed in this study express their dissatisfaction with the money they receive as salary. Recently, a portion of the money of PNs working at these institutions was reduced owing to budget constraints. Their overtime money and Sunday lunch money, to be precise, was reduced without their knowledge or consent. What disheartened these PNs is the fact that no one, not even the management, informed or warned them about these sudden changes. This makes them feel unappreciated and unsupported by the management. This is in line with a study by Mokoka et al. (2010).

6.4.5 Shortage of Resources

Alburquerque-Sendn et al. (2018) affirm that despite their importance in providing high-quality mental health services, resources are extremely scarce in South African mental health care institutions. The conditions in which staff members work should be conducive to encouraging professional nurses and other members of the healthcare team to provide MHCUs with high-quality treatment (de Kock & Pillay, 2018). Oleribe et al. (2019) claim that MHIs in Africa are not fully equipped to meet the needs of people utilizing mental health treatment, and the environment is also unsuitable for professional

nurses. For instance, the lack of running water at the psychiatric hospital is a problem because good sanitation depends on running water. According to a study by Bartram et al. (2015), one out of every three hospitals in underdeveloped nations lacks flowing water. sanitation.They further emphasised that adequate water, sanitation, and hygiene are critical features for rendering a health service. In this study, shortage of hot water was raised as a concern.

Shortage of resources was also highlighted as a concern by the PNs in the current study. The majority of PNs working in these institutions struggle with basic resources to provide care for patients. The study has shown general lack of resources in the hospitals studied. The shortage of resources for patients that they face are essential and basic things such as linen, clothes, and body lotion. These are small, basic resources yet essential for patients' personal hygiene. The issue was so significant that PNs mentioned it in their passages. In addition, in order to temporarily offer medical services, patients' clothing had to be borrowed from neighboring wards. These results supported Makhakhe's conclusions (2010). Without these basic resources, patients tend to be frustrated, and take their frustration out on nurses. Nurses reported all these challenges to the authorities, but nothing was done. Participants in this study reported that not only was there a shortage of equipment used for patient care, but there was also a shortage of cleaning materials. Due to a lack of resources, the wards were not always clean, according to these PNs.

According to a South African, over 80% of district hospitals in the provinces of Limpopo, KwaZulu-Natal, Mpumalanga, and the Northern Cape have MHCUs residing with other patients due to appropriate infrastructure in public mental health care institutions. (Docrat and others, 2019) Similar to this, Manyisa et al. (2017) agreed that providing mental healthcare is hampered by the deteriorating physical state of the buildings, wards, and overall layout of psychiatric facilities. Nwaopara et al. (2016) observed in a study done in Nigeria that unconducive environments expose nurses to physical and mental harm, which inhibits them from providing psychiatric care.

According to these PNs, the structure of Evuxakani and Hayani hospitals is not appropriate for psychiatric patients. The participants described the environment as

unsuitable and inappropriate for working. They feel that the wards were not initially built for psychiatric patients; hence, they are not fit to accommodate patients with chronic mental illness. There were rooms that were supposed to be included in a proper psychiatric hospital which are not in place at these mental institutions. For example, there is an absence of seclusion rooms. General yet imperative materials like toilets, toys, TV, and air conditioners are amongst the resources that are lacking in these institutions. The present study found that in one of the institutions, there are no toilets for staff members. These specific staff members have to use the toilet in the other ward, which means they have to leave their post unattended. Basic medical materials like BP machines and seclusion rooms were reported to be absent or unserviceable in some wards, which again hinders patient care. Consultation rooms for nurses and doctors appeared also to be a challenge to these PNs. The researcher experienced the shortage of consultation rooms for nurses in that a few interviews were conducted in the nurses' duty room and in the ward.

Rehabilitation equipment for patients was also reported as an obstacle to patient care by PNs. PNs in the current study revealed that they do not have rehabilitation resources which have a huge impact on patients care. They end up utilising their own non-rehabilitated equipment in order to keep the chronic mentally ill patients busy and entertained. These PNs are expected to have group activities to enhance patient care but there is no equipment provided for that. The infrastructure of the wards is also a problem in these three mental health institutions.

6.4.6 Shortage of Treatment

The final challenge that the PNs encountered has been identified as a shortage of pharmaceutical supplies and medicines. The feedback from the participants shows that sometimes patients do not receive their prescribed medications owing to a shortage of drugs. A shortage of treatment is a serious concern to PNs because patients relapse when they have not taken their medication. It was found that a lack of drugs in these mental health institutions expose PNs to severe violence from patients. Furthermore, the majority of patients display aggressive and violent behaviour when they have relapsed. The other concern that the PNs have is that patients take long to recover from

the relapse, which delays their entire recovery journey. Similar results were reported in a South Africa study by Sunkel and Viljoen (2017), where the mental health care system has a serious shortage of psychiatric medications, mostly in rural public health institutions. Additionally, fluoxetine and basic antipsychotics were among the key psychiatric drugs that were frequently unavailable in national and district mental health settings, according to a study done in Mozambique (Wagenaar et al., 2015).

There is a scarcity of essential medications for MHCUs, according to a second study done in Tanzanian mental institutions. Due to inefficient purchasing procedures and budgetary restrictions brought on by competing needs, it was difficult to maintain a consistent supply of basic psychiatric medications (Ambikile & Iseselo, 2017). Similar findings were discovered in Ghanaian mental health facilities, where severe corruption and management hindered the regular provision of medication, according to Oppong et al. (2016). There is a significant difference in how people are treated in Africa due to the lack of mental health medications (Ambikile & Iseselo, 2017). It is evident that the above-mentioned challenges affect both PNs and patients negatively. It is crucial to note that the challenges that nurses encounter in these three MHIs have a massive impact on the psychological, emotional, and physical well-being of the PNs. These PNs use numerous strategies to cope with the caring burden.

6.5 Coping Mechanisms Used by PNs

Another theme that the current study identified is the coping strategies that PNs use to cope with the caring burden. Roets et al. (2018) claim that psychiatric nurses used a variety of stress-reduction techniques. Some of the coping mechanisms employed by these nurses include effective time management, prearranged team meetings, support systems, and improved communication routes both within and between professional specialties and sections. This study discovered that PNs apply both maladaptive (negative) and adaptive (positive) coping mechanisms to manage their caring burden. The coping mechanisms that these PNs use are prayer, faith or belief in God, teamwork, self-counselling, and absenteeism. The findings of this study revealed that most of the PNs seem to use positive coping mechanisms to deal with their caring duties and responsibilities. These positive coping mechanisms are prayer, faith or belief

in God, teamwork, and self-counselling. Absenteeism was the only negative coping mechanism that a few PNs reported using to cope with their caring burden. All the coping mechanisms that the PNs presented with are outlined underneath.

6.5.1 Prayer

The PNs participating in this study reported using prayer as a way of coping with their caring duties and their problems. Most of PNs use prayer to cope with the challenges that they come across because they are Christian. Prayer has been found to be a commonly used coping mechanism in most Christian PNs. Consistent with the findings of this study, Koen et al. (2011) discovered that healthy lifestyle and spirituality are coping mechanisms used by nurses. Nurses use their inner strength and spiritual resources to deal with their fears, uncertainties, and inquiries, according to Monareng (2012). Others even go to the extent of praying with their family members to manage and solve their problems.

6.5.2 Faith in God

Believing in God was also discovered to be one of the coping mechanisms that PNs used in the current study. The participant's faith in God served assisted the nurses to accept their circumstances, and simultaneously giving a source of meaning in life. Numerous researchers agreed with this concept that nurses practising a religion, spirituality and faith have greater coping abilities (Cameron & Brownie 2010; Zander et al, 2010; Zheng et al. 2017). The participants said that they found the strength and capacity to deal while at work through religious activities such as personal prayer and meditation, as well as group prayer with other nurses. All the nurses participated in this study were actively religious people, at the time of the interview. All of these nurses mentioned that religious standards influenced their performance in a positive manner, enabling them to find meaning amid catastrophe. Faith in God was also found to be one of the coping mechanisms utilised by the PNs interviewed in this study. These nurses believe strongly that their faith in God assists them to cope well with their caring burden. The PNs revealed that they get their strength to care for patients with chronic mental illness from God.

6.5.3 Teamwork

One of the other adaptive coping strategies that PNs in these three mental health institutions use is teamwork. A large number of PNs emphasised that working as a team was important to support them in making patient related decisions and assisting them manage their problems. These PNs are of the opinion that working together, or unity, is power. Furthermore, they indicated that having a good working relationship with colleagues helps them to offer good care to patients. Since they have a good working relationship with each other, they are able to cover and stand in for each other when a need arises. Ramalisa et al. (2018) share the same view by indicating that teamwork between colleagues, multidisciplinary members, and supervisors improved participant's resilience. They further indicated that working as a team provided them the bravery to share cases with managers and boosted their morale. Social support from colleagues was seen a positive attitude in these PNs, which included habit of going to others for communication, advice and comfort.

For nurses and healthcare professionals, the literature review chapter has identified a variety of social support systems. Both at home and at work, specifically from family members, spouses, and friends, were sources of social support. Support at work came from supervisors, colleagues, and coworkers. Support comes from a family, a personal support system, other coworkers, and an organization, according to Ramalisa et al. (2018). The organisation's and coworkers' support is essential to the direct delivery of treatment since poor collaboration can compromise patient care. Amarneh et al. (2010) looked into how Jordanian hospital nurses' job performance was affected by social support from their coworkers. The study's conclusions showed that perceived social support from coworkers increased job performance, lowered working stress, and increased commitment to one's employment.

6.5.4 Self-Counselling

Self-counselling was highlighted as another adaptive coping mechanism used by PNs to maintain their psychological health while rendering professional service. Since they have studied basic psychological counselling as part of their modules, they decided to use what they had learnt and to counsel themselves when they have problems. These

PNs also mentioned that the other reason for self-counselling is that the psychological services in these hospitals are mainly for patients, not for staff. The reasons for not seeking psychological services are unavailability of psychological practitioners, fear of discussing their personal issues with a colleague, and poor relationships between the nursing and psychology department. This concept of self-counselling was adopted as a coping strategy by nurses after realising and accepting their work challenges.

6.5.5 Adaptation

Adaptation has been discovered as one of the methods that PNs use to cope with their caring burden. Adaptation is defined as the human ability to adapt to different situations. Lints (2012) agrees by stating that in generally, adaptation as a process is possibly about changing something can be itself, others, the sounding so that it would be extra convenient for certain reason than it would have otherwise been. Furthermore in psychology, adaptation is interested in how people mentally cope with different life changes. From the feedback given by nurses interviewed in this study, some nurses adapt to the situation, in this case the caring burden, as a coping mechanism. This coping mechanism is often used after acceptance of the situation. According to these PNs, after realising that they cannot fix most of their challenges, they decided to adapt to the situation.

6.5.6 Absenteeism

The results of the current investigation also showed that employee weariness and absenteeism were caused by a staffing shortfall. According to a study by Garcia et al., this is accurate (2015). There are many people that miss work for a variety of reasons. According to Singh (2012), absenteeism has been seen to predominate among PNs working with chronic mentally ill patients. Nurses use absenteeism as a way of coping with work demands. PNs reported being tired because they are working too much, which results in absenteeism. Many of them mentioned that they take sick leave and do not go to work as a way of coping with their caring burden. According to the nurses, this negative coping mechanism is perpetuated by the shortage of staff and by financial problems that are prevalent in these institutions.

6.6 Support Structures and Programmes Available to PNs

Another theme of the current study is support structures and programmes available to assist the nurses with their caring duties and responsibilities. The researcher found it essential to determine the support structures and programme for nurses in order to develop a support programme for them if none was available. The reason for this inclusion is to check whether nurses have support structures and how effective those structures are before developing a support programme. The responses gathered in this study revealed that not all institutions and wards have support structures and programmes. The majority of the PNs from the three MHIs indicated that they do not have formal and functional support structures and programmes. The support structures and programmes available in these institutions are mostly for patients, not for nurses.

In addition, PNs indicated that they do not have support from most multidisciplinary team members (MDT). Procedurally, patients with chronic mental illness were supposed to consult with 90 per cent of the MDT members but in these institutions it is not like that. In these institutions, nurses and doctors are the ones who are consistently consulting with patients and caring for them. Consequently, patients end up not receiving holistic treatment. PNs stated that the involvement of other MDT personnel is crucial to optimal patient care and overall treatment.

However, a minority of PNs reported having some form of support structures in place for nurses. These support structures include union forums, support visits from their supervisors, and other nursing-related meetings. All these support structures are aimed at addressing the challenges that PNs experience while caring for patients with chronic mental illness. It is like a venting session of some sort. These meetings are usually held once a month. The target group is all the nurses with their operational managers and matrons. Sadly, the result of this study revealed that a large number of PNs participating in the present study do not have functional formal support structures and programmes, which necessitates the development of a support programme. Functional support structures and programmes are a must-have and are critical in that they will allow the nurses to share their experiences and to find healthy ways of coping with their caring

duties and responsibilities. The PNs recommended the following support programme to assist with their caring duties and responsibilities.

6.7 Suggested Support Programmes for Nurses

The main goal of this study is to provide a support system for PNs who caring for patients with chronic mental illness. Given that occupational stressors are one of the major psychosocial hazards for PNs, developing a valid and reliable support programme that can assist with nursing duties and responsibilities will be of paramount importance. Such a programme could ultimately lead to better patient outcomes. Considering the phenomenological experiences shared by the PNs and the challenges that they face, it is essential to have a support programme for these professional nurses. Stress, exhaustion, and burnout among nurses are all possible outcomes of emotional and psychological difficulties without an effective support system. As a result, this may have an impact on nurses' well-being and productivity at work, and the quality of their care delivery negatively.

In consistence with the results of Setona et al. (2020), mental health nurse specialists need support. The implementation of the 2020 Strategic Plan, the creation of a mental health cabinet, the establishment of district leadership in mental health, consistent support, and the requirement for advanced certification(s) for mental health nurse managers are among the recommendations they have made to help support mental health nurse specialists. Considering the results from previous themes, it is evident that the developing of a support programme is needed and will be beneficial to all nurses and patients. When asked about a suitable support programme to help with the caring duties, PNs' suggestions fell under five categories, namely family support, support by colleagues and supervisors, financial support, psychological support, and general social support. All of these suggestions and recommendations are discussed as follows:

6.7.1 Family Support

In the current study, PNs emphasised the need for continuous support from families of the chronic mental health care patients. They highlighted that they would be delighted to have the family members getting involved in the patients' lives. The kind of support that is needed is social and financial support. Social support can be achieved when family

members of the mentally ill patients contribute by maintaining continuous contact with the patients. They can call the patients, visit them, and take them home for leave of absence and home visits. Still in terms of family support, PNs think financial support from the families can be beneficial to patients. This financial support can be in the form of money and presents. For instance, the family members can bring home-cooked food and toiletries for patients at every visit. These PNs are optimistic and believe that some teamwork between nurses and family members is crucial and will definitely be beneficial to patients.

6.7.2 Support by Colleagues and Supervisors

As stated earlier, PNs alluded to having insufficient support from MDT members and from the management of the institutions. As a result, they appealed to their colleagues and supervisors to support them and to be more active about in-patient care. The PNs indicated that their colleagues (MDT) can offer support by doing ward rounds with them, see patients when they refer them, counsel them and many more. The PNs who participated stated that their managers do not consider their well-being. They viewed the hospital management team as unsupportive in term of ensuring that resources were always available to provide adequate healthcare to the patients. These nurses long for and need support from their managers, which can be in the form of words, and by hiring more staff.

The managers can also portray gratitude and support by showing interest in the well-being of nurses; not only of patients. Nurses would be ecstatic to receive attention and to hear from the management of these hospitals. Actually, these PNs would like to see an improvement in the area of communication. According to these PNs, management should listen to them and consult with them before making major changes and decisions. The professional nurses suggested some form of support and motivation by management would make a huge difference in the workplace. Some professional nurses stated that the multidisciplinary team requires some strengthening and learn to work together with other stakeholders.

More often than not nurses were commonly seeking informal support from their families, friends and colleagues (Zhang et al., 2021). According to these findings, Zhou et al.

(2017) found that informal assistance from friends and family serves as a person's primary source of support while dealing with stress, with formal support typically only being sought after informal support has failed. One possible explanation for this is because one of the most direct and convenient forms of support for nurses is assistance from family and friends. Peer support in professional atmospheres is seen as a productive method. Regarding formal support, nurses revealed their deep desire emotional help and support from managers. Nurses are discouraged by the absence of consistent assistance from supervisors following a distressing event. Additionally, managers who consistently accuse nurses without providing any supporting evidence cause secondary harm to nurses and underreport violent episodes. Post-incident counseling is advised by nurses since it is necessary as a significant intervention to lessen the negative effects of the incidents. Like the law, judicial institutions are beneficial to victims of abuse (Zhang, et al., 2021). According to Hassankhani et al., organizational support is crucial (2018).

6.7.3 Financial Support

Another kind of support that PNs recommended is financial support. From the responses of these nurses, they would appreciate financial support in the form of money or incentives. They somehow feel underpaid. These PNs would like to see their overtime and Sunday lunch incentives reinstated. Participants in the current study acknowledged that their supervisors have nothing to do with their incentives cut, but felt that they should have been informed of such change. The PNs would appreciate if the government can consider their hard work and compensate them accordingly.

6.7.4 Psychological Support

The PNs participating in this study recommended psychological support as a support programme that will help them cope better with caring duties and responsibilities. According to these nurses, talking about their challenges to an expert is vital and beneficial. There were three PNs who sought private psychological services to deal with their personal challenges and were able to get help; as a result they recommend it. The other reason for the request for psychological services is because most PNs advocate the importance of the mental well-being of patients, so they also see the requirement to

look after one's own mental wellbeing. This psychological support programme that they have in mind can be in the form of counselling, debriefing, and therapy. The PNs mentioned that the counselling sessions can be done, preferably in a group; and that personal sessions can be done individually. Venting and talking about their work-related problems should be the main focus of the psychological support programme, so they say. According to these nurses, this psychological support programme can be held once a month or bimonthly. It will be subject to the therapist's schedule. The sessions can be conducted either in the ward, or hall, or whatever place is convenient to PNs and the therapist.

6.7.5 General Social Support

Besides the above-mentioned support programmes, PNs require the need for consistent general social support to deal with their caring duties and responsibilities. In this study the general social support needed includes having staff outings, exercising, and playing sports. These nurses believe strongly that the examples stated above of general social support will help to improve their mood and will ultimately enhance their mental well-being. These PNs would like to have some time outside of their workplace to socialise as colleagues. This is confirmed by a study by Al-Sagarat et al. (2017), which found that practicing favorite hobbies outside of work and realizing that life is wonderful, fun, interesting, and worthwhile outside of work were the most common coping methods used by psychiatric nurses.

6.8 Conclusion

The findings of the study were discussed in depth in this chapter. Chapter 8 discussed in length the results, which were carefully introspected and compared with relate studies conducted in other parts of the globe. Many similarities and differences were seen and discussed in this chapter. This chapter was structured according to the following theme: natural common diagnoses, phenomenological experiences of the nurses, challenges that PNs encounter while giving care, coping mechanisms adopted by these PNs, support structures and programmes available, and support programmes suggested by PNs to assist with their duties and responsibilities. Chapter 6 will present guidelines regarding the development of a support programme for nurses.

CHAPTER SEVEN

DEVELOPMENT OF A SUPPORT PROGRAMME

7.1 Introduction

After data collection and analysis, the findings of the study outlined that PNs in the three MHIs do not have formal structured support programmes to equip and empower them with their caring duties and burdens. The data collected and analysed, and the feedback and responses from the PNs were used to develop specific strategies that speak to the identified needs of nurses. In other words, a support programme has been extracted from the participants' responses and needs. The primary purpose of this programme is to provide psychosocial support to nurses with the intention to ease their caring burden. A method that was utilised for the development a support programme for nurses caring for patients with chronic mental illness is the ADDIE model.

7.2 Methodology for the Development of a Support Programme

According to Branch (2009), the ADDIE model is a didactic design method which comprises five stages, namely Analyse, Design, Development, Implementation and Evaluation. Only three of these steps will be discussed in this study. These phases are arranged in a sequential order and are presented as follows:

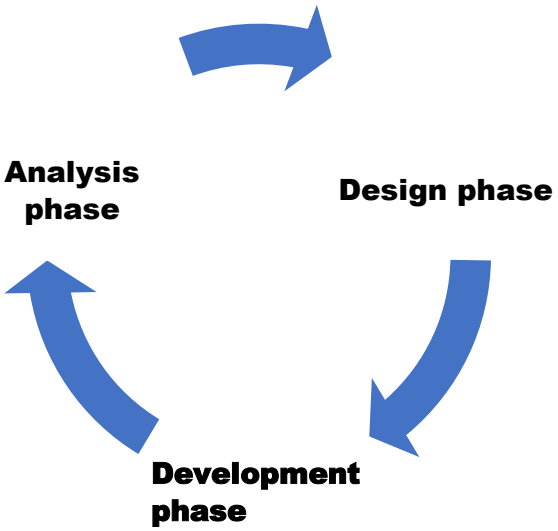

Figure 7: *ADDIE Model*

Phase 1: Analyse

The analysis phase serves as the groundwork for all subsequent phases of didactic design. During this stage, the researcher conducted a needs analysis using the phenomenological experiences extracted from the nurses' responses. The phenomenological experiences of the nurses include the need for a support programme since most of the nurses did not have one. From the researcher's analyses, nurses are faced with huge challenges, use both negative and positive coping mechanisms, and have few support structures and programmes to help with the caring burden. This alone shows that there is a void that has to be addressed.. The needs analysis was done by administering semi-structured interviews to the participants.

Phase 2: Design

The design phase involves using the results from Phase 1 to plan and come up with a strategy for the development of a support programme. Here, the researcher illustrates the objectives of the programme and the content of the programme. The support group programme's target population is all nurses. This programme will be using a therapeutic method with the objective of equipping, empowering, and supporting nurses with their caring burden. This programme will entail the following:

1. All categories of nurses. This means the composition of the group session will be professional nurses, enrolled nurses and auxiliary nurses registered with SANC, working at these MHIs.
2. It will be hosted and conducted in a conducive place, either in a hall or conference area of each hospital.
3. The programme will be conducted once a month.
4. It will be facilitated by psychology practitioners and social work officers.
5. The content of the programme will include but will not be limited to the following topics: challenges faced by nurses, coping mechansms, recommended solutions and health education and awareness among the nurses.

6. It will also include psychological games and team-building activities that will enhance their coping mechanisms.
7. Methods of teaching will include discussions and presentations.
8. Posters and brochures on stress, stress management and work-related conflict management will also be available.

NB: If a need arises during the session, managers, supervisors and other relevant stakeholders will be invited to the session.

Phase 3: Development

The main goal is to create a support program for nurses working in the three mental health facilities in the province of Limpopo who are caring for patients with chronic mental illnesses. This program will give them coping strategies and life skills to lessen the stress of their caregiving. Furthermore, it aims to employ the coping strategies that these nurses have indicated are most useful for them. The development phase builds on both the analyse and design phases. In this phase, the programme content is developed. All of the psychosocial materials required are in place. Psychological and social health education, activities and games are available. The facilitators like psychologists and social workers are on board.

The proposed support programme will include the following key areas of attention:

1. Teamwork among all nurses. All nurses will be taught about the importance of working together. They will also be equipped with team-building exercises and activities that will assist them to work together.
2. Family involvement. Family involvement will be one of the focus areas. In one or two sessions, families and relativies of the MHCUs will be invited. The nurses will highlight their needs and the areas where family can be involved in providing support. Families will be asked to take responsibility and to play their part by visiting, taking patients home for leave of absence visits, encouraging patients to drink their medication while at home, etc. Nurses will be given an opportunity to raise their challenges related to families and what families can do to help address those challenges for the sake and benefit of patients.

3. Community members. Community members will also be asked to support nurses while caring for patients. Nurses will involve the community by conducting health awareness projects.
4. Multidisciplinary team members. It is common knowledge that patients need a holistic approach to treatment, which involves the expertise of all members of the multidisciplinary team. In one or two sessions, multidisciplinary team members will be invited to attend sessions with the nurses. Nurses will be given an opportunity to raise their concerns and to ndicate how their colleagues can assist in addressing those concerns. Things like how essential follow-up is with patient referrals and submitting required reports or feedback on time, and many more will be addressed.
5. Management: support. Management of these three mental health institutions will also be requested to attend a few sessions with the nurses. The focal point of the sessions that management will attend is to formally address the nurses' challenges and concerns formally. In those sessions, there will be a secretary who will record the meeting, two or three members will be selected who will be dedicated to arrange follow-up meetings with the management. Issues will be addressed in that session like appreciating nurses, listening to their opinions, sending them to school to further their studies, attending workshops, improving facilities, and addressing the shortage of staff.

Psychological support

2.1 Debriefing sessions: debriefing sessions will be made a priority to people who were actually involved in a traumatic incident and those who witnessed the traumatic incident. Debriefing sessions will be conducted whithin 72 hours after a traumatic incident. Preference will be given to the ones who were directly involved rather than those indirectly involved. Members will be advised to seek individual counselling to avoid the development of PTSD.

2.2 Group sessions: Group sessions will take place the form of a venting session with the nurses. They will be conducted once a month; an industrial psychologist will also be invited to one of the sessions to do team-building activities and presentations.

2.3 Prevention and promotion programmes and awareness with nurses, family members and community members. These will also encompass the distribution of posters, brochures, and pamphlets, and making oral and static presentations to the three groups. The nurses will also conduct outreach programmes with the MPT members to nearby areas.

7.3 Conclusion

In this chapter the first three steps of the ADDIE Model were used to develop a support programme. These steps include the analysing phase, designing phase, and developing phase. This support programme would be functional and effective when nurses and psychology practioners work together. The implementation of this support programme also involves supervisors, management, and government. The following chapter outlines the summary, recommendations, and limitations of the study.

CHAPTER EIGHT

SUMMARY, LIMITATIONS AND CONCLUSION

8.1 Introduction

The previous chapter presented guidelines that assisted in developing a support programme. This chapter outlines the summary of the study, implications of the study, and limitations of the study.

8.2 Summary of the Study

The study's objective was to create a support system for nurses working with patients suffering from chronic mental illness. The study's main objective was to learn about and comprehend the professional nurses' life experiences, difficulties, coping methods, and support systems while they provided care for patients with chronic mental illness. The majority of the study's findings is congruent with the themes identified: the nature of chronic mental illness, phenomenological experiences of professional nurses, challenges faced by professional nurses, coping mechanisms of PNs, support structures and programmes available for PNs, and support programme suggested by these PNs.

The nature of chronic mental illness was seen as one of the themes emerging from the current study. According to DSM 5, there are many types of chronic mental illness, which range from mild to severe diagnoses. In the present study, not all chronic mental illnesses were present. The most prevalent mental illnesses in the present study were schizophrenia, schizo-affective disorder, ADHD, mood disorders, and intellectual disability. The most prevalent diagnosis in this study was schizophrenia. Some of the patients admitted to these three MHIs had dual diagnoses. Of the patients, 30 per cent were diagnosed with medical conditions such as epilepsy, diabetics, and high blood prsssure.

From the second theme, phenomenological experiences of the professional nurses, PNs shared their lived experiences with the researcher. After being asked ‘How is it to care for patients with chronic mental illness? they shared various emotions and feelings.

The experiences of these PNs included both positive and negative emotions. The majority of PNs find their caring duties to be challenging and stressful. PNs found their caring duties overwhelming and stressful owing to factors like shortage of staff, resources, over-and-above tasks and non-nursing-related tasks. There were a few who were comfortable and passionate about their work and about nurturing patients. The third theme focused on various challenges that nurses encounter while caring for patients with chronic mental illness. These challenges not only affect the PNs but also patients. For instance, the shortage of treatment. When there is no treatment, patients relapse and that causes a lot of damage and eventually disturbs the treatment journey. Challenges that nurses face were discovered to be the personnel shortage, inadequate support from families, MPT and supervisors, the shortage of treatment, the shortage of resources, and a lack of incentives. These challenges have been reported to the authorities but have not been resolved. These challenges also put more physical and psychological strain on nurses, which results in absenteeism, backaches, and fatigue.

The fourth theme that was identified is the coping mechanisms used by PNs. This study reveals that PNs tend to use both adaptative and maladaptive coping strategies to handle their challenges. The majority of the nurses use adaptive coping mechanisms to ease their caring burden. These adaptive coping mechanisms comprise teamwork, self-counselling, adaptation, prayer, and faith in God. Few PNs in the present study were found to use absenteeism as a maladaptive coping mechanism. The fifth theme is support structures and programmes. The feedback received from the PNs reveals that there are no formal or structured of support structures and programmes in place to assist nurses with their caring duties. Hence, the current study seeks to provide a support programme for these nurses. The final theme comprises suggestions and recommendations for a support programme from the PNs who participated in the present study that can ease the caring duties. The suggested support programmes entailed social support, financial support, general support, and psychological support. The suggested support programme extracted from these PNs was used to develop the support programme outlined in the previous chapter.

8.3 Implications of the Findings

This section will present the implication of the finding of the current study. The implications of the study are relative to theory, clinical practice, research and policy. All of these will be discussed below:

8.3.1 Implications of Theory

Taking care of people with chronic mental illness is the primary mandate of nurses working in mental health instituitins; hence, a formal structured support programme is needed. The researcher based the study on the Dickoff et al. practice theory (1968), which was utilised to develop a support programme for nurses after listening to the phenomenological experiences of professional nurses, the challenges they face while caring for patients, and the coping mechanisms they employed. The Dickoff et al. practice theory has six aspects of activities and their related key questions to consider when developing a programme. These six essential points guided the development of a support programme. This theory helped the researcher to articulate the research findings and to develop a support programme for nurses because it provided insights and understanding of their caring duties and their challenges. This theory is suitable for the current study.

8.3.2 Implications for Clinical Practice

The conclusions of this study may be helpful in creating the framework for subsequent research, either to support or refute its findings. The results may also motivate additional research into the creation of a support program for all sorts of nurses who treat patients with chronic mental illness. A study that will develop a support programme for nurses working in general hospitals is also receommended. There should also be more communication and support between nurses and psychology practitioners for the developed support programme to be functional and effective.

8.3.3 Implications for Research

According to Makgahlela (2016), knowledge production is essential in advancing the objectives of any professional ground and in keeping the experts informed on the most recent advancements in their area of expertise. There is a need for larger-scale research that encompass different nursing specialties like enrolled and auxiliary nurses

working in MHIs. A study with nurses who have fewer than three years' working experience can also be conducted. The same study should be conducted with different methodologies. In the future, it should be thought about conducting a quantitative study with a larger sample size to provide a clear picture of the difficulties faced by professional nurses working in mental health care facilities and the coping strategies they employ, and then to develop a support program for them. Since the findings of this study cannot be generalized, similar investigations ought to be carried out in a variety of settings and in additional South African regions. The findings of this study, however, can be used by other provinces to manage and resolve problems that nurses face while delivering care. The results of this study may also contribute to the body of knowledge on nursing education in terms of how to assist nurses caring for chronic mental illness.

8.3.4 Implications for Policy

The findings of this study could be very helpful to managers and supervisors of mental health institutions in providing support in the form of training to nurses who provide ongoing support to chronic mentally ill patients. The finding may also enlighten government to develop policies that include the well-being of nurses also because most policies on mental health are patient oriented.

8.4 Recommendations

The Mental Health Care Act, 17 of 2002 should be reviewed by the government, according to one of the study's recommendations, because it only addresses the rights of MHCUs and makes no provisions for the safety, well-being, or legal rights of professional nurses or other mental health care providers. Additionally, to improve the safety of nurses and other mental health care personnel, the management of the institutions should inform the Department of Health about the need to hire more security officers and male nurses. Given that nurses are frequently the target of violent behavior, it is advised that regular in-service training about the handling of aggressiveness be implemented and strengthened immediately at these MHIs. All employees should be urged to participate in such training. The interdisciplinary team members and risk management officers may conduct frequent workshops as part of the in-service training, which should be primarily focused on practical applications. More so, a support

programme developed in this study should be implemented to improve their coping mechanisms in line with stress associated with work. Resources that are necessary for the proper operation of the mental health care facility and patient care should be made available by the Department of Health.

8.5 Limitations of the Study

This part of the chapter concentrates on the limitations, restrictions and challenges which the researcher experienced while conducting the study.

- To start, only licensed nurses were a part of the study's population. Another study might include additional nurse types, such as enrolled nurses and auxiliary nurses who care for patients with chronic mental illnesses in these facilities. This means that the results of the present study cannot be generalised to all caterories of nursing.
- Second, the data was collected in English, which is the medium of instruction. However, many professional nurses, particularly the older ones, struggled to express themselves fully because they often talk to their patients and colleagues in either Xitsonga, Tshivenda or Sepedi.
- Third, the research was carried out with participants who were working day shift at that time. Although most of the participants had experience of working night shift, the study could have benefited from professional nurses working night shift.
- Lastly, the fact that the researcher was not allowed to visit all wards owing to COVID-19 restrictions and hospital protocols is one of the limitations of the study. Additionally, the findings of this study only apply to the demographic that was studied and not to all nurses working in other wards.

8.6 Conclusions

In conclusion, mental illness is a global challenge, which not only affects patients but also nurses and families who offer care to the patients. The study's conclusions show the degree to which professional nurses are faced with numerous challenges with no support structures and programmes to help them cope with their caring burden. The results could lead to the suggestion that nurses caring for mental ill patients really need support from their supervisors, from the patients' family, and from relatives and

colleagues. Generally, participants were found to be overwhelmed with no support; hence, the present study. For us to fight and win the battles related to mental illness, we need to focus on every person who is involved and to provide adequate support to those people.

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APPENDIX A: PERMISSION LETTER FROM TURFLOOP RESEARCH ETHICAL COMMITTEE (TREC)

University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3935, Fax: (015) 268 2306, Email: anastasia.ngobe@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE

ETHICS CLEARANCE CERTIFICATE

MEETING: 4 July 2019

PROJECT NUMBER: TREC/127/2019: PG

PROJECT:

Title:	Development of a support programme for nurses who care for patients with chronic mental illness in three Limpopo Province mental health institutions.
Researcher:	TG Rikhotso
Supervisor:	Prof T Sodi
Co-Supervisor/s:	Prof T Mothiba
School:	Social Science
Degree:	PhD in Psychology

PROF P MASOKO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

Note:

i) This Ethics Clearance Certificate will be valid for one (1) year, as from the abovementioned data. Application for annual renewal (or annual review) need to be received by TREC one month before lapse of this period.

ii) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee, together with the Application for Amendment form.

iii) PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

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APPENDIX B: PERMISSION LETTER FROM PROVINCIAL DEPARTMENT OF HEALTH, LIMPOPO PROVINCE

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

Department of Health

Ref : LP- 202001 - 011
Enquires : Ms PF Mahlokwane
Tel : 015-293 6028
Email : Kurhula.Hlomane@dhsd.limpopo.gov.za

Tsakani Rikhotso

PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITIES

Your Study Topic as indicated below;

Development of a support programme for nurses who care for patients with chronic mental illness in three Limpopo Province mental health institution.

1. Permission to conduct research study as per your research proposal is hereby Granted.
2. Kindly note the following:
   a. Present this letter of permission to the institution supervisor/s a week before the study is conducted.
   b. In the course of your study, there should be no action that disrupts the routine services, or incur any cost on the Department.
   c. After completion of study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
   d. The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   e. The approval is only valid for a 1-year period.
   f. If the proposal has been amended, a new approval should be sought from the Department of Health
   g. Kindly note that, the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated

pp

Head of Department

12/03/2020

Date

Private Bag X9302 Polokwane
Fidel Castro Ruz House, 18 College Street. Polokwane 0700. Tel: 015 293 6000/12. Fax: 015 293 6211.
Website: http\www.limpopo.gov.za

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APPENDIX C: PERMISSION LETTER FROM MOPANI DEPARTMENT OF HEALTH, LIMPOPO PROVINCE

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
MOPANI DISTRICT

Student number : 201015468
Enquiries : S Chuma
Tel Direct : 015 811 6661

To: **Ms. Rikhotso Tsakani Glory**
P.O Box 334
Hoedspruit
1380

Dear Ms Rikhotso T.R

RE: **PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITY: YOURSELF**

1. We acknowledge receipt of your request received on the 23 March 2020.
2. It is with pleasure to inform you that permission has been granted for you conduct research at Evuxakeni Hospital on " **The development of a support programme for nurses who care for patients with chronic mental illness in Limpopo mental health institutions**".
3. Note the content of the Departmental permission dated the **12 March 2020** for your adherence and compliance.
4. You are advised to furnish the Head of Institution with this letter and the letter from the Provincial office for the purposes of access and assistance.
5. You will also be expected to observe and comply with all ethical standards and acts governing the public service to keep the integrity of the health facility and the department.
6. Wishing success in your studies.

S. h—a
.....
ACTING DIRECTOR: CORPORATE SERVICES

2020/03/23
.....
DATE

APPENDIX D: PERMISSION LETTER FROM VHEMBE DEPARTMENT OF HEALTH, LIMPOPO PROVINCE

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OFHEALTH
VHEMBE DISTRICT

Ref: S5/6
Enq: Muvari MME
Date: 06.10.2020

Dear Sir/Madam RIKHOTSO T.G

Permission to conduct a research on the
« DEVELOPMENT OF A SUPPORT PROGRAMME FOR NURS...

1. The above matter refers.

2. Your letter received on the 06.10.2020 requesting for permission to conduct a research is hereby acknowledged.

3. The District has no objection to your request.

4. Permission is therefore granted for the study to be conducted within Vhembe District. You are expected to submit the results to the District.

5. You are however advised to make the necessary arrangements with the facilities concerned.

Wishing you success in your endeavors.

CHIEF DIRECTOR: DISTRICT HEALTH — DATE 6/10/2020

Private Bag X5009 THOHOYANDOU 0950
OLD parliamentary Building Tel (015) 962 1000 (Health) (015) 962 4958 (Social Dev.) Fax (015) 962 2274/4623
Old Parliamentary Building Tel: (015) 962 1818, (015) 962 1852, (015) 962 1754, (015) 962 1001/2/3/4/5/6 Fax (015) 962 2393, (015) 962 227

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APPENDIX E: PERMISSION LETTER FROM CAPRICORN DEPARTMENT OF HEALTH, LIMPOPO PROVINCE

02-10-2020
RECEIVED

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH: CAPRICORN DISTRICT

REF : 5.5/3/1/2

ENQ : Hlatshwayo MM

TEL : 015 290 9154/9096

FROM : DISTRICT EXECUTIVE MANAGER

TO : RIKHOTSO TSAKANI
UNIVERSITY OF LIMPOPO
SOVENGA

SUBJECT : PERMISSION TO CONDUCT RESEARCH ON DEVELOPMENT OF A SUPPORT FOR PROGRAMME FOR NURSES WHO CARE FOR PATIENTS WITH CHRONIC MENTAL ILLNESS IN THREE LIMPOPO PROVINCE MENTAL HEALTH INSTITUTION.

The above matter refers:-

1. Permission to conduct the above study at **Thabamoopo Hospital** is hereby granted effective from the date of approval.
2. Kindly be informed that :
   - In the course of your consultation there should be no action that disrupts the services.
   - After completion of the research, it is mandatory that the findings should be submitted to the Department to serve as a resource.
   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   - Kindly note that the Department can withdraw the approval at any time.
3. Your cooperation will be highly appreciated.

02-10-2020

DISTRICT EXECUTIVE MANAGER DATE

1

APPENDIX F: SEMI-STRUCTURED INTERVIEW GUIDE

Objective	Interview questions
1.To investigate the challenges that nurses experience daily.	a) As a nurse, how is it to take care of a person who is diagnosed with chronic mental illness?
	b) Would you explain to me the difficulties and challenges that you face when taking care of these people?
2.To determine the support structures available to nurses.	c) Kindly share with me the kind of support structures available to help you with the caring burden?
3.To identify strategies used by nurses to cope with chronic mentally ill patients.	d) Caring for chronic mentally ill patients is not easy, so what methods are you using to cope with this role?
4.To describe strategies used by nurses to cope with chronic mentally ill patients; and	e) Would you please explain in detail some of the methods that you utilise to cope with the caring role?
5.To develop support programmes useful for nurses.	f) Can you tell me about any support programmes that you know of that can help you to better manage people with chronic mental illness? g) Kindly share with me what you think should be the components of such a support programme? h) Do you have any other suggestions regarding the development of such a support programme that will assist with caring for people with chronic mental illness?

APPENDIX G: PARTICIPANTS' CONSENT FORM

Department of Psychology

University of Limpopo

Private Bag X1106

Sovenga

0727

Date: _____

Thank you for demonstrating interest in this study that focuses on the development of a support programme for nurses caring for patients with chronic mental illness in three mental health institutions in Limpopo Province. The purpose of this study is mainly to develop and implement a support programme for nurses caring for patients with chronic mental illness in Hayani, Evuxakeni, and Thabamoopo mental institutions.

Your responses to this individual interview will remain strictly confidential. The researcher will not attempt to identify you with your responses to the interview questions or to disclose your name as a participant in the study. Please be advised that participating in this study is voluntary and that you have the right to terminate your participation at any time.

Kindly answer all the questions and reflect your true reaction. Your participation in this research is vital. Thank you for your time and your cooperation.

Kind regards

_____ _____

Tsakani Glory Rikhotso Date PhD student

Prof T Sodi _____

Supervisor Date

APPENDIX H: CONSENT FORM TO BE SIGNED BY PARTICIPANT

CONSENT FORM

I_____ hereby agree to participate in a PhD research project that focuses on the development of a support programme for nurses caring for patients with chronic mental illness in three mental health institutions in Limpopo Province.

The purpose of the study has been fully explained to me. I further understand that I am participating freely and without being forced in any way to do so. I also understand that I can terminate my participation in this study at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project, whose purpose is not necessarily to benefit me personally but also South Africa and the world at large. I understand that my details as they appear in this consent form will not be linked to the interview schedule and that my answers will remain confidential.

Signature: _____

APPENDIX I: LETTER FROM LANGUAGE EDITOR

Editing Certificate

Prof. T. Sodi
Faculty of Human Sciences
University of Limpopo

Editing of a Doctoral Thesis

I, Marietjie Alfreda Woods, hereby certify that I have completed the editing and correction of the doctoral thesis: **Development of a Support Programme for Nurses who care for Patients with Chronic Mental Illness in Three Limpopo Province Mental Health Institutions** by **Tsakani Glory Rikhotso,** submitted in fulfilment of the requirements of the degree **Doctor of Philosophy** in the **Faculty of Human Sciences** at the **University of Limpopo.**

It is believed that the thesis meets with the grammatical and linguistic requirements for a document of this nature.

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