NURSES’ INTERACTION WITH PATIENTS WHO ARE HIV/AIDS INFECTED

BY

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DECLARATION

I declare that the work presented, except that which is listed and acknowledged, is original and has never been submitted at any university for academic purpose.

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DEDICATION

This study is dedicated to:

- My mother, Seemole Phuti Mohlamme.
- My sons, Kenny, Thapelo and Phenyo, granddaughters, Makosha and Mathapelo, for their understanding and support throughout my studies, even in unbearable situations.
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ABSTRACT

The nurses who work in the hospitals are constantly in interaction with the patients. As the HIV infection has now reached the AIDS phase, most people who were infected five to ten years back are now sick due to HIV/AIDS compromised conditions. The statistics inform us that mostly young people are dying. This has reversed nature, in that elders are now burying the youth. The HIV/AIDS infected people who are ill are admitted to general hospitals for health care. At present the patients are cared for in the general wards with other patients who may not be HIV/AIDS infected. In the hospitals they are cared for by the health team, of which the nurses are with these patients for 24 hours a day.

This study focused on the interaction between nurses and admitted patients who are HIV/AIDS positive. The patients may have been admitted due to opportunistic diseases or any other illnesses. Most patients with HIV/AIDS suffer from opportunistic diseases, pain and stress. Nurses become aware of the patient’s HIV/AIDS status for health care reasons. Nurses are in most institutions the first contact in health care. Therefore the nurses are engaged in established relationships with patient, families, friends and the community for the purpose of the provision of health care services. These relationships entail interaction. The interaction between the nurse and the patients plays a major role in the care of the patient. This interaction between the nurses and patients entails a number of aspects, such as communication, be it verbal or non-verbal. The latter includes behavioural and affective aspects, such as attitudes, the way care is provided and how the parties feel about the interaction.

Nursing is a human interaction. In this interaction the nurse and the patient build a therapeutic relationship, resulting in assistance to facilitate the well-being of the patient and rapid recovery. The HIV /Aids infection affects the patient as a whole because of the stigma attached to the disease, therefore
the affected patients need to be assisted in order to cope with the illness and its consequences.

Therefore the purpose of the study was to:

- To explore and describe the nurses’ and patients’ (who are HIV/AIDS infected) experience of their interaction.
- To develop and describe a model that would assist the nurses to facilitate the promotion of mental health in patients who are HIV/AIDS infected.

A theory generation research which is qualitative, descriptive and explorative and contextual in nature was conducted with permission from the Department of Health authorities, hospital authorities, admitted patients with HIV/AIDS, the NGO that looks after the patients in the community after discharge, the nurses who work in the general wards and the University of Johannesburg Ethical and Research committee.

Pilot interviews were conducted with one nurse-participant and patient-participant that met the selection criteria.

The research method followed the four steps in theory generation recommended by Chinn and Kramer (1995: 111) as outlined below:

**Step One: Concept analysis**

The concept analysis followed two steps, namely concept identification and concept classifying and definition using the survey list of Dickoff, James, and Wiedenbach (1968, 428). During concept identification a qualitative research strategy, which is descriptive, explorative and contextual in nature, was conducted through fieldwork. The sample consisted of seven nurses and eight patient-participants who were purposively selected. The triangulation method was used whereby the field worker interviewed nurse-participants while the main researcher collected data on patient-participants. The interviews were
audio-taped with permission from the study participants. Data were analysed according to Tesch’s method (Creswell, 1994: 155) and an independent coder verified the analysed data.

Patient-participants presented their interaction with nurses as more frustrating and unhelpful than they expected. Nurse-participants also presented their interactions as horrible, difficult, frustrating and of little value to the patients’ lives. This showed that nursing HIV/AIDS patients distressed nurses. The nurses forgot the aspect of promotion of health. They did not see the patient-participants as whole persons that embodied dimensions of body, mind and spirit (Rand Afrikaans University, 2002:4). The results were validated through literature control. The reasoning strategies described by De Vos (2000: 336) such as, analysis, synthesis, inductive and deductive reasoning applied in data analysis contributed to a logical chain of evidence that supported the researcher’s conclusion after data analysis.

The major concept of the model was identified as the FACILITATION OF CONSTRUCTIVE NURSE-PATIENT INTERACTION with the aim of assisting patients who were HIV/AIDS infected to promote their mental health. In this study the strategies were used as indicated below:

**Step Two: Placing concepts into relationships**

The interrelationship statements between the concepts identified provided the links among and between concepts. The concepts are no longer seen in isolation but in relationship and represent a higher level of complexity. As concepts are identified, ideas about relationships between them begin to form. The concepts that stood alone, unrelated to others or interrelated with other concepts, were identified as well as those that could be linked to theory by assumption. The link between the concepts enabled the researcher to determine the nature or character of the relationship.

**Step Three: Description of the model**
The step describes the development of a model to assist the nurses to facilitate the promotion of mental health in patients who are HIV/AIDS infected. The model was developed and described as the **FACILITATION OF CONSTRUCTIVE NURSE-PATIENT INTERACTION**. The process of the model for facilitation of constructive nurse-patient interaction has five dimensions:

- To assist the nurses to make themselves available to assist the HIV/AIDS infected patients in the promotion of their mental health.
- Apply constructive coping strategies while caring for the HIV/AIDS infected patients to assist the patients to use their available resources to promote their mental health.
- To implement open communication with the HIV/AIDS infected patients to allow them to communicate their fears to promote their mental health.
- To provide emotional support to the HIV/AIDS infected patients as a strategy to promote their mental health.
- To assist the nurses to balance care and caring of the HIV/AIDS infected patients as a strategy to assist them to promote their mental health.

This covers an overview of the definitions of concepts, assumptions, and structural form of the model.

**Step Four: Guidelines to operationalise the model**

Guidelines to operationalise the model were developed. This involved applying the theory into practice and studying its effects on the quality of life and of nursing and on the process of health. The promoter and co-promoter as well as the independent panel of experts evaluated the model.

The trustworthiness and worth of the study was established through the application of the strategies proposed by Lincoln and Guba (1985:294) and
Krefting (1991:214) that is, credibility, transferability, dependability and confirmability.

Ethical measures were applied throughout the study.
Die verpleeg personeel werk saam in hospitale is gedurende in interaksie met die pasiënte. Die meeste pasiënte wat 5-10 jaar gelede met MIV geïnfecteer is, is nou in die VIGS stadium en dus siek met MIV/VIGS opportunistiese siektes. Statistiek het getoon dat sterftes hoofsaaklik in die jonger geslag plaasvind. Dit is in teenstelling met die natuur in die sin dat die ouer geslag nou die jonger geslag begrawe. MIV/VIGS geïnfecteerde pasiënte wat siek is, word in algemene hospitale opgeneem vir gesondheidsorg. Huidiglik word die pasiënte versorg in algemene sale saam met die nie-geïnfecteerde MIV/VIGS pasiënte. MIV/VIGS pasiënte word versorg deur die gesondheidsorgspan waarvan die verpleeg personeel 24 uur met hierdie pasiënte in kontak is.

Hierdie studie fokus op die interaksie tussen die verpleeg personeel en opgeneemde pasiënte wat MIV/VIGS positief is. Die pasiënte kan opgeneem word as gevolg van opportunistiese infeksies of enige ander siekte. Die meeste pasiënte met MIV/VIGS ly aan opportunistiese infeksies, pyn en stres. Verpleeg personeel word bewus van die pasiënt se MIV/VIGS status vir gesondheidsorg redes. In die meeste instellings is die verpleeg personeel die eerste kontak in gesondheidsorg. Die verpleeg personeel is verbind in 'n hegte verhouding met die pasiënt, families, vriende en die gemeenskap met die doel van voorsiening van gesondheidsorg dienste. Hierdie verhouding behels interaksie. Die interaksie tussen die verpleeg personeel en die pasiënte speel 'n groot rol in die behandeling van die pasiënt. Die interaksie tussen die verpleeg personeel en pasiënte behels 'n paar aspekte waarvan kommunikasie (verbaal en nie verbaal) een is.

Kommunikasie behels gedrags- en emosionele aspekte byvoorbeeld houdings, die manier waarop sorg verskaf word en hoe die partye oor die interaksies voel. Verpleging is 'n menslike interaksie. In die interaksie bou die verpleeg personeel en die pasiënt 'n terapeutiese verhouding met die resultaat van bystand tot die fassilitering van die gesondheid van die pasiënt asook spoedige herstel. MIV/VIGS infeksie beïnvloed 'n persoon in die geheel as gevolg van die stigma daaraan verbonde.

Die affekteerde pasiënte moet bygestaan word om die siektes en die gevolge daarvan te kan hanteer. Die doel van die studie is om:
Die ervaring van beide die verpleegpersoneel en opgeneemde MIV/VIGS pasiënte van hulle interaksie te verken en te beskryf.

Om ‘n model te ontwikkel en te beskryf wat die verpleegpersoneel sal bystaan in die fassilitering van die bevordering van geestesgesondheid in pasiënte wat met MIV/VIGS geïnfecteer is.

‘n Teorie genererende navorsing wat kwalitatief, verkennend, beskrywend, eksploratief en kontekstueel is, is uitgevoer met die goedkeuring van die Departement van Gesondheid, opgeneemde pasiënte met MIV/VIGS, die NRO wat pasiënte na ontslag in die gemeenskap versorg, verpleegpersoneel werkzaam in die algemene sale asook die Universiteit van Johannesburg se Etiese en Navorsingskomitee.

‘n Loods onderhoud is gevoer met een verpleegkundige deelnemer asook een pasiënt deelnemer wat aan seleksie kriteria insluit voldoen het.

Die navorsingsmetode het die vier stappe in teoriegenerering gevolg voorgestel deur Chinn en Kramer (1995: 111). Hierdie vier stappe van teoriegenerering word hieronder uitgestippel:

**Stap Een: Konsepanalise**

In konsepanalise word twee stappe gevolg, naamlik konsep identifisering en konsep klassifikasie en definisie deur gebruik te maak van die opname lys van Dickoff, James en Wiedenbach (1968: 428). Gedurende konsep identifisering is’n kwalitatiewe navorsing strategie (verkennend, beskrywend en kontekstueel van aard uitgevoer deur veldwerk. Die steekproef bestaan uit sewe verpleegkundiges en agt pasiënt wat doelgerig gekies is. Die triangulasie metode is gebruik waar die veldwerker die verpleegsterkundiges ondervra het terwyl die navorser die data van die pasiënte ingesamel het.

Die onderhoud is opgeneem met toestemming van die studie deelnemers. Data is geanalyser volgens Tesch se metode (Creswell, 1994: 155) en ‘n onafhanklike kodeerder het geanalyseerde data geverifieer.
Deelnemende pasiënte het hul interaksie met die verpleegpersoneel as frustrerend en onbehulpsaam beskryf. Deelnemende verpleegpersoneel het ook hul interaksie beskryf as sleg, moeilik, frustrerend en van min waarde tot die pasiënt se lewe. Dit toon dat verpleging van MIV/VIGS pasiente druk op die verpleegpersoneel plaas. Die verpleegkundiges het die aspekte van bevordering van (Rand Afrikaans University, 2002: 4) gesondheid vergeet en het nie pasiënte in die geheel (dimensies van liggaam, siel en gees) gesien nie.

Die resultate is gevalideer deur 'n literatuurkontrole. Die redenasie strategieë beskryf deur De Vos (2002: 336) soos analise, sintese, inductiewe en deduktiewe redenasie is toegepas in data analise en het bygedra tot 'n logiese ketting van bewyse wat die navorser se gevolgtrekking na data analise ondersteun.

Die hoof konsep van die model is geïdentifiseer as die FASILITERING VAN KONSTRUKTIEWE VERPLEEGKUNDIGE-PASIENT INTERAKSIE met die doel as die ondersteuning van pasiënte wat MIV/VIGS infekteer is, om sodoende hul geestesgesondheid te bevorder.

**Stap Twee: Plasing van konsepte in verhouding**

Die verhoudingsstelling tussen konsepte is geïdentifiseer om verbindingste tussen konsepte te voorsien. Konsepte word nie meer in isolasie gesien nie, maar in verhouding en verteenwoordig 'n hoër vlak van kompleksiteit. Die verhouding tussen konsepte help die navorser om die aard of karakter van die verhouding te bepaal.

**Stap Drie: Beskrywing van die model**

Hierdie stap beskryf die ontwikkeling van 'n model om die verpleegpersoneel by te staan in die fassilitering van die bevordering van geestesgesondheid in
die pasiënte wat MIV/VIGS geïnfekteer is. Die model is ontwikkeld en beskryf as die **FASILITERING VAN KONSTRUKTIEWE VERPLEEGKUNDIGE-PASIENTE INTERAKSIE**. Die proses van die model vir fassilitering van konstruktiewe verpleegskundige-patiënt interaksie het vyf dimensies naamlik:

- Om verpleegskundiges by te staan om hulself beskikbaar te stel om die MIV/VIGS geïnfekteerde pasiënte te help in bevordering van hulle geestesgesondheid.
- Gebruik van konstruktiewe hanteringstrategieë terwyl MIV/VIGS geïnfekteerde pasiënte versorg word, terwyl beskikbare hulpbronne gebruik word vir die bevordering van geestesgesondheid.
- Implementering van oop kommunikasie met MIV/VIGS geïnfekteerde pasiënte sodat hulle toegelaat word om hul vrese te kommunikeer en sodoende hulle geestesgesondheid te bevorder.
- Voorsiening van emosionele ondersteuning aan MIV/VIGS geïnfekteerde pasiënte as strategie ter bevordering van hulle geestesgesondheid.
- Bystand van verpleegsters in balansering van sorg en versorging van MIV/VIGS geïnfekteerde pasiënte as strategie ter bevordering van hulle geestesgesondheid.

**Stap Vier: Riglyne vir operasionalisering van die model**

Riglyne vir operasionalisering van die model is ontwikkeld. Dit omvat die toepassing van die teorie in praktyk en die bestudering van die effek daarvan op die kwaliteit van lewe, verpleging en proses van gesondheidsbevordering. Die promoter en mede-promotor asook ’n onafhanklike paneel deskundiges het die model geëvalueer.

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CHAPTER ONE

OVERVIEW AND RATIONALE

1.1 INTRODUCTION AND BACKGROUND

The study focuses on exploring and describing the nurses’ and patients’ (who are HIV/AIDS infected), experience of their interaction. The patients may be admitted due to HIV/AIDS opportunistic diseases or any other illnesses. Most patients with HIV/AIDS suffer from opportunistic diseases, pain and stress (Friedman, De la Rey & Soubrayon, 1998:16). Nurses become aware of the patient’s HIV/AIDS status for health care reasons. In most institutions nurses are the first contact in health care. Therefore nurses are engaged in established relationships with the patients, patients’ families, friends and communities for the purpose of the provision of health care services. These relationships entail experience of their interaction. The interaction between nurses and patients plays a major role in the care of the patients. In the wards the nurses’ and patients’ experience of their interaction includes behavioural and affective aspects, such as attitudes presented, communication; both verbal and non-verbal, the way care is provided and how the parties feel about the interaction.

Reihl-Sisca (1989:323) states that nursing is a human interaction. In this interaction the nurse and the patient build a therapeutic relationship aimed at facilitating the well-being of the patients and rapid recovery. The relationship needs to be taken seriously because if it is taken for granted it may hinder the helping relationship (Okun, 1992:78-79). The communication process facilitates the major aspects of the interaction. It is important for the nurse to note that either positive or negative communication has a great influence on the recovery and the mental well-being of the patient.

In any interaction communication skills are applied; either in the form of hearing verbal messages, thus cognitive, or in affective and behavioural content. The patients and the nurses perceive the behaviour of each other
according to their own understanding and respond accordingly. Both parties use their coping skills in the interaction process, which may either be approachable, or avoidance reactions (Okun, 1992:47-48).

It is often forgotten that verbal communication can be perceived as heard while non-verbal communication is understood differently. During nurse-patient interaction the cognitive, affective and behavioural aspects are important. Patients use this to uncover the underlying messages. The affective aspects include feelings and emotions that may be directly or indirectly expressed. These feelings may be grouped into major categories such as fear, anger, sadness or happiness. Affective, cognitive and behavioural communication as presented by the nurses in their interaction with the patients can be seen as negative or positive. The interaction has an effect on patient recovery and on how the patients view the whole organisation; for example, love, empathy and understanding results in the patients feeling safe in the organisation, hence there is rapid recovery; while lack of sympathy, empathy and understanding can lower patients’ self-esteem and retard the recovery progress. In their studies, Flaskerud and Tabora (1997:20) and UNAIDS (2000: 5) found that HIV/AIDS caregivers suffer from depression. Nurses are caregivers because they provide care in the hospital. They may experience depression or inner anger (Taylor, 1997:281) and stress that contributes to negative attitudes, absenteeism and staff turnover.

In my study on the experiences and coping skills of the families of people living with HIV/AIDS (Manamela 2001: 57), I found that nurses' attitude towards patients with HIV/AIDS, and their relatives raised concerns. This showed that nurses' interaction with patients with HIV/AIDS was not as positive as with other patients. Therefore it is important to explore and describe what nurses’ and HIV/AIDS infected patients, experience of their interaction.

HIV/AIDS is a killer disease; as human beings, nurses are also affected, either directly or indirectly. They may experience what the patients are suffering from and become insecure about their status. It is possible that
nurses may also be infected or just stigmatising the patients as the illness has a moral connotation.

Nurse-patients interaction may at times be brief, superficial and task orientated while the patients need more than that to come to terms with the fact of the HIV/AIDS opportunistic infections. The patients need to know more about the relationship of the present illness and HIV/AIDS. The need may only be met if the nursing interventions are sited within the helping relationships.

Nurses in general hospitals seem to lack positive skills to deal with HIV/AIDS because of a lack of training in managing patients with HIV/AIDS in the ward. In their study Colebunders, Bottieau, Willaeyes and Fileerackers (2001: 171) found that HIV/AIDS patients in general hospitals were not as satisfied with the care provided compared to that in academic hospitals. It is expected that nurses be trained in dealing with challenges such as HIV/AIDS, but it often happens that nurses in admission wards are not considered for the training that those who are specifically dealing with HIV/AIDS issues at out-patient level receive. This may leave the nurses in the admission wards without the necessary skills to approach the HIV/AIDS positive patient – hence an avoidance-attitude may result. The nurses need to develop positive defense mechanisms that encourage constructive interaction in order to promote the mental health in patients with HIV/AIDS. The health team needs to be highly skilled and well looked after so that they will be able to provide quality care to the patients. The quality care involves the five dimensions of life such as the physical, mental, social, spiritual and economical aspects of the patients (Beck, Rawlings & Williams, 1994: 354). The management and team members need to realise the importance of facilitating the nurse-patient interaction. The nurse may also be HIV/AIDS infected and become afraid of developing the same illnesses in the near future and suffer the way the patients are suffering. The nurse may distance herself from the patients though expected to provide holistic care. It will therefore be required that management consider establishing an employee assistance program for these nurses to facilitate quality services rendered to these patients.
The HIV/AIDS infected patients do experience rejection from loved ones, families and friends as well as from the community (Manamela, 2001:40). When nurses also treat them in the same way they may feel dehumanised and accept everything done to them, without being fully involved in their own care; keeping quiet instead of questioning some of the aspects of the care. The patients may experience difficulties in becoming assertive because of self-pity, guilt or blaming themselves for the infection. Therefore it is important for the nurses to realise the effect of nurse-patient interaction on the outcome of the health care and mental well-being of HIV/AIDS infected patients.

1.2 PROBLEM STATEMENT

South Africa, like other countries in the world, is severely affected by the killer disease, the HIV/AIDS pandemic. The HIV/AIDS virus contributes to mental health problems in the affected groups. Recent statistics suggests that six out of ten men, eight out of ten women and nine out of ten children living in Sub-Saharan Africa are HIV/AIDS infected (National Department of Health, 2000). According to Health Systems Trust (2002: 165), it is stated that 4.8 million South African are infected with HIV/AIDS, however, estimates from UNAIDS indicate that 38.6 million adults globally were living with HIV/AIDS at the end of 2002, of whom 29.4 million live in Sub-Saharan Africa. AIDS deaths totaled 3.1 million globally in 2002, of which 2.4 million were in Africa. In 2002 the estimated incidences of infections in both adults and children reached 5 million globally with 3.5 million in Sub-Saharan Africa. 10 million young people aged 15-24 and almost 3 million children under the age of 15 years are living with HIV in the region. South Africa has more people living with HIV/AIDS than any other country (Fact file in Sowetan, 2003/08/04: 12).

Gauteng Department of Health aimed at reducing the incidence as well as the prevalence of HIV/AIDS through use of several strategies in the preventive and promotion services (Gauteng Health Department, May, 2000: 8). Programmes such as prevention of mother to child transmission were rolled out in almost all antenatal clinics and hospitals in Gauteng Province (Gauteng Health Department, May, 2000: 8). This indicates that there are measures to
fight the spread of HIV/AIDS but what is lacking is how the infected patients are taken care of while admitted in the hospitals.

Organisations like the Treatment Action Campaign (Kweza in Sowetan, 13 June, 2003:12) believe in the reduction of prevalence and prolonging the life span of people living with AIDS through the use of anti-retroviral drugs. They accuse the government of not providing the anti-retroviral drugs in public institutions. It is indeed true that most young people died prematurely due to AIDS but the government could not provide these drugs due to the lack of funds and serious side-effects of the drugs (Silverstone in Sowetan, 2003: 04: 22).

Many young people are dying with AIDS. However Martin, Colford, Ngo and Tager (1995: 343) state that with advances in treatment of the diseases it is likely that adults contacting HIV/AIDS may continue living beyond the age of 50. Of the infected people 40 percent are mentally affected or develop mental problems after the diagnosis of HIV/AIDS. It is suggested that out of ten HIV/AIDS infected individuals at least six are mentally affected either on diagnosis or during the full-blown AIDS stage (Martin et al, 1995: 343). Although some illnesses can be treated at outpatient level, most of the patients with HIV/AIDS end up admitted to hospitals at some stage due to opportunistic diseases caused by their immuno-compromised status. The patients are admitted under section 33 of the Hospital Ordinances Act 14 of 1958 (Gauteng Provincial Legislature, 1999: 5).

In these hospitals the patients are engaged in an interaction with the nurses. During the interaction the nurses present skills, knowledge, attitudes and behaviours, as well as interests, important aspects of individual personal style, which affect how the relationships are managed (Squire, 1994:319). According to Liaschenko (1997: 45-46) relationships are seen as the vehicle for the work of nursing. Nurses and patients have a relationship by virtue of the fact that they share a connection or set of circumstances that bring them
together. The circumstances are that the patients require help with health care problems and the nurses can do something to assist.

It is expected that the nurses will always demonstrate empathy, warmth and caring (Walsh, 1997:485) during their interaction with the patients. The issue is whether the interaction yields these or not. In the study conducted by McLaughlin (1997:1221) nurses reported to be satisfied with their interaction with the patients, the satisfaction on the part of the patients, of their experiences of their interaction with the nurses is equally important, most importantly on the patients who are HIV/AIDS infected. It was revealed that the nurses’ behaviour towards the HIV/AIDS patients’ relatives was unsympathetic, showing a lack of empathy and understanding (Manamela, 2001: 36). How much more towards patients who are HIV/AIDS infected? Therefore it is important to explore and describe the nurses’ and patients’ (who are HIV/AIDS infected) experience of their interaction.

Gauteng Health Department (September 2001: 7) HIV/AIDS sero-prevalence survey on pregnant woman estimated an over ten percent increase in the HIV/AIDS infection rate, rating Gauteng fourth in terms of prevalence in South Africa. The women’s sexual partners may be infected as well and over time these people develop AIDS. These patients need health intervention programs, of which the nurses are important team members. The patient ends up admitted in a general hospital for treatment for any of the opportunistic diseases. These patients are engaged in interaction with the nurses for 24 hours a day while the other team members are involved only periodically. The nurses are expected to provide nursing care as guided and stipulated according to their nursing standards and code of practice (Searle, 2000: 98-99). According to the Theory for Health Promotion in Nursing, Rand Afrikaasns University, (2002:3) the patients are persons who are seen holistically as whole persons with body, mind and spirit.

The nurses are the first contact for the patients admitted to an institution. The nurses and the patients become engaged in an interaction, which will contribute to the well-being of the patients. The interaction entails both verbal
and non-verbal communication (Okun, 1992: 47). The nurses who have already developed intervention plans then call in the other team members.

This shows that nurses have a very important role to play. Most patients who are HIV/AIDS infected, suffer physically, socially and mentally. Those who suffer mentally do present with mental illness or problems. Although the actual cause of the mental illness is unknown, predisposing and precipitating causes have a major role to play (Maddison & Kellehear, 1982: 134), and HIV/AIDS is one of many contributory factors. The nurses' interaction with these patients can also contribute to undermining the patients’ mental well-being. HIV/AIDS leads to an overpopulation of patients admitted to the hospital and with shortage of staff and poorly maintained facilities the patients are not properly cared for. These patients frequently receive a lower quality of services including mental health care in the wards than those patients without HIV/AIDS opportunistic diseases (Otello, Nieves & Charter, 1997:95). In their study, Boutcher and Gallop (1996:196) found that nurses’ behaviour towards patients with psychiatric illnesses due to sexually related infections was one of avoidance, which re-inforces the patients’ feeling of their experiences as “too bad or too unpleasant” to discuss with nurses. Some nurses’ behaviours were found to be unsympathetic on sexually related illnesses (Manamela, 2001:57).

The difficulty in balancing the role of the nurses and the bureaucracy of the hospitals together with insufficient resources, overwork and poor working conditions may have a negative impact on nurses’ interaction with the patients (Sammut, 1997:20). The questions that arises from this problem are: What are nurses’ and patients’ (who are HIV/AIDS infected), experience of their interaction and what could be done to assist the nurses to facilitate the promotion of mental health in patients who are HIV/AIDS infected?

1.3 OBJECTIVES

- To explore and describe the nurses’ and patients’ (who are HIV/AIDS infected), experience of their interaction.
To develop and describe a model that will assist the nurses to facilitate the promotion of mental health in patients who are HIV/AIDS infected.

1.4 PARADIGMATIC PERSPECTIVE

The school of Nursing Science, University of Johannesburg follows the principles of the Theory for Health Promotion in Nursing (Rand Afrikaans University, 2002: 5) as its paradigmatic perspective. This theory focuses on the whole person and embodies the dimension of the body, mind and spirit. The theory implies that the person functions in an integrated, interactive manner with the environment. The person needs to be assisted to mobilise available resources in order to promote the health of the individual, families and the community (Rand Afrikaans University, 2002:3). The researcher will adopt this theory as a theoretical framework that guides this study.

1.4.1 Metatheoretical assumptions
According to this theory the following statements can be made:

Persons refer to nurses, patients, families and communities, field workers and the researcher. They are all seen holistically in the interaction with the environment in an integrated and interactive manner.

Hospitals are health institutions approved by the government as stated in the Hospital Ordinance Act, 1958: section 33 to admit people who are sick for provision of health care services and recovery (Gauteng Provincial Legislature, 1999: 5).

Mental health is a specialised area in psychiatric nursing practice. It is an integral part of health and reflected on the persons’ health status (Poggenpoel, 1992:8). The patterns of interaction between the internal and external environment of nurses and patients determine their mental health status.
Environment implies the internal and the external environment of the patients and the nurses. The internal environment entails the body, mind and spirit of each person. The external environment comprises the physical, social and the spiritual dimensions. In this study the external environment of the patient refers to other in-patients, team members and nurses, the wards in which they are admitted and systems utilised to help them recover. The nurses’ external environment will include the patients, team members and the patients’ families, infrastructure and the resources used to render nursing care.

1.4.2 Theoretical assumptions
The theoretical assumptions are measurable and offer epistemic pronouncement about the research field (Botes, 1994: 5) and include models and theories (Mouton & Marais, 1990: 20). The study of existing theoretical announcements can also be made to state the theoretical assumptions and can also be added in qualitative studies after the data collection and analysis (Botes, 1994: 5). In this study the theoretical assumptions will be added.

1.4.3 Theories and models
The research took place within the context of nursing in a hospital. The researcher will go to the field without any preconceived ideas or conceptual framework. After data collection and analysis the results will be reflected with the Theory for Health Promotion in Nursing (Rand Afrikaans University, 2002) as well as recontextualised in the literature. The research methodology will follow the research model proposed by Poggenpoel and Myburgh (1998). According to them the research has dimension process, step by step starting with the problem statement up to the publication of the results, depending on the design selected.

1.5 LITERATURE CONTROL

Literature will be incorporated during the discussion of the research results in the light of the information obtained from similar studies (Poggenpoel, 1994: 131).
1.6 THEORETICAL DEFINITIONS

Nurses:
Nurses are educated and trained individuals employed in the provision of health care services who have registered with the South African Nursing Council, either as professional nurses, enrolled nurses or enrolled auxiliary nurses (South African Nursing Council, Act 50, 1978). They are educated, trained and developed in such a way that they will be able to interact with the patients in a goal-directed way in the provision of health care, including assisting them to mobilise their environmental resources to facilitate their promotion for mental health (Poggenpoel, 1994:54). The nurses work together with the multidisciplinary health teams.

Interaction:
Interaction is the process of allowing direct two-way communication or establishing relationships between the individuals or the groups with the purpose of having an effect on each other (Longman Dictionary, 1995: 734).

HIV:
HIV refers to the Human Immune-deficiency Virus. This virus is recognised as an agent that leads to immune suppression, resulting in Acquired Immune Deficiency Syndrome (AIDS). The antibody is the factor determining whether an individual is HIV negative or positive. According to Schoub (1994:31-36), HIV positive refers to the condition when antibodies against the HIV are present in the blood of a human. This virus penetrates the body and establishes itself in the human body affecting as many organs and human tissues as possible. The HIV positive status is caused by a retrovirus that changes the genetic information in the cells from RNA to DNA.

AIDS:
AIDS is an acronym, which stands for Acquired Immune Deficiency Syndrome. AIDS is the illness triggered by HIV (Evians, 1995:267).

Patients infected with HIV/AIDS:
Patients infected with HIV/AIDS in this study refers to any individual who has undergone HIV/AIDS testing and is confirmed to be positive, has already suffered or is suffering from AIDS-related disorders. Nurses are aware of these patients’ status for health care provision reasons. The patients are willing to be involved in the study (Evians, 1995:15).

Model:
A model is defined as a structural design consisting of organised and related concepts or a pictorial representation that shows the simplified details of a concept or concepts considered relevant to measuring the specific outcomes of a discipline (Reihl-Sisca: 1989: 7). Chinn and Kramer (1991: 120) define a model as a symbolic representation of an empiric experience that provides an understanding of theoretical relationships in an attempt to objectify the concepts represented. Botes in Lenkwane (2001: 11) describes a model as a conceptual framework that classifies manifestations in terms of structures which systematises the relationships between the manifestations and variables.

A model therefore offers an account of the dynamics of the manifestations by way of a simple portrayal of the relationship between the main elements of the process. The model assists in clarifying, depicting and organising and simplifying reality (Tiffany & Lutjen, 1998: 15). In this study a model is considered as described above.

1.7 METHODOLOGICAL ASSUMPTIONS

Methodological assumptions are assumptions about the nature of the research process. The methodological assumptions guiding this research are in line with the research model proposed by Poggenpoel and Myburgh (1998) which proposes that the dimensions of the research process follow step by step, starting with the problem statement, objective, paradigmatic perspective, considering ethical measures, research design and method up to report writing and lastly publication of the results, depending on the design selected which may either qualitative or quantitative. The research process will result in knowledge generation, and the knowledge generated in this research will be
applied to nursing practice in order to provide quality care to patients. In this research the development of an interactive model will serve as a framework for the nurses to facilitate the promotion of mental health in patients who are HIV/AIDS infected. To ensure rigor in the research, measures of trustworthiness (Lincoln & Guba, 1985:294) are applied. The principles of logic and justification are adhered to.

1.8 RESEARCH DESIGN AND METHODS

A theory generation, qualitative, explorative, descriptive and contextual research design will be followed. The four steps of theory generation described by Chinn and Kramer (1991:79) will be followed (to be discussed in Chapter Two).

**Qualitative research** refers to a systematic, interactive and subjective approach that can be used to describe life experiences and give them meaning (De Vos, 1998: 242, Burns & Grove, 1997: 6,1999:27). Qualitative research is a theory- generating design (Chinn & Kramer, 1991: 79). In this study an explorative, descriptive qualitative design following a phenomenological approach is appropriate to explore the nurse-patients interaction.

**Explorative study** refers to a study designed to increase knowledge by exploring the phenomena, the manner in which they are manifested and the relationship thereof, while observing and documenting takes place (Burns & Grove, 1997:303). The research aims to explore the nurse-patient interaction following a phenomenological approach.

**Descriptive study** aims at discovering new facts about the situation, people or events and to provide an in-depth account of characteristics (Mouton & Marais, 1996: 43) of any nurse and patient willing to take part in this study, to discover their experiences and uncover the interaction and the manner in which they occur, then categorise them (Burns & Grove, 1997: 30).
Phenomenological approach emphasises a shift from theoretical abstractions to reality lived experiences and investigating their structure (De Vos, 1998:445). The researchers directly explore, analyse and describe a phenomena (Streubert & Carpenter, 1995: 36).

The four steps of theory generation described by Chinn and Kramer (1991:79) will be followed (to be discussed in Chapter Two). See Table: 1.1.

**TABLE: 1.1 Summary of the steps in theory generation**

<table>
<thead>
<tr>
<th>Theory generation</th>
<th>Data collection</th>
<th>Data analysis</th>
<th>Reasoning strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step One</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Concept analysis</td>
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<tr>
<td>Step One</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concept identification</td>
<td>Purposeful sampling.</td>
<td>Dickoff, James and Wiedenbach, (1968:197-203) survey list.</td>
<td>Inductive Analysis</td>
</tr>
<tr>
<td>Concept definition and classification</td>
<td>Phenomenological interviews, audio tape recordings and transcriptions of field notes.</td>
<td>Literature control</td>
<td>Synthesis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Synthesis</td>
</tr>
</tbody>
</table>
### Establishing interrelations between concepts.

Construction of theoretical relationship.

<table>
<thead>
<tr>
<th>Step Three</th>
<th>Categorising the concepts in relation to statements through interrelational statements.</th>
<th>Statements that most classify the interactions.</th>
<th>Synthesis</th>
</tr>
</thead>
</table>

### Step Four

Description and guidelines to operationalise the model

<table>
<thead>
<tr>
<th>Deduction and recommendations</th>
<th>Guidelines to operationalise the model in the nursing practice and education.</th>
<th>Deductive</th>
</tr>
</thead>
</table>

### 1.9 SAMPLING

Sampling refers to the process of selecting a portion of the population that conforms to a designated set of specifications to be studied (Polit & Hunglar, 1997:355 and Uys & Basson, 1991:87). In this study nurses and patients will be selected by means of purposive sampling, which indicates conscious selection of individuals who meet criteria (Burns & Groves 1999:246). Participants will be involved in in-depth interviews until saturation of data take place (Burns & Grove, 1997:23).

### 1.9.1 Sampling techniques
Purposeful sampling strategy (Polit & Hunglar, 1999:335 and Uys & Basson, 1991:87) is opted for because only admitted patients infected with HIV/AIDS and nurses providing care in admission wards will be sampled.

1.9.2 Target population
The population will consist of the admitted patients who are infected with HIV/AIDS and nurses working in general admission wards.

1.9.3 Study participants
The patients who are HIV/AIDS infected and nurses working in admission wards, all above eighteen years of age, who are willing to give consent and meet the sampling criteria, will participate in the study. They will be the persons who are once admitted to and employed in a hospital respectively; both genders will be allowed to participate in in-depth interviews until data saturation are achieved.

1.9.4 Recruitment of participants
Participants will be recruited with permission from the hospital management and the non-governmental organisation that takes care of the patients after they are discharged.

1.10 PILOT STUDY
One participant from each group will take part in a pilot study, where the same interview questions will be asked and then analysed with the aim of assessing whether the research is relevant and correcting the research question.

1.11 THE RESEARCH INSTRUMENT
The researcher is the manager of the institution where the research will be conducted; therefore she will appoint a field worker who will interview the nurse-participants while the main researcher collects data on patient-
participants. A semi-structured interview guide will be used for collecting data (See Annexure A).

1.12 DATA COLLECTING METHODS

Qualitative data will be collected using in-depth interviews and field notes will be recorded. Participants will be interviewed in the language that they prefer and understand. Verbatim translation will be done and data will be translated into English (see discussion in Chapter Two).

1.13 DATA ANALYSIS

Data will be read and re-read to get the idea of the whole. Verbatim transcription of all the data will be done. Themes will be organised and coded; categorised and classified. Patterns; meaning; commonalities and differences will be identified. Lastly data will be interrogated and systematically explored to generate meaning. Appropriate methods will be used to display data (Coffey & Atkinson, 1996:46).

1.14 CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

Conclusions will be formulated, limitations discussed and recommendations made on the basis of the research findings in respect of nursing practice, mental health education and psychiatric nursing research.

1.15 REPORTING THE FINDINGS

A report about the findings will be documented and submitted for publication. Information about the study will be disseminated to the relevant authorities.

1.16 TRUSTWORTHINESS
The method of establishing trustworthiness will follow the strategies recommended by Lincoln and Guba (1985:294) as follows: credibility, transferability, dependability and confirmability. (To be discussed in detail in Chapter Two).

1.17 ETHICAL CONSIDERATIONS

Ethics refers to a science or study of morals and morality, which is the standard of behaviour followed by individuals or groups. As this research involves human beings it will be ensured that participants’ rights are protected as stipulated in “You and Your Constitution” (Constitutional Assembly, 1997: 12). It is therefore imperative that good research and ethical standards be applied equally to the community during research (National Department of Health, January, 2000: 6). Therefore the following principles will be adhered to:

**Respect for human dignity:** This indicates that the participants have the right to self-determination and the freedom to participate or not to participate in the research. The researcher and field worker will explain to the participants that they have the right to respect of their human dignity and whatever information they give will not be used to undermine their dignity. The participants have the right to withdraw without penalty (Polit & Hunglar, 1999: 139, Burns & Grove, 1997: 99 and Bandman & Bandman, 1995: 32).

The nursing profession’s ethical guidelines for research will be applied in this study, and used as a guide by which hospital management and nurses as advocates for the patients, can judge the research. The rights and responsibilities of the various role players will be clarified (Democratic Nurses of South Africa, 1998: 5).

Consent to participate will be obtained in writing from the participants. The participants will be informed about the purpose of the study, that participation
is voluntary and that they may withdraw from the study without any penalties. The fact that the study carries no physical risk will be explained, that privacy, anonymity and confidentiality will be ensured. The study is approved by the Rand Afrikaans University, Faculty of Education and Nursing Ethical committee, which will ensure that the ethical principles are complied with. The study will also be submitted to the institutional ethical committee’s examination for approval (see annexure E).

The right to privacy: The right to privacy involves issues around the private information given by the participants. This may include feelings, beliefs, attitudes, behaviour and opinions. Research information will be destroyed immediately after the research results are published, the right to privacy will be adhered to; there will be no mention of names (Lobiondo-Wood & Haber, 1990: 189).

The right to anonymity and confidentiality: Anonymity requires that the participants’ identity must not be linked to their responses. Confidentiality requires that information shared by participants must not be linked to the participants and that real names will not be used. The researcher will ensure that no unauthorised person gains access to the data. Data will be kept safe and destroyed on completion of the study.

Informed consent: Informed consent refers to the participants’ documented agreement to participate in the study. The consent to participate will be obtained in writing from the nurses taking care of the admitted patients who are HIV/AIDS infected and from the same patients. The participants will be informed about the purpose of the study, that participation will be voluntary and they may withdraw from the study without any penalties. The fact that the study carries no physical risk will be specified.

The participants will be informed and it will be explained to them what the study is all about and that they voluntarily choose to take part. The researcher will explain about the background of the study, the purposes and the objectives of the study, research designs and methods to be followed, ethical considerations and reporting systems.
The participants will be allowed to ask questions for clarity. The researcher will ensure that the participants understand all the details of the study and will request them to sign informed consent documents. The researchers will make available their contact details in case the participants would like to contact them for anything related to the study. The rights of the participants will be protected as indicated above.

1.18 DIVISION OF CHAPTERS

- Chapter One: Overview and rationale
- Chapter Two: Research design and method
- Chapter Three: Discussion of results and literature control
- Chapter Four: A tentative model for the promotion of mental health
- Chapter Five: Description of a final model and guidelines for operationalisation
- Chapter Six: Summary, conclusions, limitations and recommendations

1.19 CONCLUSION

This chapter outlines an overview, the background and rationale of the proposed study. Therefore it is important to explore and describe the nurses’ and patients’ (who are HIV/AIDS infected) experience of their interaction and to develop and describe a model that will assist the nurses to facilitate the promotion of mental health in patients who are HIV/AIDS infected. The next chapter will discuss the research designs and method.
CHAPTER TWO

RESEARCH DESIGN AND METHODS

2.1 INTRODUCTION

Chapter One gave an overview of the proposed research, background and rationale. In Chapter Two, research design and methods is discussed.

2.2 THE PURPOSE OF THE RESEARCH

The overall purpose of the study is to explore and describe the nurses’ and patients’ (who are HIV/AIDS infected) experience of their interaction. Based on the results of the research a model will be developed and described to assist the nurses to facilitate constructive interaction in the promotion of mental health in admitted patients who are HIV/AIDS infected.

2.3 RESEARCH DESIGN

Research design followed a theory-generative, qualitative, explorative, descriptive and contextual method using a phenomenological approach. The application of the above designs in this study is outlined in the following discussion:

2.3.1 Theory generation

Theory generation is a creative, rigorous structuring of ideas that projects a tentative, purposeful and systematic view of phenomena.
The ideas are structured as concepts, represented by words or symbols (Chinn & Kramer, 1999: 72-73). This is a development of a body of knowledge that will be applied to practice, which will be expressed in terms of concepts. These concepts are interrelated and used systematically to explain approaches to nursing care and to predict the outcome. In this study the concepts will be inter-linked with each other to form new theories. These theories are simple yet generalisable as a basis for testing and utilisation as guidelines in the nursing practice.

In this study a theory generation approach will be undertaken through in-depth interviews and analysis by means of Tesch’s (Creswell, 1994: 153-154) open coding, and theory will be generated from data collected (De Vos, 1998: 58). An inductive approach of theory generation that is qualitative, explorative, descriptive and contextual will be followed using a phenomenological approach.

### 2.3.2 Qualitative research

Qualitative research design is a holistic approach that allows the participants to describe their life experiences. In this study this design will be applied to explore and describe the nurses’ interaction with the admitted patients who are HIVAIDS infected. Inductive reasoning is eminent in the building of relationship statements leading to conclusion. Data will be collected in a systematic interactive nature and emphasise the dynamics, holistic and individual aspects of the human interactions. Data collection will capture aspects such as communication, behaviors, feelings, insights and attitude in their entirety within the context of those who are affected (Burns & Groves, 1997:791 and Field & Morse, 1985:11). The research takes place in a specific general ward of a specific hospital in Gauteng Province.

### 2.3.3 Exploratory research

Exploratory research aims at exploring the dimensions of phenomena, the full nature, the manner in which phenomena exist, manifest and other related factors. The researcher explores what is
going on in a given situation, identifying problems, making judgments and justifying the current situation (Burns & Grove, 1999:25 and Polit & Hunglar, 1999:18). In this study this method will be applied to explore the nurses’ and patients’ (who are HIV/AIDS infected) experience of their interaction in the admission wards. The researcher will not allow predetermined ideas to direct the research (Mouton & Marais 1996: 108). After the process of exploration of the interaction is achieved, the findings will be described - hence descriptive design is also important in this study.

2.3.4 Descriptive research
Streubert and Carpenter, (1995:36) state that descriptive research aims at discovering new facts about a situation, people, activities or events through collection of information, looking at portrayal of the characteristics of a person’s encounters, how they occur and categorisation of the results. The researcher explores, analyses and describes a particular phenomenon. The research presents an accurate description of what has been studied; therefore in this study the nature of the nurse-patient interaction will be described. Based on these descriptions, a model will be developed and described to assist the nurses to facilitate the promotion of mental health in patients who are HIV/AIDS infected.

2.3.5 Contextuality
Contextuality is a philosophical element of qualitative research. In contextual methods the researcher usually studies a certain phenomenon because of its immediate contextual importance. The person is viewed as integral to the environment. The focus is generally on certain events or individuals and certain cases are selected for the study (Mouton & Marais, 1996: 133). This research is contextual in nature as it takes place in South Africa, in a district hospital of the Department of Health where the situation of nurses and patients who are HIV/AIDS infected have immediate importance within the context of the study. The research is bound to the context of exploring and describing the nurses’ and the patients’ (who are
HIV/AIDS infected) experience of their interaction with the aim of developing a model that will assist the facilitation of constructive interaction in the promotion of mental health in patients who are HIV/AIDS infected. The research takes place in a unique context within the specific hospital in Gauteng Province.

2.3.6 Phenomenological approach

Phenomenological approach emphasises a shift from theoretical abstractions to reality lived experiences and investigating and their structure (De Vos, 1998:445). The researcher directly explores, analyses and describes a phenomena (Streubert & Carpenter, 1995: 36). In this study the researcher and the field worker will follow this approach in an effort to explore and describe the nurses’ and patients’ (who are HIV/AIDS infected), experience of their interaction. Based on the results the researcher will then develop and describe a model that will assist the nurses to facilitate the promotion of mental health in patients who are HIV/AIDS infected.

2.4 REASONING STRATEGIES

According to De Vos (2000: 336) reasoning strategies used in data analysis contribute to a logical chain of evidence that supports the researcher’s conclusion after data analysis. In this study these strategies will be applied as indicated below:

2.4.1 Analysis

Data collected through fieldwork will be analysed. According to De Vos (2000:336) analysis takes the complex whole and resolves it into its parts. This leads to identifying, refining, classifying and sharpening of the concepts. Coding is done to identify categories. The researcher will apply this reasoning to dissect the data into parts so that it can be understood. The aim is to classify the data in order to form the statement.

2.4.2 Synthesis
Synthesis is the process of building up separate elements into a connected whole. In this study the strategy will be applied to identify the relationships between concepts and categories, which are reconstructed to provide insight into aspects that are studied. A theory will then be generated.

2.4.3 Inductive reasoning
According to Burns and Grove (1997: 9) inductive reasoning is used to move from the specific to the general. The researcher seeks regularities and similarities through close scrutiny of the data. Moving from the specific to the general, to formulate theoretic statements (Chinn & Kramer, 1991: 197). A conceptual framework is formed, therefore inductive abstraction and generalisation takes place (De Vos, 2000:336, Mouton & Marais, 1990: 103). This strategy will be applied in this study.

2.4.4 Deductive reasoning
Deductive reasoning strategies entail moving from the general premise to the specific, or to a particular situation or conclusion (Thibodeau, 1983, 32). According to Chin & Kramer (1991:196) in deductive logic, two or more premises as relational statements are used to draw a conclusion. Deductive reasoning will be used in this research in describing the model and guidelines to operationalise the model as a frame of reference to assist the nurses to promote the mental health of patients with HIV/AIDS.

2.5 RESEARCH METHOD AND THEORY GENERATION

In the first step of theory generation a field study will be conducted to identify concepts. The experience of nurse-patient interactions will be explored and described; thereafter the identified concepts will be defined and classified. The relationships between the concepts will be identified, then the model will be developed and described to assist the nurses to facilitate the constructive interaction with the aim of promoting the mental health of the admitted patients who are HIV/AIDS infected. The study will follow the four steps of theory generation as suggested by Chinn and Kramer (1991: 111).
2.5.1 Step One: Concept analysis

Concept analysis is the strategy that allows one to examine the attributes or the characteristics of concepts, with the purpose of distinguishing between the likeness and unlikeness of concepts. In this study concept analysis will follow two steps, namely, concept identification and concept classification and definition, using the survey list of Dickoff, James, and Wiedenbach (1968, 428).

2.5.1.1 Identification of central concepts

Chinn and Kramer, (1991: 114) state that in theory generation the concepts should first be identified. The concepts may emerge from life experiences, clinical practice, basic or applied research and literature searched. In this study conceptual definition will be arrived at from fieldwork during the exploration and description of the nurses’ and patients’ (who are HIV/AIDS infected) experience of their interaction. As the experience of nurses and patients are explored, conceptual meaning related to nurses’ and patients’ experience of their interaction will surface. Consequently the results from analysed data will be utilised for identification, definition and classification of the concepts relevant to assisting the nurses in promoting the mental health in admitted patients who are HIV/AIDS infected.

- **Fieldwork**

In fieldwork the researcher makes face-to-face contact with the study participants during data collection and analysis. During this period the establishment of the trust relationship to ensure effective data collection is important (De Vos, 2002: 297). Before entering in the field some preparations will be made.

The first step in the preparation is to establish rapport with the participants. This will put the participants at ease during interviews. The participants will be made aware of the purpose of the study (see ethical considerations). Data collection accessories that will be necessary for the interview such as the audiotape recorder and cassettes that will be utilised during data collection,
discussion schedule guides, foolscap paper and pens for field notes, large envelopes and files will be prepared in advance. An interview room will be prepared to prevent any interference and ensuring confidentiality.

- **Ethical considerations**
  Ethics refers to a science or study of morals and morality, which is the standard of behaviour followed by individuals or groups (Thompson, Melia & Boyd, 1994:3 and Medical Research Council, 1993: 32; 111). As this research involves human beings there is a need to ensure that participants' rights are protected. Therefore the ethical principles will be adhered to (see Chapter One).

- **The research sample**
  **Sampling:** Sampling refers to the process of selecting a portion of the population that conforms to a designated set of specifications to be studied (Polit & Hunglar, 1997:355 and Uys & Basson, 1991:87). In this study nurses and patients (who are HIV/AIDS infected) will be selected by means of purposive sampling, which indicates conscious selection of individuals who meet criteria (Burns & Groves 1999:246). The participants will be involved in in-depth interviews until saturation of data is reached, meaning that the interview take place until there is no more new information provided and participants repeat the themes (Burns & Grove, 1997:556). The inclusion criteria will be:

  - The patient participants had to have been admitted in a hospital and be HIV/AIDS infected and aware of their status. They may or may not have suffered from an AIDS related condition.
  - Nurse participants had to have been trained and registered with the South African Nursing Council, providing nursing care at any level and had to be nursing the affected patients.
  - All participants are to be above 18 years of age and of any gender.
  - The participants have to be able to communicate clearly in their own language or English and not have a hearing disability.
Only those who are willing to give a written consent will take part.

The research population: According to Uys and Basson (1999:51) and Brink and Wood (1989:161) research population refers to the entire population or individuals who meet sampling criteria; thus the sum total of all cases that meet the definition of a unit of analysis. In this study the research population will consist of the entire population of nurses caring for admitted patients who are HIV/AIDS infected and the same patients who are or were once admitted to a hospital while infected.

- Data collection

The researcher will request permission to collect data before the research is conducted (Field & Morse, 1985: 74). Permission to conduct the study will be obtained from Gauteng Department of Health, through the hospital’s authority, (Annexure F), the Ethics Committee of the Faculty of Education and Nursing of Rand Afrikaans University (Annexure E) Non Governmental Organisation (Annexure H) and the study participants (Annexure I).

Gaining access to the field: The researcher will identify the key informants who will introduce the researcher to the gatekeeper who controls access to the study-participants (De Vos, 2002, 385). The researchers will establish a relationship with the nurse manager who will assist in identifying the participants.

The role of the researcher: In qualitative studies the researcher serves as an instrument. The researcher is the senior person in the hospital therefore cannot interview the nurse-participants to avoid her influence on the study participants, therefore the researcher will appoint a field worker who is highly qualified in interviewing skills, with a Masters Degree in Psychiatric Nursing, to do in-depth interviews. The researcher and the field worker are qualified Psychiatric nurses with extensive experience in psychiatric nursing and interviewing skills and are registered with the South African Nursing Council (South African Nursing Council, 1978: 50). The tool for data collection will be
a semi-structured phenomenological interview. This is a flexible technique that allows verbal communication between the researcher and the participants. This allows the researcher to extract more information in depth (Burns & Grove, 1997:353). The researcher will probe for more information until no additional information is elicited.

The process: The central questions to all the participants will be as follows:
“Tell me how it is to interact with nurses in this ward, “ directed to the patients

or

“Tell me how it is to interact with patients who are HIV/AIDS positive, “ directed to the nurses

The role of the researcher will be to encourage the participants to continue talking until data are saturated. The researcher will carefully employ communication techniques such as reflection, clarification, questioning, nodding and maintaining eye contact. The interview will be audiotaped with permission from the participants.

Field notes: Field notes will be documented during the interview. The field notes will be written in different types:( as follows)

- Observation notes: These are descriptions of events observed and experienced during the interview and will be written on foolscap paper or in a personal diary.

- Theoretical notes: These are purposeful attempts to derive meaning from observational notes while listening.

- Methodological notes are those used to remind the field worker or researcher about the methodological approaches that are fruitful for the study.

- Personal notes are the researcher or field worker’s reaction and experiences related to the interview (Wilson, 1989: 4434-436)

In this study the field notes will be kept and used during data analysis.
• Data analysis
The audiotape transcriptions from the in-depth interviews will be analysed, using Tesch’s method of qualitative analysis proposed by Creswell (1994:153-154). The following steps will be followed:

- Audiotapes will be listened and re-listened to. Some ideas will be noted down as they come to mind. Verbatim transcriptions done will be read and re-read to understand the data properly and to get a sense of the whole.
- The underlying meaning of the data will be sought. Thoughts will be written in the margin.
- Lists of topics will be made, and then similar topics will be clustered together. Thereafter columns will be drawn to identify major topics, unique topics and leftovers. Redundant data will be eliminated.
- The list will be used to compare the data, topics abbreviated as codes and re-codes written next to segments of data while looking at any new categories.
- Similar data will be identified and categorised as the list is reduced.
- The topics related to each other will be grouped together and given a name or a most descriptive word.
- Each category will be checked and alphabetised
- All data belonging to each category will be assembled in one place and a preliminary analysis performed.
- Existing data will be recoded, interrogated and systematically explored to generate meanings.
- Recording of data will take place and participants asked to validate analysed data.
- An independent coder will be requested to examine and analyse the transcribed data. This will be followed by a discussion between the coder and researcher to see if there is consensus on the

- Literature control
The results of the study will be discussed in correlation with the literature review, to establish the relevance and uniqueness of the study.

2.5.1.2 Definition and classification of concepts
The definition and classification of concepts will be carried out by providing dictionary meanings, contextual definitions, people sources, professional literature and contrary cases. All the sources of experiences related to the concepts will be considered. Chinn and Kramer (1991, 112) indicate definitions as explicit (a list of definitions) and implicit (as part of narrative meaning) that are conveyed for a concept. The definition clarifies the nature of the abstract constructed in a way that can be comprehended by others. How words represent ideas are expressed in empirical reality. Therefore questions can be asked, such as: “How are concepts defined? Are implied definitions consistent with explicit definitions?

The other method of defining concepts is to determine the extent to which the definition is general or specific. This leads to questions such as: “Is the definition specific or does it suggest what it is used for?” In this study the researcher will establish whether similar or differing definitions emerged for the same concepts. The researcher will use explicit definitions that are a combined method of analysis offered by Wandelt and Steward (1975, 204) and Wilson (1989, 243). This method identifies the characteristics of concepts from general dictionary definitions, people sources and professional literature and contrary cases.

- Contrary cases according to Chinn and Kramer (1991: 86) are those that are certainly not an instance of concepts and can represent something that most observers will recognise easily as what one is not talking about. This
indicates the opposite of what is expected. In this study the contrary concepts will be utilised.

- **General dictionary** definitions provide synonyms and antonyms and convey commonly accepted ways in which words are used. According to Chinn and Kramer (1991: 84) the dictionary can trace the origin of the word to get clues to the core meaning of the concepts.

- **People sources** involve situations whereby the researcher seeks the opinion of the other professionals regarding the definitions of concepts in establishing how meanings are integrated into a theory (Chinn & Kramer, 1991: 89).

- **Professional literature** will be researched as meanings for concepts are explored from within the profession. In this study the meanings that are pertinent to the nursing discipline will be identified (Chin & Kramer, 1991: 89).

The concepts will be defined several times during different time intervals until a satisfactory outcome is achieved (Walker & Avant, 1988: 69). Copi (1986: 157); Kim (1993: 82-83) and Van der Steen (1993:109) propose that definitions should adhere to the following rules:

- A definition should state the essential attribute of the species.
- A definition must not be circular.
- A definition must not be too broad or too narrow.
- A definition must not be expressed in an ambiguous or figurative language.
- A definition must not be negative when it can be affirmative.

Once the concepts are identified, defined and classified they will further be evaluated for signs of maturity to ascertain if they are:

- Consistent and cohesive,
• Whether the characteristics or attributes are identifiable: The description of the attributes or characteristics is important as they provide the determinants for the application of the concepts in the context.

• Whether the preconditions and outcomes described are demonstrated.

• Whether the conceptual boundaries are delineated: The demarcation of the boundary is indicative of the uniqueness of the maturity of the concepts, of which a well developed one will have clearly delineated boundaries (Morse, Mitcham, Hypcey & Tason, 1996: 385-390).

After the concept evaluation and classification, the list of Dickoff et al (1968: 415) will be utilised to assist in the construction of the theoretical relationship among concepts. The list will consist of the following six aspects:

• Agency (who or what performs the activity?)
• Patiency or recipients (who or what is the recipient of the activity?)
• Framework (in what context is the activity performed?)
• Terminus (what is the end point of the activity?)
• Procedure (what is the guiding procedure, or protocol of the activity?)
• Dynamics (what is the energy source of the activity, whether chemical, physical, biological, mechanical or physiological?) Dickoff et al, 1968: 415 and Dickoff & James, 1968: 105).

2.5.2 Step Two: Placing the concepts into relationship

According to Chinn and Kramer (1999: 113) relationship statements provide the links among and between concepts. Concepts are no longer seen in isolation but in relationships and represent a higher level of complexity. However, the nature of the relationship in a theory may take several forms. As concepts are identified, ideas about the relationship between them begin to form. Questions that arise are: “Are there concepts that stand alone, unrelated to others or interrelated with other concepts? Or are there concepts to which several other concepts relate but that in turn are not related?” Some concepts can however be linked to theory by assumptions.
The link between the concepts enables the researcher to determine the nature or character of the relationship. The nature of the relationship can still be examined by asking whether the relationships basically describe or do they explain any meaning or understanding. At the end it can be established whether the relationship statements are descriptive, explanatory or predictive.

2.5.3. Step Three: Description of the model
Chinn and Kramer (1999: 81-82) provide the following ingredients for describing a model: Purpose or goals, assumptions, definition of concepts, relationship statements and structural format. This study will follow the above ingredients as proposed by Chinn and Kramer (1999: 81-82).

2.5.3.1 Purpose or goals
Goals indicate why the theory is formulated, the overall purpose, whether broad or narrow. Does the purpose reflect understanding, create meaning, description, explanation and prediction?

2.5.3.2 Assumptions
Chinn and Kramer (1991: 118) define assumptions as those basic given or accepted “truths” that are fundamental to theoretical reality; assumptions may take the form of a factual assertion or may reflect a value position. Factual assumptions are those knowable or potentially knowable empiric experiences. Value assumptions imply that which is right, good, or ought to be. In this study the assumptions on which the theory is based will be identified as they may influence other aspects of structuring and contextualising the theory. The assumptions from the theory of Health Promotion in Nursing, Rand Afrikaans University (2002: 8) and the researcher’s personal assumptions will be added.

2.5.3.3 Definition of concepts
The concepts will be identified from the results of the completed fieldwork. The concepts will be defined according to the methods as proposed by Wandelt and Steward (1975: 64-69) and Wilson (1989); Copi (1986:169) and Chinn and Kramer (1991: 84) as discussed above.
Chinn & Kramer (1991: 80-89) indicate that conceptual meaning should be created and formed from empiric experience. This means the perception of objects, other people, visual images, behaviour and others, which may convey thoughts, feelings and ideas that reflect experience. Symbols, objects or property and feelings play an important role in conceptual meaning. The process explores the various feelings, attitudes and values that are associated with the experience and with words. Conceptual meaning also depends on the mental process where structures or ideas are used to represent the experiences, because what is mentally constructed is expressed in words.

2.5.3.4 Relationship statements

The relationship of the concepts of the model will be established. The list of Dickoff et al (1968: 415) as discussed above, will be utilised to assist in construction of the theoretical relationships among concepts. The list consists of six aspects as follows:

- Agency (who or what performs the activity?)
- Patiency or recipient (who or what is the recipient of the activity?)
- Framework (in what context is the activity performed?)
- Terminus (what is the end point of the activity?)
- Procedure (what is the guiding procedure, or protocol of the activity?)
- Dynamics (what is the energy source of the activity, whether chemical, physical, biological, mechanical or physiological?)

2.5.3.5 Structural format

- Clarifying the purpose
  The purpose for the theory will be clarified, standards will be set while boundaries and limits will be set so that the process can carry on. If the purpose is clarified it will not be difficult to differentiate the closely related concepts.
• **Data sources**
According to Chinn and Kramer (1991: 84), use can be made of multiple data to generate and refine criteria that include indicators for the concepts. The purpose determines the source of data to be used. For the purpose of this study, data sources from related cases that represent interactions explored, popular, classical and professional literature and people sources will be used in the development of the model to assist the nurses to facilitate the promotion of mental health in patients who are HIV/AIDS infected.

• **Formulating criteria**
Criteria provide guidelines for reorganising the empiric experience if one needs them to be representative and to differentiate them from other similar experiences. There will be a set of criteria to guide this research (Chinn & Kramer, 1991:90).

• **Theoretical and empirical clarification of concepts**
Theoretic and empiric clarification of concepts will be described so that the quality of the theory is strengthened.

• **Structuring and contextualising theory**
According to Chinn and Kramer (1991: 93-99) structuring and contextualising the theory involves forming systematic linkages between and among concepts, leading to a formal theoretical structure. The approach includes: identifying and defining concepts in order to specify the ideas on which the theoretical structure is built, identifying assumptions to clarify the underlying truth in order to proceed with the theoretical reasoning and clarifying the context within which the theory is placed; then describing the circumstances within which the theoretical relationship will be empirically relevant, and designing relationship statements whereby the projected and evolving relationships between and among concepts of the theory are described. In this study structuring and contextualising the theory will form part of the study.

• **Generating and testing theoretical relationships**
Generating and testing theoretical relationships have sub-components such as empirical grounding and emerging relationships. The researcher will
present empiric evidence that suggests the empiric support for projected relationships in this research as well as explicating empiric indicators and validating relationships through empiric methods such as deductive testing (Chinn & Kramer, 1991:99).

2.5.3.6 Evaluation of the model
The panel of experts will do the evaluation of the model and provide feedback. The experts hold Doctoral Degrees in Nursing Science and have extensive experience in research and theory generation. Seminars and group discussion can provide inputs on the model. Consultation and discussions around the interaction and dimensions is important so that the model can be refined as suggested by Chinn and Kramer (1995:127-137). The evaluation process will cover the following aspects:

- How clear is this theory/model?
- How simple is this model?
- How general is this model?
- How accessible is this theory?
- How important is this theory?

2.5.4 Step Four: Developing guidelines to operationalise the model
Deliberative application of theory draws on research method to apply the theory to achieve the objectives. This involves applying the theory in practice and studying its effects on the quality of life, nursing and on the process of health service provision.

Three sub-components that have been identified are: Selecting the clinical setting, determining the outcome variables for practice and implementing a method of study (Chinn & Kramer, (1991:102-103). In this study the guidelines to operationalise the model in practice will be described to assist the nurses to
facilitate constructive interaction in the promotion of mental health to patients who are HIV/AIDS infected.

2.6 STRATEGIES TO ESTABLISH TRUSTWORTHINESS

It is important in any research to enhance the worth of the study. In this research the method of establishing trustworthiness will be done according to Lincoln and Guba (1985:294) and Krefting (1991:214) using the following strategies: Credibility, transferability, dependability and confirmability.

2.6.1 Credibility

**Credibility seeks to establish whether the researcher has enhanced the confidence in the truth of findings in subjects and context. Applying the following criteria can ensure credibility (see Table 2.1).**

Table 2.1 Measures to ensure credibility

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Criteria</th>
<th>Applicability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credibility</td>
<td>Interview questions</td>
<td>All participants will be taken through the same questions.</td>
</tr>
<tr>
<td></td>
<td>Authority of the researcher</td>
<td>Researcher and field worker are trained in Psychiatric Nursing; both completed Master of Nursing Degrees in Psychiatric Nursing, which emphasises interviewing skills, have extensive experience in psychiatric nursing, which requires interviewing and counseling skills.</td>
</tr>
<tr>
<td></td>
<td>Prolonged engagement</td>
<td>Researchers will establish rapport with participants and build trust relationships. Notes will be taken. The main researcher will check and analyse data.</td>
</tr>
<tr>
<td>Structural coherence</td>
<td>Inconsistency will be prevented.</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------------------</td>
<td></td>
</tr>
<tr>
<td>Reflexibility</td>
<td>Field worker and researcher will collect data and continually reflect on own background so as not to influence the data. The researchers will use a personal diary or foolscap paper to reflect their own thoughts, feelings, and ideas generated during data collection such as frustrations and problems concerning the study process.</td>
<td></td>
</tr>
<tr>
<td>Triangulation</td>
<td>Data will be generated from nurses and patients. The interview sessions will be audio-taped. The field notes will be used to verify some concepts.</td>
<td></td>
</tr>
<tr>
<td>Peer examination</td>
<td>The findings will be discussed with the qualified researchers who will check categories.</td>
<td></td>
</tr>
<tr>
<td>Member check</td>
<td>Member checks will be done with participants to ensure that translated information is correct.</td>
<td></td>
</tr>
</tbody>
</table>

### 2.6.2 Transferability
At the end of the study the results will be applied to nurse-patient interaction in other hospitals. Therefore it is important that transferability strategies be considered to ascertain the worth of the study. Table 2.2 indicates that trustworthiness regarding transferability will be ensured:
Table 2.2 Measures to ensure transferability

<table>
<thead>
<tr>
<th>Transferability</th>
<th>Authority of the participants</th>
<th>The study participants will be only those who meet the criteria. The content of the interview guide will be well structured. Background of participants will be ascertained. Member check will be done.</th>
</tr>
</thead>
</table>

2.6.3 Dependability

Dependability relates to the consistency of the findings. The strategy is used to ascertain as whether another researcher may conduct the same research can arrive at the same results. Table 2.3 ensures that dependability criteria will be met:

Table 2.3 Measures to ensure dependability

<table>
<thead>
<tr>
<th>Dependability</th>
<th>Research design and method</th>
<th>Research design and method will be fully described.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data collection</td>
<td>The findings will be well defined, starting with the research methods, data gathering analysis and then interpretation. During analysis code-recoding procedure will be done and the results will be compared.</td>
</tr>
<tr>
<td></td>
<td>Dependability audit</td>
<td>Any researcher can be able to follow evidence trial used. Code-recoding strategies will be used several times.</td>
</tr>
</tbody>
</table>
Stepwise replication technique will be applied between the researcher and the field worker; then the results will be compared.

2.6.4 Confirmability

This criterion requires neutrality in the study, that the researcher imposed ideas be guarded against. Therefore the strategy will be used to ascertain whether neutrality is ensured and that other researchers can arrive at the same results. The strategies to ensure confirmability are summarised below (Table 2.4):

**Table 2.4 Measures to ensure confirmability**

<table>
<thead>
<tr>
<th>Confirmability</th>
<th>Researcher</th>
<th>Authority of supervisor and involvement of other researchers (Audit trial)</th>
<th>The researchers will be neutral throughout data collection and carefully guard against researcher-imposed ideas.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Researcher</td>
<td></td>
<td>The supervisors will guide and monitor the researcher’s work throughout. Other researchers are at liberty to audit the study. Documented work will be available for scrutiny by the promoter and co-promoter and/or any audit committee.</td>
<td></td>
</tr>
<tr>
<td>Reflectivity</td>
<td></td>
<td>The field notes and observations noted will be used with audio-tapes during data analysis.</td>
<td></td>
</tr>
<tr>
<td>Peer examination</td>
<td></td>
<td>The results will be discussed with psychiatric nurses and other interested</td>
<td></td>
</tr>
</tbody>
</table>
2.7 CONCLUSION

This chapter concludes the research design and methods, including the purpose of the research, population and sampling, ethical considerations, data collection, analysis, strategies to establish trustworthiness and the process of developing a model to assist the nurses to facilitate the promotion of mental health in admitted patients who are HIV/AIDS infected. The next chapter will discuss the results, incorporating the literature.
CHAPTER THREE

DISCUSSION OF THE RESULTS AND LITERATURE CONTROL

3.1 INTRODUCTION

Chapter Two of this thesis dealt with a description of the research design and method. This chapter deals with the research findings and incorporates a literature control.

3.2 DESCRIPTION OF THE SAMPLE

The sample comprised of eight patient-participants and seven nurse-participants. Data were collected until saturation was reached. Triangulation of data collection methods was used. The main researcher collected the data on the patient-participants while the researcher field worker collected data on nurse-participants. Participants were sampled with permission from the hospital authorities' and with the participants’ consent.

3.2.1 Nurse-participants

The nurse-participants were recruited from female and male general wards. Their ages ranged between 25 and 49 years. They were all from ethnically diverse backgrounds including Zulu, Sotho and Shangaan. The nurse-participants were permanently employed in the institution. The ward admissions included patients who were HIV/AIDS infected. The nurses interacted with these patients during the provision of nursing care. The nurses were aware of the patient-participants’ HIV/AIDS status for care reasons.

3.2.2 Patient-participants

Patient-participants were identified from male and female general wards admissions. They were sampled with documented consent. These patients are HIV/AIDS infected, and either admitted or were once admitted in these
wards, female or male wards while ill whether as a result of HIV/AIDS opportunistic diseases or not. Their ages ranged from 18 to 49 years. They were all from ethnically diverse backgrounds including Zulu, Sotho, Shangaan and Southern or Northern Sotho. As most patient-participants were observed to be very ill during admission and could not concentrate well, though they managed to give consent, it was difficult to interview them in the hospital. The main researcher was working in the hospital. Therefore the interviews took place outside the hospital setting, either at the Non-Governmental Organisation that took care of HIV/AIDS infected patients in the community after discharge from the hospitals or at their homes, and/or at the researcher’s home.

A written request was made to the Non-Governmental Organisation for permission and recruitment. After an approval was granted, the participants were recruited with written consent. They were above 18 years of age, HIV/AIDS positive and aware of their status, once admitted in the hospital, mentally sound and able to speak without being tired. They gave written consent to participate in the study and willingly took part in the interview sessions. The interviews took place either at the participant’s home, the researcher’s home or at the non-governmental organisation.

**TABLE 3.1 Demographic data of the participants**

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Patient-participants</th>
<th>Nurse-participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Females</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>25-31</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>32-38</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>39-45 and above</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Race</td>
<td>Black</td>
<td>Black</td>
</tr>
</tbody>
</table>
Total participants= 15

3.3. THE INTERVIEW PROCESS

The research topic was introduced, the purpose, objectives and the ethical principles considered. The process of data collection and the potential benefits were explained to the participants. Ethical principles considered were the right to privacy, anonymity and confidentiality, informed consent and respect for human dignity.

3. 3.1 The research question

The research question addressed the experience of the interaction between the nurses and the patients who are HIV/AIDS infected. The research participants were asked the central questions as follows:

“Tell me how it is to interact with nurses in the ward.” (directed to the patients)

or

“Tell me how it is to interact with patients who are HIV/AIDS positive.” (directed to the nurses)

Data were collected using semi-structured interviews, audiotaped with permission from the participants. Each participant was taken through the same question. The interview was continued until data were saturated and later transcribed verbatim and translated into English.

The role of the researcher was to encourage the participants to continue talking until data were saturated. The researcher carefully employed communication techniques such as reflection, clarification, questioning, nodding and maintaining eye contact. Research participants’ experience of interactions with each other were explored and described until data saturation was established.
3. 3.2 Field notes
The field notes were written during interview sessions. The field worker and the main researcher took notes during the interview. The field notes were of different types as follows:

3.3.2.1 Observation notes
These are descriptions of events experienced during interviews and were written on foolscap paper and used during data analysis. Observational notes were written as follows:

- One family was practically supportive while others were not.
- One patient participant had all his belongings in the same bedroom, for example, packets of Jungle Oats, dishes, and toiletries (A sign of discrimination and rejection by family). In their study on the barriers to life-care services, Heckman, Somlai, Peters, Walker, Otto-Salaj, Galdabini and Kelly (1998: 368) found that the community practiced discrimination on patients living with HIV/AIDS.
- Patient-participants were not appreciative of what the family did; one patient refused meals and did not want to talk to the family.
- A family was devastated and frustrated and wished that their son could get anti-retroviral drugs and requested that I make an appointment with a private doctor who issues these drugs.
- All patients were clean as the Non-Governmental Organisation care workers visited them at home for bathing and feeding.
- Care workers visited and also assisted with medication and psychological support.
- Nurse-participants were emotionally affected, some observed to be crying during the interviews.

3.3.2.2 Theoretical notes
These are purposeful attempts to derive meaning from observational notes while listening and were used during the research discussion. Theoretical notes were written as follows:
• Participants were informed of their rights during the sessions.
• Families still need help and education on HIV/AIDS.
• A need was identified for the debriefing of all the participants after the sessions. The field worker provided psychological support after the session while the main researcher counselled and prayed with the participants.
• A referral telephone number for support was given to the field worker to give to the participants to telephone Telefriend Counseling Services.
• The importance of continuous counseling remained a priority.
• The accompanying care worker from non-government organisation also assisted by supporting the family while the researcher was in the interview sessions.
• Spiritual help and prayer remained the best medicines as the family and participants were happy after prayer.

3.3.2.3 Methodological notes
These notes are used to remind the field worker or researcher about the methodological approaches that are fruitful for the study and to assist the researchers and the independent coder to remain focused. Methodological notes were written as follows:
• To keep the participants on the topic. The participants were at times mostly off the topic – the researchers had to bring the participants into focus.
• The telephone number for the support services was supposed to be given before the session.
• The main researcher provided counseling to the patient-participants and their family and still issued the Telefriend telephone number for future counseling.
• It was ensured that audiotape recording machines were in order before the session started.
3.3.2.4 Personal notes

Personal notes are the researcher’s or field worker’s reaction and experiences related to the interview (Wilson, 1989: 4434-436). These notes are considered in relation to the purpose of the research and applied where necessary. Personal notes were written as follows:

- The researcher was emotionally touched and saddened by the discrimination that took place in some families.
- The support that some families offered the people living with HIV/AIDS while they were sick was appreciated.
- The hopelessness and denial experienced by some patients would hinder dealing with the infection.
- It was affecting and draining emotionally to observe that all the patient-participants have lovely children who would be orphans.
- Thrilled by the assertiveness of the three participants who attended non-governmental group therapy and engaged in activities that gave hope in life and strengthened them. They didn’t need prayer. Kalichman, Sikkema and Somlai (1996:589) confirm that the HIV/AIDS patients who attended support groups experienced less emotional distress.
- The non-governmental organisations were observed to be doing a great service by bathing the patients and making them feel wanted and accepted. What a great service!
- The nurse-participants needed emotional support and the field worker provided that.

The field notes were kept and used during the discussion of the results. This included aspects such as personal identification, appearance, behaviour, and attitude (Polit & Hungler, 1999: 642; Field & Morse, 1985:14).

3.4. DISCUSSION OF THE RESEARCH RESULTS
The discussion was based on analysed and coded data. The transcribed verbatim data were coded. Phrases, sentences, statements and paragraphs were classified and categorised. Coded segments were reviewed and refined, then discussed with the independent coder until consensus was reached. Field notes were used during research discussion. The discussion incorporated literature review. According to Kemppainen, O’Brien and Corpuz (1998: 330) less is known about patient provider interaction from the patient’s perspective than is known from the provider’s perspective. It was of great benefit that in this study the patients’ perspective was considered in their experience during the interaction with the health care providers – nurses in particular. Patient-participants described their interaction with nurses as more frustrating and unhelpful than they expected. Nurse-participants also described their interactions as horrible, difficult, frustrating and of little value to the patients’ lives. This showed that nursing the HIV/AIDS patients distressed nurses.

Burgess and Lazare (1976: 210) documented that people expressed psychological distress through their behaviour and sometimes the behaviour became unproductive and increased tension instead of reducing it. The nurse-participants in this study manifested this. The nurses forgot the aspect of promotion of health, did not see the patient-participants as whole persons with dimensions of body, mind and spirit (Rand Afrikaans University, 2002:4). According to Walsh (1997: 487) the nurse-patient relationship includes elements such as empathy, warmth, caring and positive connectedness and transference.

The patient-participants experienced their interactions with nurses as unacceptable and frustrating in that the nurses demonstrated a “busy nurse syndrome,” providing care without caring, limited communication, exposed the patients to emotional harassment and coping by presenting avoidance-avoidant behaviours. A few nurses were seen demonstrating a positive behaviour and patient–participants wished that all the nurses could be like them.
The patients were troubled by the infections and the uncertainty of the HIV/AIDS diseases and their response to the treatment, hence they needed to have someone to depend on like nurses but it was difficult for nurses as they were reported to have no time for the patients. Nurses’ interviews revealed that nurses unknowingly agreed with what the patient-participants experienced during the interaction. The nurses were supposed to help the patients to understand their feelings and teach them to improve communication skills in order to understand their feelings. It was obvious that the nurses failed to establish constructive nurse-patient relationships characterised by unconditional acceptance, love, understanding, empathy and sympathy for the HIV/AIDS infected patients as advocated by Kreigh and Perko (1983: 87) for patients with mental problems.

The interaction with the patients needs to be seen as therapeutic, aimed at improving the health of the patients. Therapeutic touch and just being there can be used to put the patients at ease (Shives, 1998: 297). Walsh (1997: 486) cited that interaction with the patients is a therapeutic technology through which treatment is delivered. HIV/AIDS infected patients have mental problems - hence they need nursing care planned in totality and given holistically.

The demands of the HIV/AIDS pandemic put more strain on health care services and nurses unconsciously coped by applying negative coping strategies such as keeping themselves busy with other things rather than providing helping relationships (Johnson, 1993:11). The nurses presented themselves as “busy bees.” The patient-participants experienced these interactions as discriminating and rejecting of them because of their HIV/AIDS status. It is acknowledged that hospitals are full of terminally ill HIV/AIDS patients, but nurses are still expected to present a caring attitude to all patients regardless of their HIV/AIDS status (UNAIDS 2000, 10). Nurses are required to care for their patients holistically regardless of the patient’s diagnosis. Beck et al (1994: 64) mention five dimensions in life, which should be realised if a person is taken care of. These include the psychological, physical, social, spiritual, and economic dimensions. It is of great value not to
separate these when caring for the HIV/AIDS infected patients. In the study conducted by Howe (1999: 35) it is documented that if the nurses start by properly assessing the patients’ needs, this will help in diagnosing the patients’ condition.

The codes under each of the agreed categories were identified and separated into six themes with sub-themes. The major themes were identified and tabulated as follows:

3.4.1 Major themes

- A “busy nurse” syndrome
- Care versus caring for patients with HIV/AIDS
- Limited communication with patients with HIV/AIDS
- Emotional harassment of patients with HIV/AIDS
- Avoidance-avoidant interaction with patients with HIV/AIDS
- Positive behaviour nurses, “health service provider assets”

In Table 3.2 an application of the various themes and sub-categories are presented. Thus are:

TABLE 3.2 Major themes and sub categories

<table>
<thead>
<tr>
<th>Major theme</th>
<th>Sub-categories</th>
</tr>
</thead>
</table>
| A “busy nurse” syndrome                         | • The invisible nurse
|                                                 | • A busy “bee” nurse
|                                                 | • Patients left alone
<p>|                                                 | • Nurses moving up and down                         |
| Care versus caring for the patients with HIV/AIDS | • Dissociation and unhelpful attitudes              |
|                                                 | • Procedure orientated nurses                       |
|                                                 | • Illtreatment and aggression                       |
|                                                 | • Non-sympathy and lack of empathy                  |</p>
<table>
<thead>
<tr>
<th>Lack of clarity and understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Limited communication with patients with HIV/AIDS</td>
</tr>
<tr>
<td>• Prevailed uncertainties</td>
</tr>
<tr>
<td>• Hunger for Interpersonal relationships</td>
</tr>
<tr>
<td>• Impeded two-way communication</td>
</tr>
<tr>
<td>• Shaded non-verbal communication</td>
</tr>
<tr>
<td>Emotional harassment of patients with HIV/AIDS</td>
</tr>
<tr>
<td>• Confusion and frustration</td>
</tr>
<tr>
<td>• Insults and scolding</td>
</tr>
<tr>
<td>• Depersonalisation and lowered self-esteem</td>
</tr>
<tr>
<td>• Degradation and sadness</td>
</tr>
<tr>
<td>• Frightened and hurting</td>
</tr>
<tr>
<td>Avoidance-avoidant interaction with patients with HIV/AIDS</td>
</tr>
<tr>
<td>• Avoidance-avoidant strategies</td>
</tr>
<tr>
<td>• Isolation and loneliness</td>
</tr>
<tr>
<td>• Stigmatisation and discrimination</td>
</tr>
<tr>
<td>• Patient neglect and rejection</td>
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<tr>
<td>Positive behaviour nurses, “health service provider assets”</td>
</tr>
<tr>
<td>• Sympathetic and empathetic caring assets</td>
</tr>
<tr>
<td>• Moral support assets</td>
</tr>
<tr>
<td>• Hope enriching assets</td>
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<tr>
<td>• Helpful assets</td>
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<tr>
<td>• Empathetic assets</td>
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</tbody>
</table>


3.4.1.1 A “busy nurse” syndrome

The nurses in this study presented with a “busy nurse” syndrome behaviour. It was found that they seemed to have a lot of work or many tasks to perform and were not free to be with the patient-participants and presented with the act of giving other things a lot of time and attention (Oxford Dictionary, 1998: 83) rather than being there for the patients with HIV/AIDS. The patients with HIV/AIDS perceived such actions as ways of neglecting them.

Nurses are health professional workers who have to be registered with the South African Nursing Council Amended Act (1978) Regulation (R425) in order to obtain permission to practice as nurses. Therefore Nursing Acts and Regulations give them an obligation of caring for the sick as required by their profession (http://it.mns/encarta, 18/08/2004: 2). Green-Edelstein (1986: 10) describes nursing as an example of professional nurturance, a humanistic care in which an empathetic bond between a nurse and client is reciprocally shared. According to a Theory on Health Promotion in Nursing, (Rand Afrikaans University, 2002: 4) nursing is an interactive process where the nurse, as a sensitive therapeutic professional, facilitates the promotion of health through mobilisation of resources. However in this study the nurse-participants were unwilling to provide the professional nurturing although the nurses were expected to guide the patient to achieve self-care (Orem in Green-Edelstein, 1986: 10).

The nurses presented themselves as having a complex of symptoms that prevented them from being there for the patients with HIV/AIDS. The complex of symptoms is seen as a syndrome. A syndrome refers to the physical and mental effects that show that someone has a particular disease (Longman Dictionary, 1995: 1462) and there are no effective drugs for that. According to Dorland's Pocket Medical Dictionary, (2001: 801) syndrome means a set of symptoms occurring together as the sum of morbid state. The nurse-participants were so busy that they failed to use the opportunity during admission of the patient to identify the patients' needs. Therefore they were
unable to provide efficient nursing care. The sub-categories of “A busy nurse” syndrome are tabulated in Table 3.4 and discussed below:

**TABLE 3.2.1 Sub-categories of a “busy nurse” syndrome:**

<table>
<thead>
<tr>
<th>A “busy nurse” syndrome</th>
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</thead>
<tbody>
<tr>
<td>• Invisible nurse</td>
</tr>
<tr>
<td>• A busy “bee” nurse</td>
</tr>
<tr>
<td>• Patient left alone</td>
</tr>
<tr>
<td>• Nurses moving up and down</td>
</tr>
</tbody>
</table>

Patient-participants experienced that nurses seemed to be busy all the time. The approach to nursing care by the nurses gave the impression of a “busy nurse” all the time. The nurses were not visible in the ward; they left the patients alone with no time to talk and be with them. The nurses’ interviews also confirmed what the patient-participants had indicated, and unknowingly presented during their interview sessions that they were always busy. The following statements from patients’ interviews are evidence of a “busy nurse” syndrome:

“Ba a tla ba o fa dihlare, o ka se sa ba bona, wa tseba,” (They will come and give you medicine, you will never see them again you know).

“Be ke fila gore ba nthuse go understanda bolwetsi bo.” (I just felt that they can make me to understand what I should know about the disease).

“Ba be ba sa bonale,...”(They were not visible, ...).

“Go bohloko ge a robotse go se yo a o thusago”(It is painful if you are lying on the bed and no one is there to help you).

“Ga o kgone go ba le nako le bo nurse, (you hardly have a good time with them).

“O ba bona ka noka tse dingwe,” (You see them sometimes).

“Ba bonala ba le busy o ka ba le nako le wena mam.” (They seem very busy to be with you).
“Ga ke gopole ba dula le nna ke kgopela thuso mma” (I cannot remember sitting with them and asking them anything mam).

A “busy nurse” syndrome developed from both nurses’ and patient-participants’ interactions where the patient-participants perceived nurses as busy, with no time to speak to them, and were observed moving up and down the ward. Nurses also mentioned in their interview sessions that they were always busy in the ward with no time to sit and talk to the patients. The following statements from nurses confirmed the nurses’ “busy” syndrome:

“Yes, kulungile, but uwa bona nawe ngu busy la e wardini.” (Yes, it’s okay, but you can see for yourself it is busy in the ward).
“A kuna isikhathi” (There is no time).
“Time is limited, patients are encouraged to socialise with other patients.”
“There is an overload of work here, there are not enough nurses, this shortage of nurse is too much.”

In the study conducted by Tyson, Lambert and Beattie (1995: 49) nurses spent minimal time with the patients and conversation tended to concentrate on the physical tasks being performed. In this way the nurses may miss and ignore some important issues related to the care of the patient. It is important to note that increasing time spent with the patient would form part of quality nursing care (Siminoff, Erlen & Sereika, 1998: 147). The nurses put aside the patients’ needs as social beings who need others around them. The significance of social support was not realised as important to improve the traumatised patients’ mental health. Mullis and Beyer (1987) in Ngubane and Uys (1994:6) emphasise the significance of social support. Patients reported a need to have someone to depend on.

“Go be go se yo a tlago le ge o beditse”(There was no one who ever came back to me even if I called).
“Manurse be ba le kgole le nna ba le busy ka mosomo”(the nurses were far too busy with their work).
The nurses’ remarks showed that they used the lack of time as an excuse for not providing helping relationships (Johnson, 1993: 12). It is evident that the nurses were uncomfortable working with HIV/AIDS patients admitted to their wards. The following nurses’ statements give evidence:

“You know, this issue of HIV/AIDS, it is difficult.” “It is very scary”.
“Luka kugula kwe HIV/AIDS” (This sickness of HIV/AIDS) has become the worst enemy of South Africa.
“Modimo wa ka (My Lord), it hurts,”
“It is painful to see people dying in front of you on a daily basis.”


“Ba bonala ge ba re fa dihlare fela”(The only time they come to us is when they gave us medication).
“Ga ba dule le wena, ba busy ba ya godimo le fase”(They do not sit down with you, they are always busy moving from ward to ward).

The nurses in this study presented “busy nurse” syndrome symptoms that indicated that they were busy. The following sub categories further describe a “busy nurse” syndrome:

- The invisible nurse
- A busy “bee” nurse
- Patients left alone
- Nurses moving up and down

- The invisible nurse

The patient-participants experienced their interaction with the nurse participants as frustrating and unhelpful because the nurses were not there for
the patients. The research results showed that the nurses were always busy. The nurses were invisible to the patients as evidenced by the results of the interview sessions; the patient participants did not have nurses to assist them as they were expected.

The patient-participants stated that nurses were seen or visible for nursing procedures only and when need arised. According to the Longman Dictionary (1995: 752) something that is invisible cannot be seen (although one knows that it exists). Patient-participants knew that nurses were to take care of them but the nurses were mostly not available for the patients in the wards. The statements below show that nurses were invisible to the patients:

“Ga sanka ke tseba manurse a berekang ka mo warding” (I never knew nurses well, who were working in the ward).

“Ba be ba le gona but ba sa bonale” (They were in the ward but I hardly saw them).

“Busy mama”

Ke lemogile gore manures baphela ba ya godimo le fase” (I realised that these nurses are always moving up and down).

“Ka na ba busy or not, ke bona ba ya godimo le fase,” (whether busy or not but I saw them passing by my ward now and then).

“Ene o ba bona ge ba tlo dira sesengwe.” (And only come to you when they have to do something to you).

“Ba ka se dule le ten minutes le wena” (They could hardly spend even ten minutes with you).

“Ka nako tse ntshi re tee ka warding.” (In most of the time we were left alone in the ward).

It appears that nurses in these wards did not follow the nursing process, where they have to start by assessment, planning, implementing and evaluating the nursing care according to the patients’ needs (Ward, 1993:9) which includes provision of holistic care. Payson, Wheeler and Willington (1998: 33), suggest that assessing the needs of the client is the key to achieve the desired outcome for the patients. If the nurses start with
assessment of patients’ needs, they will be able to plan nursing programmes that will result in quality services. In this study the nurses reported that they were discouraged and having difficulties in providing nursing care, that they were despondent as the patients were dying and that the treatment was not effective. It is possible for the nurses to be invisible to avoid the stress they were undergoing, hence the following statements:

“Uyazi, lendaba ye HIV/AIDS inzima ugu sebenza ngayo” (You know this issue about HIV/AIDS it is heavy/difficult to work with).
“Psychologically, to work with these patients uya kathala.”(You get tired).
“Modimo wa ka (My Lord), it hurts, it is painful to see people dying in front of you on daily basis.”

Getting tired psychologically is a sign of psychological stress that indicates that nurses lack coping resources. Bishop (1994: 126) describes stress as a transaction between a person and the environment, including a person’s appraisals of the challenges posed by the situation, as well as available coping resources, along with the psychosocial and physiological responses to these perceived challenges. The nurses in this study found themselves in a challenging environment and lacked coping resources - hence they avoided the patients by being busy all the time.

How could a tired person plan effectively? The nurses uttered remarks that reveal that they suffered from a high level of stress and burnout. Bellani, Trotti, Pezzotta, Musciatin, Gncchi and Bellotti (1993: 536) in their study discovered that AIDS caregivers presented with higher levels of burnout.

Because the nurses were also burned out, they were invisible in most cases. The busy nurses denied the patient-participants an opportunity to clarify issues related to nursing care and to the uncertainties due to HIV/AIDS. Patient care was not planned, as planning would include the psychological and social needs of the patients. It is a fact that AIDS patients present with
delay in responding to the treatment. This can be exacerbated by the psychological trauma associated with the HIV/AIDS infection.

Nurses seemed to feel uncomfortable to work with patients who have HIV/AIDS. In their study Siminoff et al (1998: 149) reflected that nurses rated working with HIV/AIDS patients as the most stressful job because families want to know about the patients’ problems and nurses cannot tell them due to confidentiality reasons. It is obvious to realise that they coped by becoming busy with other things rather than being with the patients. The nurses confirmed this:

“You know, this issue of HIV/AIDS, it is difficult to work with”
“ As a person you don’t feel free always”
“It is painful to work with these people and anyhow we nurses have a problem that we cannot stay for a long time with patients because we are short staffed.”

It is evident that nurses used their tight schedule as an excuse not to have time with the patients. It is shown that nurses were always busy and did not consider spending time with the patients as part of patient care. The statement below reflects the invisible nurse:

“You will find that in the ward there is not much time to talk to these patients.”
“Ke dira mmerekwa ka ka fetsa”(I just do my work and finish).

In the study conducted by Siminoff et al (1998: 147) increased time spent with HIV/AIDS patients resulted in increased quality of care. The nurse-participants’ interviews revealed that the nurses were not happy with their working conditions. Most people who were infected with HIV during early 1980s and 1990s have now developed full-blown AIDS. Severinsson and Hallberg (1996: 365) found that the nurses’ ability to influence duties such as relationship with the patients and decisions made for care have an impact on the patients’ attitude towards treatment.
The working milieu depends on specific working conditions. In this study patient-participants reported an unhelpful environment while admitted. The working conditions for nurses were difficult, patients’ response to treatment was observed to be very slow and contributed to stress nurses as a persons, hence they were not visible to patients, trying not to see patients in that state. The nurses provided care without considering the attributes for efficient nursing care such as just being there for the patients. Nurses confirmed that in the following statements:

“It hurts, it is painful to see people dying in front of you on a daily basis”

“Akuna isikhathi, ama patients siya ba nanazela ukuthi bahlale bacoce namanye ama patients, ba bonge nempiolo e banayo” (Time is limited, patients are encouraged to socialise with other patients and appreciate their lives).

The nurses saw the importance of social support but could not offer that. The nurses could not see any way out of the staff shortage and the overcrowding of patients admitted in the wards. They fell into the trap of mental disengagement where they lacked measures that could help in dealing with the stressors and gave up, then remained invisible to the patients and turned to the other activities that distracted their attention from the patients with HIV/AIDS infection (Bishop, 1994:157).

- A busy “bee” nurse

The patient-participants remarked that nurses had no time for them. Time is something that is measured in minutes, hours and years using a clock (Longman Dictionary, 1995:1513). In this study nurses did not have minutes, let alone hours to spend with the patient-participants.

The nurses were observed by the patient-participants as busy as “bees,” thus they were seen to give other tasks a lot of time and attention rather than being with the patient-participants. The patient-participants perceived these activities as a way of neglecting them. The patients described the nurses as always busy. Therefore the nurses were described as busy as “bees.” A bee
is a black and yellow flying insect with a round body that makes honey. These insects enjoy being busy and/or very active (Longman Dictionary, 1995:101). The bees are always busy making honey, if one stands in their way one gets stung and the pain is terrible.

The nurses in this study were seen as always busy with no time to be with the patient-participants. They seemed busy all the time, concentrating on important work other than the patient-participants and became visible only when giving medications and performing other nursing procedures.

The nurses were described as busy “bees.” In their study Kemppainen, O’ Brien and Corpuz (1998: 331) remarked that nurses were seen as coming and going with no personal contact with the patients. In this study the patient-participants reported that they were left alone. They saw nurses as always busy and having no time for them. They experienced rejection and loneliness, felt isolated and interpreted this as discrimination because of their HIV/AIDS status.

This was evidenced by the behaviours and attitudes of the nurses as experienced by patients. Nurse-participants mentioned the problems of being overworked and having no time for the patient-participants. This jeopardised patient care. The Health Systems Trust (2004:195) reported the immense impact of AIDS on already strained health workers and indicated that the increased number of AIDS patients call for the increase in the number of health workers. In this study it was demonstrated that there is a need for additional nurses. This was evidenced in the patient-participants’ statements as indicated below:

“Batho ba ba bonala ba le busy goba a ba nyake go re bona” (These people seemed very busy or they just didn’t want to see us).
“Ga ba dule le wena” (They do not sit down with you),
“Manurse be ba le kgole ba le busy ka mosomo wa bona” (The nurses were far, too busy with their work).
According to Scanlon and Weir (1996: 296) nurses have to develop the client-practitioner relationship that will make nurses available to the patients needs. In this research the nurses failed to establish a caring nurse-patient relationship. Angst and Hochstrasser (1994: 29) found that nurses who were distanced from the psychiatric patients failed to diagnose patients with depression and there was a high incidence of suicide in that ward. HIV/AIDS patients are also at risk of depression and suicide as the infection is stigmatised and has no cure, therefore the nurses need to identify health risks like suicide in patients who are HIV infected. It will be difficult to identify such risk if the nurses distanced themselves from the patients. In the Sowetan newspaper, (19 May, 2004:18) the Minister of Health, Manto Tshabalala-Msimang reassured infected people that HIV/AIDS is not a death sentence. It is acknowledged that HIV/AIDS has no treatment yet; therefore the AIDS impact has a grave social and economic impact on all sectors of the society (Van Rensburg, 2004:296), including health. However, that does not call for health workers to succumb to defeat and become hopeless like the nurses in this study.

Nurses’ interviews also confirmed what the patient-participants have indicated, and they unknowingly indicated during their interview sessions that they were always busy. The following statements testified to the “busy bee” nurse:

“Ke o re (I Mean) my time is running, I can’t even eat.”
“Time is limited,”
“La ewardini akuna isikathi for ukuhlala no kukhulama na lama patients, (In the ward there is no time to sit and talk with these patients),”

It is discouraging to realise that some nurses see these patients as not normal because the patients cannot understand their illness; they needed more time to explain what HIV/AIDS entails. This indicated that they lacked knowledge on how to handle and develop helping relationships (Johnson, 1993: 11) and therefore they shielded behind the excuse of being busy. Niven and Knussen (1999: 171) found that nurses were distressed when caring for patients with
HIV/AIDS because they lacked knowledge, troubled by workload and discomfort. The nurse-participants kept themselves busy in order to avoid the discomfort they were experiencing. The below statements confirm:

“Time is limited, patients are encouraged to socialise with other patients.”

“It is not easy to see patients dying in front of you on daily basis.”

“You will find that in the ward there is not much time to talk to these patients.”

“It is very scary.”


Patients were reported to be angry after being informed of their status, and when they were angry with nurses who did not know how to assist angry patients it would be difficult to provide quality nursing care. In their study Kemppainen et al (1998: 331) found patients to be angry about the care they received when nurses were afraid and anxious in touching them.

“Fela ke nnete re a tshaba.” (It is true we are afraid).

“Patients become angry when we care for them.”

According to Kemppainen et al (1998: 330) patients presented with anger, which is reflected in increased irritability with advanced illness and intense psychological response towards the AIDS diagnosis. In this study nurses reported having to deal with anger and irritability from the patients and their families. Therefore it was clear that the nurses coped by keeping themselves busy with other things and leaving the patients alone.

One can acknowledge that HIV/AIDS infected patients do become angry but that cannot be used as an excuse for the nurses to present as busy “bee”
nurses at all times. It was clearly demonstrated that the patients expected nurses to attend to them as they indicated below:

“Gobe go se bao ba ka re thusang ka mo warding ntle le manurse” (There were no other people in the ward to care for us except the nurse).

It was also obvious that the nurses kept themselves busy with other things as a means of separating themselves from the patients. They unknowingly agreed that they have no time for the patients. This was viewed as one of the nurses’ means of coping with their difficult situation at work and is evidenced by following comments:

“Most of our patients a di (they do not) survive... a di (they do not) survive”

“In the ward there is no time to sit and talk to these patient, admissions are overflowing.”

The researcher also realised this during visits to the ward to identify the participants. The patients were also very ill so that more time was taken to assist one patient than it used to before the problem of HIV/AIDS (UNAIDS, 2000: 46).

• Patients left alone

The patient participants reported being left alone in their beds with no one to talk to. Left alone means that there is no one else with you, you are on your own, by yourself, lonely, lonesome (Longman Dictionary, 1995: 36). The nurses were not available for the patients; there was no face-to-face contact between the nurses and the patient-participants; the nurses did not feel for the patients; not feeling what the patients felt and not empathetic and sympathetic. The patient-participants stated:

“Ba dira mereko wa bona ba tloga” (They did their work and left).

“A... a ba dule le wena fase.” (They do not sit down with you).
Patient participants felt that they were left alone to die. Nurses failed to realise the need for the patients’ mental well-being. They saw themselves as the bearers of the nursing procedures and nothing more. The patients needed support yet nurses left them alone. Crystal, Bilder, Mersel and Sambamoorthi (1993:120) suggest that depression and anxiety are associated with “escape avoidance.” The nurses in this study were anxious and depressed about the environment of providing care to AIDS patients in overflowing wards. The caregivers for AIDS patients were found to experience multiple problems including stress (Hansell, Hughes, Caliandra, Russo & Budin, 1993: 20). In this study nurses presented the same frustrations coupled with staff shortage and environmental problems. Nurses could not cope but left the patient alone.

“La eawardini akuna isikathi for ukuhlala no kukhulama na lama patients, ama admissions maningi” (In the ward there is no time to sit and talk with these patients, admissions are overflowing).

Jamison (1993: 9) cited that HIV/AIDS challenges the government to maximise resources, which should include human resources. Nurses gave the impression of being interested in doing their work and finish, not bothering to plan for the patients’ total needs. This might be because of the shortage of nurses that they should complete nursing procedures before the end of the day shift.

”Ba… ba be ba le kgole ba dira mmerekwa bona, (They were far, busy with their work).
“Ba sa mpotsise gore go reng”(They did not even come to me and ask how do I do)?
“Eng, ke letile ka ge a rile o tlo boa, e…e ge a boa a re o a tshaisa” (Yes, I waited there, waiting as she says she will be back, E…e… when she came back she says she is going off).

The nurses confirmed to be feeling bad about the patients’ illnesses and that they will just do their work. Therefore they coped by being busy all the time as they were emotionally affected by the way the patients suffered:
“A child saying: Is there any thing that you can do for me?”
“Ke dira mmereko wa ka ka fetsa” (I just do my work and finish).

The explained sufferings alone could explain why nurses left the patients alone. In the study conducted by Kemppainen et al (1998: 333) patients reported to be left alone: “I am just left there- flat on the bed, nurses are in control.” The patients were not happy with this type of care. The patients are social beings, therefore they have social needs, a need to belong, to be with others and to be recognised as human beings. In their study, Melgar, Santana, Aplaska, Paladin and Monzon (1993: 805) found that individual counselling to assist patients to deal with day-to-day stress helped in building patients’ confidence and self-assurance. In this study the patient-participants needed to have one-to-one counselling which was impossible because the nurses kept themselves busy.

- Nurses moving up and down in the ward
Nurses in the wards were seen moving up and down. This refers to people or persons who are so busy and active that they cannot realise other important aspects (Longman dictionary, 1995: 931). Although some patients innocently thought the nurses were busy, it is doubtful that nurses who accepted the responsibility of taking care of the patients could be seen moving up and down the wards without communicating to the patients what is actually happening.

“O kwa ba sepela, ga go yo a tlago go o boledisa” (You can hear nurses’ footsteps but nobody will come and talk with you).
“Be ke nyaka go bolela fela go be go se motho o fetsa o tsea dilo ka moo o bonang” (I wished to speak to them but there was no one to talk to and you end up perceiving things the way you think).
“I think ba ka thusa manurse go ba le nako le balwetsi, gona le gore ba be busy all the time” (They can help nurses to be able to have time with the patient, avoid being busy all the time).”
“I tried to call them but they could not hear me, ka ba ka ema lefasetereng,” (I stood up next to the window).
The fact that HIV/AIDS results in opportunistic diseases that are notoriously bad for the patients’ psychological well-being and social consequences appeared to be not important for the nurses (Crove, Hoy & Mills, 1996: 489). Nurses were anxious on account of their fear of infections and the difficulties of caring for HIV/AIDS patients. However nurses were educated and guided in applying universal precautions when performing any nursing procedure (National Department of Health, January 2000:6).

The nurses in this study suffered from a high level of burnout. Bellani et al (1993: 536) discovered that AIDS caregivers presented with higher levels of burnout than those nursing patients with other illnesses. Kemppainen et al (1998: 331) state that nurses were seen as coming and going with no personal contact with the patients. According to Edwards (2000: 225) nurses can build patient confidence by displaying attitude of warmth. In this case if nurses were seen moving up and down by the patients, not asking about their progress, it would be difficult to understand the mental problems HIV/AIDS could bring to patients. The nurse-participants could not even handle the patients who were anxious; they find it difficult to be available in the environment of the patients then coped by being busy with other things than being next to the patients. The nurses’ stated:

“Ba itebelela, ba bona ba fedile and motho ate potsise gore gona otla felela kae” (They look at themselves and see themselves ending and a person asks himself where will he end up).
“Patients are very anxious when you talk to them, they want to know if the treatment is going to be effective.”

They reported that HIV/AIDS disease is a horrible sickness, embarrassing and difficult to work with. They were afraid of HIV/AIDS patients and applied the “escape-avoidance” strategy as cited by Crystal et al (1993:120) by seeming very busy, while moving up and down to guard against any complications from afar. An institutional setting with such lack of positive feedback and a ward overflowing with patients contributed to this type of attitude. Enzmann, Gusy and Klebe (1993: 119) described the effect of the setting on the quality of
work. Squire (1994: 322) also emphasized that the environment has a tremendous effect on the carer. In this study nurses presented to be managing AIDS patients in busy, overflowing wards and faced with anger from AIDS patients and families. They further stated:

“Di paciente ga ba se no go bolwela gore ba na le bolwetse bo ba HIV/AIDS ba tenega, ba kwata” (The patients after being told about this disease of HIV/AIDS they become irritable, and angry).

It is true that this can affect the nurses in such a way that they tend to work far from the patients. The nurses remarked that the patients need to socialise with other patients, as the nurses had no time for them.

“Ama patients siya ba nanazela ukuthi bahlale bacoce namanye ama patients, ba bonge nempilo e banayo” (The patients are encouraged to socialise with other patients and appreciate their lives).

Peter, Schumacher, Rubbert, Schwab, Olbrich and Kalden (1993: 20) showed that HIV/AIDS patients are distressed and have evasive regressive coping – hence they need professional support. However nurses should have been there for the patients and demonstrated and exhibited the greatest caution on the prevention of infections even with the patients whose HIV/AIDS status was unknown. When performing any procedure nurses and other health workers were to exhibit the greatest caution (National Department of Health January 2000:6).

3.4.1.2 Care versus caring for the patients with HIV/AIDS

Leininger in (Green-Edelstein, 1986: 9) states that caring is the most unifying, dominant and central intellectual and practical focus of nursing. Nurses therefore facilitate the caring aspect through the nursing process, which includes: assessment, planning; implementation and evaluation in a continuous and integrated manner (Rand Afrikaans University, 2002: 5). According to Nikkonen (1994: 1191) caring is to care about, and to take an
overall responsibility and that the moral foundation of caring is to take responsibility for another person.

The sub-categories of “care versus caring” are tabulated in Table 3.2.2:

**TABLE 3.2.2. (a) The sub-categories of care versus caring**

<table>
<thead>
<tr>
<th>Sub-categories of care versus caring of the patients with HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Dissatisfaction</td>
</tr>
<tr>
<td>• Procedure orientated nurse</td>
</tr>
<tr>
<td>• Dissociation and unhelpful attitude</td>
</tr>
<tr>
<td>• Illtreatment and aggression</td>
</tr>
<tr>
<td>• Non-sympathy and lack of empathy</td>
</tr>
<tr>
<td>• Lack of clarity and understanding</td>
</tr>
</tbody>
</table>

According to ([http://it.mns/encarta](http://it.mns/encarta), 18/08/2004: 2) care means to be concerned for somebody or the provision of whatever is needed for the person in need of care while caring refers to showing concern, compassion and looking after the physical, psychological, social and general welfare of the person in need of professional care. The Table 3.2.2 (b) below presents the comparison between care and caring:
TABLE 3.2.2. (b) A comparison between care and caring

<table>
<thead>
<tr>
<th>Care</th>
<th>Caring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Means concern for others</td>
<td>Show concern for others</td>
</tr>
<tr>
<td>Provide whatever is needed, especially physical needs.</td>
<td>Looking after people and their needs for physical, mental, social, functional, economical, and spiritual interest.</td>
</tr>
<tr>
<td>Easily separates a person from other dimensions of life, concentrating only on addressing existing needs/problems.</td>
<td>Considers a person and environment, caring for a person as a whole.</td>
</tr>
<tr>
<td>Not worried if the plan did not work.</td>
<td>Strive to achieve success in difficult situations. Refuse to fail.</td>
</tr>
<tr>
<td>Based more on responsibility than on love.</td>
<td>Love, mercy, understanding, empathy, sympathy, unconditional acceptance, warmth and clarity are the basis of caring.</td>
</tr>
</tbody>
</table>


Nurses are expected to take care of the ill individual in totality and holistically. In this study nurses were unable to provide care and caring for the patients in totality and in a holistical manner. The patient-participants were not satisfied with the care that was provided. The nurses felt that the working conditions affected the quality care they were expected to provide, as evidenced by the statement below:

“Even when you do an admission of a patient there is no time to go into details of the patients’ history.”

“There is an overload of work here, there are not enough nurses, this shortage of nurse is too much.”
“Go fedile …o ke le wa bona, ba mo (It is finished … can you see they are) in terminal stage.”

The nurses had already lost hope for the life of the patients. This showed that very limited efforts were made to provide caring. It is difficult to see any positive measures to provide quality services while frustrated. The nurses were to consider the pain and emotional trauma that HIV/AIDS can cause on the patients. It appeared that they could not realise that HIV/AIDS may lead to depression and that patients with depression are up to four times more likely to suffer fatal heart attacks (Robotham, 2002: 17). The statement below demonstrated the nurses’ discouragement and lack of hope:

“And then community ya rona ba expecta di miracles, ba (they) expecta gore (expect that) that person ge a tla mo go rona re mo tsose!” (And then our communities expect miracles that we should heal the patients).

It is significant to note that patient-participants admitted in the ward left the hospital with a lot of uncertainties. Lack of clarity on what was going on about the infection and its consequences left the patient-participants with a lot of uncertainties related to their illness. The nurses reacted in an unacceptable manner to the patients’ need. Consequently they lost focus of the holistic care needed. According to Dworkin, Albrecht and Cooksey (1991: 240) the AIDS epidemic has already had major ramifications for the health care workers especially those employed by the hospitals. This was evidenced by how nurses in this study provided nursing care. Findings documented by Boutcher and Gallop (1996: 182) state that the nurses should examine themselves; their own values and attitudes regarding sexuality; identify their prejudices and bias against HIV/AIDS care. This would assist nurses to guard against their personal prejudices related to HIV/AIDS infections. Nurses’ impact and effect on the quality of interaction is very important for the well-being of the patients. Therefore their daily emotional reaction to their daily work role should not be put aside. This could have an everlasting effect on the patients’ recovery. The patient-participants stated that it was difficult for them to
understand what was taking place and that they wished to be discharged earlier. The following statements evidence this:

“Ga o kgone go nagana ga botse, gore o atla, o a tloga or o a fola, you die but …” (You are not able to think right whether you are going or coming or healing).

“Mo sepetelele manurse ba a kwata” (In the hospital nurses are also angry).

“Ke kwele bohloko” (I felt very bad and hurt).

“Ba na le go re omanya, ba fotla.” (They have a tendency of scolding, people and not give good care).

Patient-participants said they were devastated when the nurses scolded them. Nurses have a great impact on health services, through their attitudes, providing care and demonstrating professional skills. It is important to note that nurses reported feeling affected by AIDS, either directly or indirectly. This may have absenteeism as the consequence. That in turn creates an extra staff shortage for the already strained nurses remaining. Therefore loss of staff due to illness, and other effects of HIV/AIDS is possible. This leaves the remaining staff with the difficulties in providing excellent care. Low staff morale results with the increased burden of AIDS patients. Nurses confessed of being afraid of infection as mentioned below:

“Hey… HIV/ AIDS patients are stressing.”

“Fela ke nnete re a tshaba” (It is true we are afraid).

“ As a person you don’t feel free always.”

- Dissatisfaction

According to Longman Dictionary, (1995: 394) dissatisfaction means not satisfied because something is not as good as you expected. The patient-participants expected nurses to provide holistic nursing but they experienced the opposite. The patient-participants interview results revealed the following:

“Hlokomelo, hlokomelo ga e go,” (Care… Care is not there).
“Tshomisano ebe e sa kgotsofatse, Care ya bona ga e amogelege” (The interaction and care were not satisfactory to me).

Patients continually reported dissatisfaction with the care that was given, just as the patients in the study done by Siminoff et al (1998: 148). Even the physical care was neglected. The total care should include giving information, guiding and clarifying issues related to HIV/AIDS care. The patient-participants further stated:

“Go be go le boima mma” (Hey... it was difficult mam),” ke gopolake palelwa ke go hema” (I remember I had difficulty in breathing).

“Ke sa tsebe gore ke direng ke re ke a hwa” I didn’t know what to do, I thought I was dying, “ka leka go bitsa fela ba sa kwe,” (I tried to call them but they could not hear me).

“Di drip di sa some fela ba nkomanya” (The drip was not running well and the other one scolded at me for the drip).

“Ba ile ba ba angry” (The nurses were angry with me).

It is clear from this study that patients satisfaction was not a priority on the part of nurse-participants. Patient satisfaction is an aspect of quality care, as distinct from efficiency or effectiveness of the service (Beck, Griffith, Fitzpatrick, Mandalia, Carrier, Conlon, Mandel, Ong, Pozniak, Tang, Tomlinson, & William, 1999: 332). Fitzpatrick (1993) in Beck et al (1999: 332) defines patient satisfaction as the cognitive evaluation of an emotional reaction to health.

” Ke dira mmerekwa ka ka fetsa” (I just do my work and finish).

The nurses admitted to be doing only their work and leaving. They were not concerned about patient satisfaction, about the caring, providing warmth, compassion, showing love and acceptance to the patients. According to Squire (1994: 320) smaller wards with high staff –patient ratios produced a better climate of support, than larger wards with lower staff –patient ratio. Patients indicated the need to be advised, directed and assisted at some
stage. However, that did not seem to be on the nurses’ daily work programs. They rather carried out medical doctors prescriptions. It is acknowledged that nurses and doctors are overburdened in the public health care sector and that this sector cannot cope with the large number of sick people that need to be treated (Democratic Nurses of South Africa, 2002: 38). This does not mean that quality care should be compromised. Patients were not satisfied at all, they complained about infiltrated drips, thus even care was not of good quality.

“Di drips di be di nkgobatsa di goga madi” (The drips were so dry that there was blood running off into the drip from my veins).

“Ba ka se o bontshe tsela” (They can’t show you the way).

“Care ya bona ga e amogelege, mohloomongwe ba.....” (Their care is totally unacceptable, may be they should be...).

“Nka dira bjang mola ba sa tle go nna? Ga ke a ba bona ka ge ke be ke le in pain, ke re l am dying.”(How can I do that if I cannot see them coming to me because I was in pain and thought I was to dying).

“Ke ba bone fela ge ba mpha treatment.” (I saw them when they were coming to give me treatment).

The patients complained that they saw nurses just come and go with no personal contact with them. In order to ensure patient satisfaction the nursing standard of care should be used to guide the care provider. Steven, Ewers and Hevekr (1993: 73) suggest that nursing standards be developed; implemented and continuously monitored. The supervisors are to make themselves available and known to the patients or put in place systems to deal with dissatisfactions. In this research patient-participants were unable to find out who the supervisor was, as all the nurses were all behaving the same.

“A ba o botse selo, o tla tseba bjang in charge?”(They never tell you anything, how will you know that there is someone who is in charge)?

In the same way the environment has an impact on the nurses’ attitude, it will as well have impact on the patients’ attitude. Issues of patients’ anger may
also have contributed to the nurses to present procedure orientation behaviours. However the nurses were trained to understand what the patients might be experiencing when they are ill. There was no reason for nurses to provide compromised care to any patients just because the patients were irritable and angry. The patients need to be involved in the planning of their care (Fisher, 1984: 489). The planned care results in adherence to treatment. Involvement and participation in all those plans can lead to early recovery. The nurses need to realise that the patients are under their care and may be undergoing the experiences of masked depression (Andreasen & Black, 1995: 9), due to having been diagnosed with HIV/AIDS, which may not be observed. Patients reported being helpless and not knowing what to do in this predicament, they may even commit suicide. The patients need to be supported in all dimensions of life. The nurse-participants stated:

“Patients become angry (ba ba bogale) when we care for them.”

“Nawe uya saba ngoba una abantwana a ba lingana nama patients wakho” (You’re scared because you have children of the same age as your patients).

“Go thomola pelo” (It breaks one’s heart).

“Most patients ba re ba bonang mo sepetlela sa rona ba lwala thata” (That we see in our hospital are very sick).

“Balwetse ba rona ba na le denial.” (Our patients have denial).

“It is painful to see the patients waste away.”

- Procedure orientated nurses

The patient-participants reported that the nurses were available for the nursing procedures. Dorland’s Pocket Medical Dictionary (2001: 681) defines procedure as the manner or a method or technique of performing something while orientation refers to the awareness of one’s environment with reference to time, place or people (Dorland’s Pocket Medical Dictionary, 2001: 612). The nurses failed to present what Walsh (1997: 486) cited as more technocratic in nature, which is focused on the nurse-patient relationship and nurse-patient interaction as therapeautic technology through which treatment may
be delivered, and allowing a more communicative encounter with the patients. In this study nurses were observed being interested in performing the procedures only as cited in the statements below:

“The only time ba tla go rena ke ge ba re fa dihlare” (The only time they come to us is when they gave us medication).

“Ba dira mereko wa bona ba tloga” (They did their work and left me).

According to Poggenpoel (1997: 30) this type of interaction is ineffective in that it stereotyped the patients, gave custodial care, enforced rules and showed lack of empathy, intimacy and caring. Murphy, Kelly, Bahr, Stevenson, Kalichman, Keobela and Milwaukee (1993: 523) found that emotional coping led to greater evidence of clinically significant change. Giving medication and neglecting psychosocial aspects for the patients with HIV/AIDS illnesses will not have much impact on the early recovery of the patients. The nurses’ interaction with the patients was found to be superficial, brief and task orientated like that in the study conducted by Poggenpoel (1997:30).

The patients were admitted for symptomatic care, as there is no cure for HIV/AIDS. The treatment believed to delay full-blown AIDS is in most countries unaffordable, unavailable and inaccessible at the moment (Wigersma, Singh & van den Boom 1998: s5). In her report Mndebele (2001:18) states that health care services are heavily burdened and cannot cope with the increased demands on its limited resources, but until primary health services are fully functioning, the symptomatic patients will still need admission to the hospital and need nursing care. The best treatment that can be offered to these patients is to consider symptomatic treatment and show sympathy, empathy and understanding but the nurses in this study only performed the nursing procedures. Nurses confirmed what the patient-participants stated:
“Ga rena passion ya selo se re se etsang” (We have no passion for what we do).
"Moya wa gago o ya ko tlase gago easy go bona di paciente di tlhokafala mo pele ga mahlo a ga go” (You feel sad, it is not easy to see patients dying in front of you).
“Dihlare tse ba leng mo go tsona a di thuse ka sepe” (Treatment does not seem to be effective).

The nurse-participants indicated that they were no longer enthusiastic about their job but were just there to give care, no more caring. Modiba, Schneider Weiner, Blaauw, Gilson, Zondi, Kunene and Brown, (2002: 37) found that most health workers are burned-out; stress and the emotional exhaustion rate was very high. Scanlon and Weir (1996: 290) suggest that nurses should move from providing care that is steeped in the patronage of task orientation and reflects the biomedically denominated hierarchy. Nurse-participants further remarked:

“And anyhow we nurses have a problem that we cannot stay for a long time with patients.”
“Hey... HIV/ AIDS patients are stressing”
“It is horrible”
“It is embarrassing”
“ke dira mmereko wa ka ka fetsa” (I just do my work and finish).
“Patients ba ba bogale (become angry) when we care for them.”

It is believed that the patients do not appreciate this type of attitude from the nursing teams. Chan, Kwen, Ilaria, Nagler and Jacobs (1993: 535) recommended that patients’ functional needs be catered for in the planning of care as part of comprehensive care. During interview session visits the researcher observed that the patient-participants were just idling at home. If they had chance to learn some skills on occupation while admitted then they would not think so much about the AIDS problem and function well in the family set-up. The need for referral to occupational therapy section should have been identified while the patients’ needs were assessed, planned for
and included in the discharge plan, so that they could also form groups to assist each other (Yalom, 1993: 247).

Patient-participants were alarmed to realise that in many circumstances the nurses made themselves available for the nursing procedures and other patient care activities but they could not show sympathy for the patients. In this study the nurses carried out their duties of being engaged in the nursing procedures, at which the patient-participants rated them better although the following evidenced that the nurses also had problems in carrying out some procedures:

“Di drips di goga madi, ke kwa bohloko” (I was feeling very much pains, as the drips were withdrawing blood).

“Drips be di nkgobatša matsoga a rurugile.” (Drips hurt me so much that my arms were swollen).

According to Lecachelevt, Meyer and Fulachier (1993: 518) it is necessary not only to provide basic health care but also to give psychological support to the HIV/AIDS patients so that they will be able to cope at home. Furthermore this requires the discharge plans to include psychological care to be carried out while at home by the patients and the family. The patient-participants lacked self-esteem, felt that they were not valued as human beings like other patients who may not be HIV/AIDS infected. The patient-participants felt that they were treated like objects, which received only one-way communication. The following statements indicated this:

“O ba bona fela ge ba dira se sengwe mo go wena” (You see them only when they have to do something to you).

Patients acknowledged seeing nurses when they had to provide nursing procedures, which also could indicate that they would also have acknowledged the psychological care if it was ever provided.

“Ba dira se ba se dirago ba o tlogela o robetse mola” (They do what they have to do and leave you to sleep there).
“Mme ke be ke nagana dilolo tse ntshi, ke boifa lehu ka ge ba re bolwetsi bo a bo ne kalafi” (Mama, I had so many things going on in my mind that I was even scared that I will die as they say the disease has no treatment).

Patients’ anger may also have contributed to the nurses to adopt the procedure orientated behaviour. They neglected patients’ psychological and social support. However, the nurses were trained to understand what the patients might be going through when sick. It was not a reason for nurses to provide compromised care to the patients. The nurse-participants raised a concern related to angry families due to the confidentiality principle. Botes and Otto (2003:281) cited the dilemma faced by nurses regarding confidentiality principle related to HIV/AIDS care. The nurses faced a dilemma on the confidentiality issue and ignored the social care of the patient by not encouraging family involvement in the care of these patients. The nurses failed the patients by considering only procedures and medications. The patients needed someone to clarify care issues, HIV/AIDS uncertainties and to offer psychological support. They were left alone with wandering minds and thinking about dying.

The patients had pain and were afraid of death. Loveless, Bell & Coodley (1993: 74) documented that pain was the most feared symptom in HIV/AIDS. The patients put their trust in the nurses to help them allay the pain and anxiety. If the patients’ psychological care was not prepared, pain and fear could remain troublesome even with attempts to relieve the pain.

“Tshepo ya rene e be e le mo manurseng.” (Our trusts were on nurses).

In my study, Manamela (2001: 38), I learned that when people living with HIV/AIDS are ill, the family can cope with care to a certain level, but at terminal stage it becomes difficult to continue supporting and caring for them (UNAIDS, 2000: 43; Goldenberg & Goldenberg, 1990: 47). Nurses and families of HIV/AIDS infected patients are caregivers; therefore they also need
support; they need to follow de-briefing procedures and education on HIV/AIDS issues.

“Fela ke nnete re a tshaba” (it is true we are afraid).
“ It is not easy to see patients dying in front of you.”
“ Our black nation is going down, statistics of this disease is rising everyday.”
“ HIV patients are really stressing ehh…”

The way the nurses managed the patients shows that the nurses had misconceptions and myths about sexuality and HIV because they were afraid and scared. Boutcher and Gallop (1996: 185) suggests that nurses be encouraged to examine their own attitude regarding sexuality and to acknowledge their prejudices and bias. This misconception further influenced the work environment. Severinsson and Hallberg (1996:395) documented in their study that the working milieu is influenced by the specific working conditions. In this study it was clear that nurses were trained for their work but cited the problems of overcrowded wards preventing them from delivering expected quality services.

- Dissociation and unhelping attitude
Dissociation refers to the situation where a person is not viewed as one, separating a person’s mental and physical health, the two are seen as disconnected from one another. In this study nurses treated the patient-participants as physical beings only.

Most patients were admitted because of the progressive immunity system deterioration and then they become terminally ill. In this crucial time quality care is very important. Unfortunately for these patients the nurses were just executing nursing procedures not providing care in totality, thus excluding psychological and social care. The statements showed that:

“………a le fully blown a smella le ge e le gore a si bi a je selo,”(They have smell even if they didn’t eat anything), it’s horrible!……we…”
“Go tlhomola pelo” (It breaks one’s heart).

“Most patients ba re ba bonang mo sepetlela sa rona ba lwala thata” (That we see in our hospital are very sick).

If the nurses could not stand the patients’ condition, how could they remain with them to try to plan the care as a whole? Therefore it is understood that nurses failed to provide helping relationships. Patients’ state of health and unfavourable working conditions also contributed to the nurses’ unhelpful attitude. The nurse-participants agreed that they were afraid and sometimes they do present with negative attitudes toward the patients. They had their own problems related to HIV/AIDS and affected by the epidemic as well.

“…..o kereye patiente ga e utlwisisi,and then nna ke nale problem ke hlagang ka yona ko gae , e be ke mo fohlela! moo nkebe ke mo advisa positively.” (You find that the patients do not want to understand and I have my own problems from home then I insult the patients).

“Le rena ba refe emunisation yeo ba bafang yona.”(Let them immunise us as well).

The nursing process is the best model of providing nursing care. It should start by assessing the patients’ need; then plan the care needed and implement and execute the nursing care according to the plan (Ward, 1993: 9). Monitoring and evaluation of the care rendered is very important. According to Payson, Wheeler and Willington (1998: 33) assessing the patients’ need is the key to the achievement of the desired nursing care outcome. In this research, although nurses admitted and acknowledged the importance of being available for the patients, providing the quality nursing care, knowing the desirable outcome of quality care, their behaviour demonstrated the opposite, characterised by remarks such as:

“Fela ke nnete re a tshaba” (It is true we are afraid).

“As a person you don’t feel free always.”

”Ke dira mmerekwa ka ka fetsa”(I just do my work and finish).
In the study conducted by Edwards (2000: 225) patients expected to be given positive care characterised by building their confidence, receiving affection and warmth, nurses having time to talk with the patients, help reduce the stigma, understand, listen and provide support to them. Patient-participants remarked as follows:

“A ba o sware pila ba re: “Aai oo yena o be a ya kae a inyakela di AIDS,” (They were not treating us well.” Saying: This one has brought AIDS upon oneself).

These remarks are disturbing and will lead to unexpected health outcomes. Instead of forming a multidisciplinary team as suggested by Kurth, Black, Wood and Kubilis (1993: 73) patient-participants in this study indicated that other team members also failed to offer a helping attitude. They described areas that disappointed them during provision of care as follows:

“O a sulafaletswa” (You become sad).
“O a kgopisega, o kwa bohloko” (You feel very bad and hurt about this).
“Ba a o Kgadimola” (They scolded/insult you).
“Batho ba ba rafo” (These people are RAFO=very bad).
“Hey...mama , ke kwa bohloko kudu” (Hey .. mam , I felt very bad and become sad).
“Moya o ba o moso” (Black spirit/heart, sad).

The patient-participants in this study had the same expectation from the nurses. The expectations that they would be given holistic care, such as becoming able and free to build trust relationship with the nurses. It was unfortunate for them that the nurses failed to consider psychotherapy as advocated by Peter et al (1993: 120), which they recommended as a result of their study where HIV/AIDS patients presented with high levels of stress. Fear of infection prevailed among the nurses. The fear of infection and stress made it difficult for the nurses to be with the patients. They separated physical care from psychological and social care. The patients could not connect and
express their emotions during their interaction with the nurses (Walsh, 1997:486). The following remarks proved that:

“Le rena ba re fe emunisation yeo ba bafang yona” *(Let them immunise us as well).*
“*In the ward there is no time to sit and talk with these patients, admissions are overflowing.*”

Nurses remarked that even when they wanted to help the patients, the patients were slow and angry and the nurses responded with unhelping attitudes and dissociated the patients:

“*With these patients mostly ba (they are) weak, ka gore ga ba sa hlole ba le sharp, o kile wa bona! Le ge o motsosa….gore le bolele…. Ke eng a ba bue….”* (When you wake them to talk they are…) *a ba open ….so a ba (they do not) open mo rona so…” (to us).

The patients were reported not to open up to nurses; they could not talk. The physical condition might have deteriorated to that level and lack of empathy from the nurse caused the nurses to feel helpless because the patients were slow and not open. They felt they were just dying of AIDS, they were not emotionally supported and that there is no cure. The nurses need to be very careful in planning the care for patients suffering from immune compromised illnesses because the patients can still lead healthy lives while they are HIV/AIDS infected.

- **Ill-treatment and aggression**

Ill-treatment is seen as an effort to treat a person badly or abuse a person (Allen, 1990:587) and aggression emanates from frustrations and manifests by attacking behaviour and hostility (Dorland’s Pocket Medical Dictionary, 2001: 232). Aggressive behavior, as suggested by Johnson (1993:284) is defined as an attempt to hurt someone or destroy something and to infringe on the right of others, by use of sarcasm, labels, and hostile statements and actions.
It is expected that nurses should inform the patients of other activities available if they could not assist them at a certain time, further that patients should be made aware of the unavailability of treatment for HIV/AIDS and the importance of early treatment of any opportunistic illness, with the emphasis on the prevention of further exposure. The advantage of being with the patients for 24 hours would have to be effectively utilised as recommended by Burnet, Baggaley, Ndovi-McMillan, Sulwe, Hang Omba and Bennet, (1999: 482). Nurses are to enhance quality of life and alleviate the adverse psychological sequel among patients with HIV/AIDS opportunistic diseases. Kilti, Gatau, Dortzbach, Meredith and O’dira (1993: 127) discovered that ill-treatment is a barrier to quality care.

The patients expected support from nurses. If the patients are supported their anxiety, hopelessness and depression would be reduced. Serovich, Brucker and Kimberly (2000: 653) realised in their study that people with high levels of social support presented with less depression. Patients reported the consequences of ill-treatment on their lives as follows:

“Hey … mam, mama, ke kwa bohloko kudu ka sulafaletswa” (Hey… mama I felt very bad and become sad).

“Ba dira gore moya obe o montsho),” (You become sad, because they make your spirit to become black, you become sad).

“A ba o sware pila ba re: “Aai oo yena o be a ya kae a inyakela di AIDS,”(They were not treating us well, Saying: This one has brought AIDS upon oneself).

It is very significant that nurses should provide support to the HIV/AIDS patients. They should consider measures to overcome obstructions in dealing with the infection’s reality rather than becoming angry with the patients, and provide psychological support. The psychological support encourages a trust relationship, which has been rated highly by patients with HIV/AIDS in the study conducted by Simoni and Ng (2000: 570).
The patient-participants stated that they were devastated and that their hearts were very painful during their stay in the admission wards. They explained that they were depressed and hurt (black and dark spirit) in the following statements:

“*Ba omanya.*” *(They also insult you).*

“*They don’t care.*”

“*Ba dira gore moya obe o montsho),”* *(You become sad, because they make your spirit to become black, you become sad).*

It was further stated that the nurses also used verbal aggression at some stage, and this caused patients hurt and pain, Scheff (1995:27) stated that verbal aggression could cause pain to the parties involved.

- **Non-sympathy and lack of empathy**

The participants further observed the interaction as non-sympathetic and with no empathy. In many areas, for example, a patient who was on intravenous infusion that ended up infiltrated and withdrawing blood backward, saw this as an “I don’t care” attitude! Demonstrating sympathy and empathy can help in the development of trust and rapport. Instead of showing empathy, which is seen as important for a positive outcome (Olson, 1995: 317) nurses were afraid of infection. The following statements indicated the lack of demonstration of sympathy and empathy by nurses during interaction:

“*Bangwe a ba na taba, they do n’t care. O bona ka moo ba o lebelelang*” *(Some of them do not care.., you see by the way they look at you).*

“*Bangwe ba ba ‘angry’ ge go sa dire ka moo ba ratag o thoma go ba afraid. ’”*(Some become angry if the things are not running as they know and in this way you are afraid to say anything to them).”

“*They were not treating us well.*”

Nurses were worried about their safety while blaming some patients that they were responsible for infecting themselves. Nurses could not cope indeed if they uttered such statements:

“*Uya zibuza ukuthi, wena (You ask yourself,) as a nurse, are you safe?”*
“Uyazi, lendaba ye HIV/AIDS inzima ugu sebenza uncarying ngayo” (You know this issue about HIV/AIDS it is heavy/difficult to work with).

One patient stated:
“A ba o sware pila ba re: “Aai oo yena o be a ya kae a inyakela di AIDS,””(They were not treating us well, Saying: This one has brought AIDS upon oneself).
“Ka gobane batho ba ba rafo” (Because these people are rough), “they do not treat you well.”

This is supported by Kemppainen et al (1998: 332) in their study on HIV/AIDS patients, who also complained that the nurses were not gentle with them (rough) especially when requested to assist with bedpans.

The nurses were frustrated and confused at times as stated below:

“Sometimes you ask yourself whether you have chosen a right career.”
“Ke gore every time ge o ya gae o tsamaya o na le stress, O tsamaya o le tired emotionally”(When you go home you are stressed and emotionally tired)
“I can’t adjust myself, its really stressing you know,”
“I think I am going to resign.”

In their study, Gordon, Ulrich, Feeley and Pollack (1993: 359) found that nurses who cared for HIV/AIDS patients started to look for new jobs. The nurses were reported to be uncomfortable and afraid of infection and of caring for terminally ill patients (Gordon et al 1993: 363). It was also found that most health workers were prepared to work where there was a low incidence of HIV/AIDS (Dworkin et al 1991: 240). The workers were also afraid of the risk of infection through contact. The nurses in this study presented with the same attitude. The fact that they see HIV/AIDS as the death sentence has a significant role to play in the care that they provide to AIDS patients. The following remark bears this out:
The nurses reported to have no passion for work. The lack of passion showed that it would be very difficult for them to be sympathetic, understanding and to demonstrate unconditional acceptance to these patients. The nurses felt they only had an obligation to care for all the patients assigned to them.

According to Lenkwane (2001: 53) empathy enables nurses to have a sense of, sharing and accepting the patients' emotional point of view. Ingram, Jones, Fass, Neidig and Song (1999:313) uncovered four types of unsupportive and upsetting responses the patients suffering from HIV/AIDS receive from others as insensitivity, disconnection, forced optimism and blaming. The above-indicated upsetting responses were also seen as part of the nurses' behaviour towards the patients in this study. Patient-participants were troubled by the insensitivity of the nurses - hence they were not happy about the nurses. Nurses have lost the most important skills in assisting the patients' psychological well-being. The development and implementation of the skills of sympathy and empathy would have been of crucial benefit for these patient-participants.

- **Lack of clarity and understanding**

AIDS compromised illnesses take a long time to respond to treatment and the affected patients need to be given information on this issue. The fact that this will affect their finances should be highlighted, as an increased length of stay requires more money for hospital fees. Mposo and Mpoke (1993: 121) stated that HIV/AIDS patients are unable to pay for their health fees. Therefore it is important that this be clarified to the patients.

In the nursing profession nurses are expected to demonstrate the ability to clarify and solve some of patients' problems. In this research this was not displayed and it showed that the nurses were not assertive on the issues concerning HIV/AIDS care. This meant that nurses did not give the patients sufficient attention in order to meet their needs. Spending more time with
patients might have allowed the patients greater opportunity for verbal interaction with the nurses and for nurses to give attention to the psycho-social care of the patients (Siminoff et al, 1998: 161). This might reduce other physical care demands as patients take part in their care. It is noted by Sikkema, Kalichman, Hoffman, Koop, Kelly and Heckman, (2000: 1311) that there are advances in the medical management of HIV/AIDS diseases that now hold promise of extending the life of the people living with HIV/AIDS. However it would still be difficult to extend their life if their mental well-being is not encouraged and unconditional acceptance and love are lacking. It is confirmed that psychological care minimised complications and delays in responding to treatment. In the study conducted by Sammut (1997: 20) the patients consider talking to nurses more helpful than medicine. Nurses have an important effect on the patients’ well-being: their behaviour; their attitude towards treatment and the outcome of any treatment. The patients need time to discuss with the caregiver or therapist, to have discourse and narrative about their care (Gillies, 1989: 509). This is evidenced in the following patients’ remarks:

“Ga ba le kgathelele” (They do not care).
“Ka nako yeo o tla be o le ‘in pains’ o lapile” (By that time you will be in pains and tired).

It is expected that nurses will assist the patients by clarifying uncertainties the patients had on HIV/AIDS issues, give important information, and guidance on what to do from there. It is unfortunate that this did not happen in this study.

“Be ba n cousela, ke masocial worker during the week fela” (I was only counseled during the week by social workers).

Nurses ignored their counselling role. This revealed that nurses could not manage patients according to the needs of the patients in terms of the five dimensions of care (Beck et al, 1994: 640). Douglas, Kalkman and Kalkman (1986) in Dworkin et al (1991: 240) found that nurses were troubled by anxiety because there is no cure for HIV/AIDS at the moment. They also found that
the nursing personnel are at a higher risk than medical officers and social workers hence nurses exhibited more anxiety than all the other groups in their study. The nurses’ need for immunisation indicated their anxiety and difficulty to provide care to the HIV/AIDS patients.

“Le rena ba refe emunisation yeo ba bafang yona” (They should also give us immunisation that they give to the patients).

“Moya wa gago o ya ko tlase, ga go easy go bona di paciente di tlhokafala mo pele ga matlhoo a gago (You feel sad it is not easy to see patients dying in front of you).

Payson et al (1998: 320 described patients’ actual needs versus perceived needs. The patients had needs for clarity on their illness while nurses considered giving medications and procedures as all that the patients needed. It is important for nurses to plan the care together with the patients (Fisher 1984: 489). Even if the nurses did identify the patients’ needs, they could not help the patient-participants in this area.

“Patients are very anxious when talked to them, they want to know more about what is going on,”

The above statement confirms that there was a need for patients to understand about their illness.

The nurse-participants indicated that there should be people to assist these infected patients, to clarify for them what the disease entails.

“Go ba ne le batho ba tlo mo hlalosetsa gore AIDS sese ruri ke eng, se teng”(There should be some people to come and explain what AIDS is).

It was surprising as the nurses were with the patients for 24 hours a day and were still trying to shift the responsibility of explaining and clarifying the uncertainty the patients were facing to other people. This confirmed that the nurses were unable to provide quality care to these patients. The nurse-participants interviews also confirmed what the patient-participants had
indicated, and as the nurses unknowingly presented during their interview sessions. The following statement from the nurses’ side evidenced the nurses’ behaviour of just giving care and not caring:

“In the ward there is no time to sit and talk with these patients, admissions are overflowing”.

Health Systems Trust (2004:207) annual report showed that there was an increase in the number of AIDS patients and that this increase placed strain on the health care workers. It was revealed in this study that nurses had no time for the AIDS patients due to the huge numbers of admissions. The patient-participants perceived such behaviours as the way of discriminating between the patients. However this could be due to the fact that there was a need for additional nurses in order to provide holistic care to all the patients.

“There is overload of work here, there are no enough nurses, this shortage of nurse is too much.”

HIV/AIDS affects everybody; it is possible that nurses are either infected or affected. Nurses could use a variety of mechanisms to deal with this, such as avoidance, rejection, discriminations and keeping themselves busy.

“Even when you do an admission of a patient there is no time to go into detail of the patients’ history.”

It is acknowledged that because of the epidemic some nurses might have experienced loss of relatives due to AIDS, and now the patients become a constant reminder of their loss. Therefore this may lead to ill-treatment or isolation of the patients as a way of avoiding going into a bereavement situation again.

The health workers are living in the environment of the HIV/AIDS epidemic and it is not strange that they will be affected. In the report of the Health Systems Trust Review as cited by South African Broadcasting Commission,
(2004/ 07 / 29) it is reported that 16 % of health care workers are HIV/AIDS positive. The nurses are health workers; some of them may be infected. It is important to increase the number of nurses. The nurses are also aware of the increased spread of HIV, hence the statement:

“Our black nation is going down, statistics of this disease is rising everyday.”

Van Rensburg (2004: 276) indicates that Sub-Saharan Africa has 29,4 million people infected with HIV/AIDS. Nurses are not exempt, as they are also human beings. Seeing patients being so sick, and dying after so much suffering, will indeed have an impact on them. AIDS renders an individual unproductive and ineffective. The problem has an impact on human resources because most employees are affected and/or infected.

It is significant to note that the people living with HIV/AIDS can make a significant contribution to the fight against the disease. The North West Provincial report on HIV/AIDS emphasised the role of the person living with HIV/AIDS in the fight against AIDS (North West Provincial Council on AIDS, October 2000:15) in issues such as prevention, intervention and care strategies. If the similar aspects can be realised in all sectors the spread of HIV/AIDS can be minimised.

3.4.1.3 Limited communication with the patients with HIV/AIDS

Communication is a cornerstone of every interaction. Communication entails both verbal and non-verbal communication. Limited communication leads to limited and shortsighted nursing care. Communication is fundamental to nurse-patient interaction and ineffective communication results in patient dissatisfaction. All the nursing care plans need to be communicated effectively. This requires that the caregiver and the receiver of care should realise the importance of communication at all times in the care setting. The sub-categories of limited communication are tabulated in Table 3.2.3 and discussed below:
TABLE: 3.2.3 Sub-categories of limited communication with patients with HIV/AIDS

<table>
<thead>
<tr>
<th>Sub-categories of limited communication</th>
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<tr>
<td>• Prevailed uncertainties</td>
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<tr>
<td>• Hunger for Interpersonal relationships</td>
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<tr>
<td>• Impeded two way communication</td>
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<tr>
<td>• Shaded non-verbal communication</td>
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Patient-participants were astonished by the behaviour of the nurses as they saw them in the ward going up and down and concluded that nurses were rejecting and isolating them because of their infections. Kemppanen et al (1998: 331) discovered the same attitudes in their study.

At the same time nurses reported they were overworked and trying to cope with the demands of patients. The patients experienced this as a way of stigmatising and rejecting them because of their HIV/AIDS status. Patient-participants needed to communicate their fears and concerns about the infection, such as treatment effectiveness, course of the treatment and others. The nurses as health providers also needed feedback on care rendered. The nurses could have first hand information from the user. Communicating aspects related to the patients' illness is very important. All the patients need to communicate their fears, anxieties and strength in dealing with the HIV/AIDS. In the study conducted by Sammut (1997: 20) psychiatric patients considered talking with the nurses more helpful than medication. In this study the patients with HIV/AIDS indicated one of their needs was to talk with the nurses. Limited communication was evidenced in the following statements from the patient-participants:

“A ba o botse selo, o tla tseba bjang in charge?”(They never tell you anything, how will you know that there is someone who is in charge)?
“Be ke nyaka tsebo in many things fela o se yo a ka nthusago” (I needed to be assisted to understand many things but there was just nobody to help me).

“Ge o dutse mola gago yo a tlago go hlosetsa selo gore dilo di sepela byang goba why ba sa o thuse ka nako” (When you were sitting there was nobody who ever came and explained how the system works, or why they will not attend to you by the expected time).

“Aowa, a sa nka ba tla ba hlosela selo” (No, they never come and explain).

Patients expected guidance and support from the nurses. They believed that nurses were educated and could then be trusted to help them, but in vain.

“Be ke nyaka go bua le bona fela ba sa bonale, ke no tsea dilo ka moo ke bonago” (I wanted to speak to them at times but it was not easy to see them and you end up perceiving things the way you think even if you are not well informed).

Nurses acknowledged the importance of communication as cited below, yet they failed to communicate effectively.

"Talking to a person is therapeutic. You need to sit and give more attention to the patient”

“Ama patients bane i nto yo kuthi aba nabo abantu aba ngakhuluma nabo” (Patients have a thing that they do not have anybody to talk to).

“Thina singa ma nurse (we as nurses) should make it.”

Throughout the interaction nurses protected themselves, gave reasons for poor communication as lack of time, deteriorating patient condition, patients as very anxious when spoken to, patient denial, anger and irritability as indicated in their statements as follows:

“Akuna isikhathi, Akuna isikhathi, ama patients siya ba nanazela ukuthi bahlale bacoce namanye ama patients, ba bonge nempilo e banayo”
(Time is limited, patients are encouraged to socialise with other patients and appreciate their lives).

“In the ward there is no time to sit and talk with these patients, admissions are overflowing.”

Walsh (1997: 486) described connectedness as an integral part of patient relationship. How can people connect if there is no communication? Poggenpoel (1997: 27) in her study states that nurses thought they effectively communicated with their patients. In contrast to the nurses’ view, the patients, families and communities complained that the nurses communicated poorly and did not listen to them. The same was found in this study.

- **Prevailed uncertainties**

The patient-participants reported their interaction as mostly non-verbal as nurses had no time for them but moving up and down, looked busy and short staffed. The lack of communication jeopardised patient care and the patients remained with uncertainties related to the infection and its management. The following statement confirmed the prevailing uncertainties:

“Be ke gopola gore ba ka nthusa go ‘understanda’ HIV” (I just felt that they can make me understand what I should know about the disease).

“Go be go se nurse yo a nhlalosetsang” (There were no nurses, who explained things to me).

“Be ke nyaka tsebo in many things fela o se yo a ka nthusago” (I needed to be assisted to understand many things but there was just nobody to help me).

In their study Siminoff et al (1998: 147) realised that increased verbal communication was associated with increased quality of care. Patient-participants in this study needed increased communication more than any thing else.

Patient-participants in the study conducted by Kemppainen et al (1998: 333) also stated that they had no say about their care; only nurses were in control.
In this study the nurse-participants cited that patients do not understand, they are weak and in denial although they accepted that they were also presenting with a negative attitude, the following statements indicate this:

“……o kereye patiente ga e utlwisisi,” (You find that the patient does not understand).

“In the ward there is no time to sit and talk with these patients, admissions are overflowing.”

“It is painful to work with these people and anyhow we nurses have a problem that we cannot stay for a long time with patients because we are short staffed.”

“Psychologically, to work with these patients uya kathala.”(You get tired).

- Hunger for interpersonal relationships

Interaction requires a two-way relationship; that the parties involved be able to demonstrate listening in verbal or non-verbal communication (Okun, 1992: 104). In this study it was revealed that only one party, nurses, dominated in the interaction. Communication that related to health provision requires that all the parties involved in the promotion of the patient’s health be drawn in. The nurses reported that the fact that families were angry towards them because the nurses could not inform them about the patients’ problem for confidentiality reasons frustrated them. If there was an open communication, the nurses would have made the patients aware of the importance of disclosure, especially to the families so that they could be supported after being discharged from the hospital. According to Corsin and Weddin (1995: 357) the patients’ problems need to be viewed within a broader context of which the family is inevitably a part. This means communication will lead to an established relationship in that the family will be seen as having a role to play in patient care. The nurses were unable to listen to the patients as shown below:

“Be ke nyaka go bua le bona fela ba sa bonale ke no tsea dilo ka moo ke bonago”(I wanted to speak to them at times but it was not easy to see
them and you end up perceiving things the way you think even if you are not well informed).

“Aowa, a sa nka ba tla ba hlalosa selo” (No, they never come and explain).

The nurse-patient relationship plays a very important role in the mental well-being of the patients. Psychological support is the first step in the care of the patient with life threatening diseases like HIV/AIDS. The patients remained hungry for communication, felt the need to build relationships with the nurses but it was not possible.

- **Impeded two-way communication**

The patient-participants needed to communicate. The two-way communication process was impeded in that the nurses would present only non-verbal communication during the execution of nursing procedures. The nurses remained in control.

It is evident from the patient-participants' statements that nurses had no time to communicate with them except during nursing procedures. There was no time for them to listen to the patients. Taylor (1986:223) recommended that the patients' need to be involved in the care provided for them is very important. How could they be involved if there was no two-way communication? It is very difficult. Ho, Thiel, Rubin and Singer (2000: 102) in their study on patient satisfaction in patients with HIV/AIDS documented that patient satisfaction included directives given to the patients and that were highly valued by the patients.

The statements below explain the lack of two-way communication:

“Be ke nyaka tsebo in many things fela o se yo a ka nthusago” (I needed to be assisted to understand many things but there was just nobody to help me)

“Ba sa mpotsise gore go reng” (They did not even come to me and ask how do I do)?
“Eng, ke letile ka ge a rile o tlo boa, e…e ge a boa a re oa tshaisa” (Yes, I waited there, waiting as she says she will be back, E…..e… when she came back she says she is going off).

The nurses’ statements also confirm what the patients indicated:

“ You will find that in the ward there is not much time to talk to these patients.”
“Ke dira mmereko wa ka ka fetsa”(I just do my work and finish).
“La ewardini akuna isikathi for ukuhlala no kukhulama na lama patients, ama admissions maningi” (In the ward there is no time to sit and talk with these patients, admissions are overflowing).

Nurses were observed as the people in control, as it happened in the study conducted by Kemppainen et al (1998: 334). The nurses never considered the fact that patients wanted to listen and talk to them. According to Cox (1988: 342) talking to the patients could help nurses to diagnose the needs of the patients. In another study conducted by Sammut (1997: 2) psychiatric patients viewed talking to nurses more helpful than medicine. In the provision of care to HIV/AIDS patients communication could result in more clarity on the care and infection management. The fact that nurses had no communication with the patients meant that the nurses denied the patients their right to free information on HIV/AIDS. The Constitution (Department of Education, 2000: 8) guarantees the right to freedom of access to information. Communicating with others relieves stress and shows support.

The significance of social support is seen as having a strong direct effect on mental health. The nurses have an important influence on the patients’ well-being including their response to health care provided to them. The nurses are with the patients for a longer time than other team members; therefore building relationships with the patients enable them to be part of the patients’ support structures. This will promote the patients’ mental health while in the hospital. But the nurses found themselves busy, and astonished by the patients’ deterioration of health and pain. The statements below confirm this:
“Aowa, a sa nka ba tla ba hlalosa selo” (No, they never come and explain).

“Modimo wa ka (My Lord), it hurts, it is painful to see people dying in front of you on daily basis.

“Our black nation is going down, statistics of this disease is rising everyday.”

“Fela ke nnete re a tshaba” (It is true we are afraid).

“As a person you don’t feel free always.”

Marelich and Murphy (2003:475) state that patients with a high level of communication with the health care provider were found to receive more information and positive influence from their nurses and have been involved in the medical decisions about their care.

- **Shaded non-verbal communication**

The non-verbal communication was shaded. It seemed as if there was a dark screen preventing (black mark obscuring) the two parties from communicating effectively, there was no verbal communication. The nurse-participants presented the non-verbal communication in a selfish and unhelping way, in that they would talk to the patients during execution of the nursing procedures and when called by the patients, their responses was unsatisfactory. The patients stated:

“Ene o ba bona ge ba tlo dira sesengwe.” (And only come to you when they have to do something to you).

“Ba ka se dule le ten minute le wena”(They could hardly spend even ten minutes with you).

“Ga ke gopole ba dula le nna ke kgopela thuso mma” (I cannot remember sitting with them and ask them anything, mam).

“Ge o dutse mola ga go yo a tiago go hlalosetsa selo gore dilo di sepela byang goba why ba sa o thuse ka nako” (When you were sitting there was nobody who ever came and explained how the system work, or why they will not attend to you by the expected time).
The nurses also confirmed that there was no verbal communication because the patients could not understand:

“……o kereye patiente ga e utlwisisi, and then nna ke na le problem ke hlagang ka yona ko gae, e be ke mo fohlela! moo nkebe ke mo advisa positively.” (You find that the patients do not want to understand and I have my own problems from home then I insult the patients).

The patient-participants reported hearing footsteps and perceived that the nurses were busy. No explanation was ever attempted to inform the patients why they were invisible, even when attempts were made to call them while assisting nearby patients they failed to come back. Davidhizar and Shearer (1993: 12) state that the efficient listener guides the interaction and encourages the parties to feel in control of the interactions. It is unfortunate that in this interaction patient-participants were never given a chance to be in control of the interaction. Weller (1993:9) cited the benefit that the patients and practitioner could have on patient care if they worked together. Working together includes communicating effectively.

“You can hear nurse’s footsteps fela ba ka se tle go wena” (but they cannot come and talk with you).
“A ba na taba, o bona the way ba o lebelelago”( They don’t care, you see by the way they look at you).
“Ba sa mpotsise gore go reng”(They did not even come to me and ask how do I do)?

The nurses continuously presented with the absence of verbal, social and physical contact with patients. This was also evident in the study contacted by Siminoff (1998: 149).

The nurse-participants stated:

“Talking to patient is therapeutic.”
“Time is limited, patients are encouraged to socialise with other patients.”
The importance of communication was realised and that it was important to talk to the patients. The nurses further admitted that there was nobody to talk to the patients because the nurses lacked time. They followed shaded non-verbal communication. The patient-participants confirmed limited communication as they struggled to have time with the nurses as stated below:

“Ga o kgone go ba le nako le bo nurse,” (You hardly have a time with them).

“O ba bona ka noka tse dingwe,” (You see them sometimes).

It is important that nurses should encourage the patients to socialise with other patients in the ward, but as the nurses acknowledged that as the wards were overflowing with very ill patients there was no chance that the patients could be able to socialise with others while they were still ill. The role of the nurse is to give information, offer the therapeutic touch, and support the patients. Socialising with others cannot effectively substitute the role of the nurses.

“Patients are very anxious when you talk to them, they want to know if the treatment is going to be effective.”

Although the nurses recognised the need to communicate with the patients they failed to find time to clarify things to the patients. The patients wanted to be involved in their care but when the nurses realised that the patients were anxious, they did not communicate. The working conditions were reported to be unbearable, there was an increased number of admissions, increased average length of stay for these patients due to delayed response to medications hence the ward was overflowing with patients. Patients who are frustrated will also respond slowly to the treatment. The nurses are still expected to provide the care holistically, considering patients as human beings with psychological needs, social needs and physical needs.

“It makes it difficult you can see that ba ba (they become) worse”
Nurses suffered from burnout. Dworkin et al (1991: 245) found that nurses working with HIV/AIDS patients were burnt out.

“With these patients mostly ba (they are) weak”
“Le ge o mo tsosa…. gore le bolele…. ke eng a ba bue… a ba open up”
(When you wake them up to talk it is difficult).
“I wish there was a centre where they can be referred,”

According to the research study on the experiences of family of people living with HIV/AIDS, Manamela (2001: 50) I found that if nurses are guided to assist patients with HIV/AIDS, they will guide the patients to be open to communicate their fears and anxieties to any person they trust. By doing this they will reduce the inward fear and anxiety. It is suggested that the nurses as care-givers should be assisted in acquiring more information to manage problems resulting from HIV/AIDS (Swanson, Cronin-Stubbs & Colletti, 1990: 79).

3.4.1. 4 Emotional harassment of the patients with HIV/AIDS

Allen (1990: 537) defines harassment as troubling and annoying a person. A person who is exposed to frustrations and stress experiences emotional harassment. Patient-participants reported being scolded and insulted by the nurses during their interaction with them. The sub-categories of “emotional harassment” are tabulated in Table 3.2.4 and discussed below:
TABLE 3.2.4 Sub-categories of emotional harassment of the patients with HIV/AIDS

<table>
<thead>
<tr>
<th>Sub-categories of emotional harassment with the patients with HIV/AIDS</th>
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<tbody>
<tr>
<td>• Confusion and frustration</td>
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<tr>
<td>• Insults and scolding</td>
</tr>
<tr>
<td>• Depersonalisation and lowered self esteem</td>
</tr>
<tr>
<td>• Degradation and sadness</td>
</tr>
<tr>
<td>• Frightened and hurting</td>
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The following statements explain how the patient-participants experienced emotional harassment during their interaction with the nurses:

“O a nyama. Ba bangwe ba dira gore pelo/ ya gago e ba e ntsho.” (You become sad, because the others make your heart/spirit to become black).

“Moya o be o montsho.” (You become depressed).

The nurses mentioned that they fell in the trap of emotionally harassing the patients in this:

"Ee be ke mo fotlela! moo nke be ke mo advisa positively.” (I scold or insult the patients instead of helping her).

South African Depression and Anxiety Group (Sadag) chief, Wilson in Pretoria news, (19 May 2004:6) stated that if society only focused on the physical aspect of HIV/AIDS, there is a danger that we would lose sight of how serious and complex the psychological and emotional needs of the people were. It is not a victory if we prolong life with anti-retroviral treatment and lost the same person because we neglect their emotional, psychological and spiritual welfare. The HIV attacks the nervous system, emotional well-
being and psychological stability of a person (South African Depression and anxiety Group (Sadag) chief, Wilson in Pretoria news, (19 May 2004:6) therefore it is important to include psychological and spiritual care, then we can prolong the person’s life.

- **Confusion and frustration**

  The nurses presented with in-ward anger as the patients and their families were irritated and hostile towards them. The nurses coped by ignoring their functions. This behaviour contributed to the patients’ frustrations and confusion. Taylor (1997:281) documented that in-ward anger is a danger to a person’s mental health.

  It was found in the research study on the experiences and coping skills of the families of people living with HIV/AIDS that confusion and frustrations are psychological experiences that traumatised and lead to the development of hatred (Manamela, 2001: 32). The patient-participants stated:
  
  “You become confused, really.”
  “You do not know what to do.”
  “Ba dira gore o hlakahlakane” (They make you to be confused).
  “A ba na taba, o bona the way ba o lebelelago” (They don’t care, you see by the way they look at you).

  Lack of proper planned care leads to confusion. The patients did not know what could be the outcome of their treatment as there was no one who bothered to explain and involve them in their care. The nurse-participants stated:

  “With these patients mostly ‘ba’ (they are) weak, ka gore a ba sa thlole ba le ‘sharp,’ o kile wa bona! Le ge o motsosa…. gore le bolele…. Ke eng a ba bue....” (They are no longer fine, even when you wake them and want to talk to them they do not talk).
Insults and scoldings

Insults and scolding refers to the act of speaking or acting rudely towards others (Oxford Dictionary, 1999:335). Patient-participants mentioned being insulted and scolded by the nurses. This is confirmed in the statement below:

"Ba a omanyaa” (They scold at you).
"Moya o ba o moso” (Your heart/spirit becomes black ‘depressed’).

The patient-participants were frustrated by the way nurses interacted with them. It is believed that the nurses forgot the impact this could have on the patients' response to treatment. The nurses should understand the cycle that hinders an effective response to the disease treatment and do not have to add to the stress by insulting the patients. Nurses created tension between themselves and the patients to the extent that the patients indicated that they might exact revenge when they met the nurses outside the hospital care environment.

"Ba lebala gore re tla hlakana le bona outside’ (they forget we will meet them outside).

Doka (1997: 237) indicated that the HIV/AIDS epidemic increases pressure on the health care systems and has the potential of creating considerable social tension. Although there is tension due to fear of the infection, this does not give nurses latitude to scold patients. It was found that the nurses presented with the same attitude towards the families of people living with HIV/AIDS (Manamela, 2001:52). It seemed that this is a big problem for nurses; therefore there is a need for strategies to assist nurses to show empathy, which is seen as important for the positive outcome of any nursing care. (Olson, 1995: 317). Nurses admitted insulting the patients:

“Ee be ke mo fotlela! moo nke be ke mo ‘advisa’ positively.” (I then scold or insult instead of advising positively)”
Nurses violated patients’ dignity by scolding and insulting them. The violation of a person’s dignity may have an impact on their self-image, have such significant, pervasive, long lasting effects that may represent a pathogenic force that destroys individuality and also the collective well-being as effectively as a virus or bacteria (Mndzebele, 2001: 31).

- **Depersonalisation and lowered self esteem**

Dorland’s Medical Dictionary (2001: 232) defines depersonalisation as an alteration in the perception of self so that the usual sense of one ‘s own reality is temporarily lost and changed. The interaction with the patients caused the patients to lose self-esteem and become depersonalised as indicated by the following statements:

“O dio ba selo fela, a o sa le motho” (You are no more a person anymore you are just a thing).

“O'fila’ ga mpe ge o sa tsewe bjalo ka motho”(You feel bad if you are not considered as a person).

“O a inyatsa” (You look down upon yourself).

“... hee ba o treata e ka a o phele”(They... they treat you like you are not alive or a person).

Patient-participants felt depersonalised and this resulted in low self-esteem.

“Ke lahlela toulo ke re a ke sa le motho”(I give up and this makes me to think low about myself).

The problem of low self-esteem affects them in that they end up looking down upon themselves.

“And at times you still feel bad about yourself.”

“A ba na taba le wena, o bjalo ka parcela Mma”(They are not concerned about you, you are like a parcel or object, mam).
The patients with HIV/AIDS are like any other patients whose physical problems cannot be separated from their mental health being. Nurses are also regarded as the hope on whom the patients can depend while admitted.

"Re be re lebeletse manures gore ba re thuse, go be go se babangwe" (We were looking on nurses to help us, there were no others).

- **Degradation and sadness**
  Degradation is experienced when a person is less valued and less acceptable than others. Degradation causes deep pain and less value about self. This leads to erode self-value (Kirkwood 1993: 46-49). In this study the patient-participants reported experiencing sadness, hurt and degradation. The fact of being diagnosed with HIV/AIDS is traumatising. Developing AIDS and being admitted to a ward was a troubling situation for the patients. It is demonstrated in the following statements on how the patients were saddened:

  "Ba bangwe ba dira gore moya o be o montsho)." (The others cause your spirit to become depressed).

According to Perdices et al (1992) in Walker, McGown, Jantos and Anson (1997: 32) progression of HIV/AIDS disease may trigger depressive responses. If the patients experience degradation the chances for depressive response would be high. HIV/AIDS is stated to be a stressor that can also compromise psychosocial functioning of the family (Amodel, Madrigal, Catala & Arand-Naranjo, 1997:1127). The patients lacked support from the nurses and they may not even get support from the family when discharged. Therefore the depressive responses could result.

- **Frightened and hurting**
  The patients alluded to the fact that nurses scolded and insulted them. The patients found this attitude unacceptable. The nursing standards and guidelines also state that insulting and scolding at patients is not acceptable (Searle, 2000: 88). This is humiliation of the human dignity.
“...they do not treat you well.”

The patients were already afraid of death. This resulted in self-condemnation. It was found that nurses had negative attitudes towards sexual illnesses. Boutcher and Gallop (1996: 182) recommended that nurses had to examine their own attitudes regarding sexuality, acknowledging their prejudices and bias regarding sexuality. In this way they would be able to guard against anything that would jeopardise patient care.

“Ke nagana gore ba tshaba bolwetsi bo ba rena”......se se dira gore ke tshoge , ka ge ba tseba go feta rena......” (I think they are just afraid of the illness and this also makes me frightend and scared, because they know more than me).

“The others will treat you the way ba ratago ba o fotlela” (The others will treat you as they wish and scolded at you).

“Ge ba omanya ke a kgopisega ka tshoga” (When they scolded me, it hurt and frightened me).

On the other hand nurses perceived the patients and their families as treating them badly by presenting with anger and high expectations. The nurses had to strive for good therapeutic relationships that would produce a positive way of handling frustration from patients and families. The statements below clarified nurses’ frustrations:

“The patients do not accept very easily that they are HIV positive”

“A re ke bolwetsi bo ba tshwikiri fela, they don't accept” (They say that it is diabetes).

It showed that nurses would ill-treat the patients if the patients became irritable and denied the HIV/AIDS; the nurses ended up just doing their work without proper nursing care. This is a sign of frustration because the patients do not improve, and nurses just felt obligated to do the work without any passion.
“Fela ka nnete re a tshaba” (It is true we are afraid).

Fear of infection prevailed, Gordon et al (1993: 359) in their study found that fear of infections is the most troublesome issue. Ward problems such as ward overload and staff attitudes are highly influential on how the care is provided and received. According to Squire (1994: 330) ward atmosphere highly affects the way in which the nurses actually interact with the patients, the patients’ behaviour towards the caregiver and care. In this study nurses experienced angry patients and their families, overworking, shortage of staff and dying patients. These aspects had an impact on the care rendered and its outcomes.

“Everybody got scared about this disease”

It is frightening to learn that even health professionals are scared about HIV/AIDS infection, regardless of the guidelines available. Dworkin et al (1991: 241) revealed that HIV/AIDS had activated and developed underlying homophobia among nurses and medical doctors. In this study nurses were troubled by fear of infection and delayed patient recovery.

“Moya wa ga go o ya ko tlase, ga go easy go bona di paciente di tlhokafala mo pele ga matlho a gago (You feel sad it is not easy to see patients dying in front of you).

“Le rena ba refe emunisation yeo ba ba fang yona” (They should also give us immunisation that they give to the patients).

Nurses were so worried that they requested that they should be immunised to care for the patients properly with freedom. The nurses wished there was an immunisation. In their study Dworkin et al (1991: 243) found only eight percent of nurses were willing to work in HIV/AIDS units with the lowest percentage from other health workers, like social workers and doctors. In this study nurses wished that social workers should find a place for the HIV/AIDS patients. This is a sign that HIV/AIDS has an added load of work among nurses.
3.4.1.5 Avoidance-avoidant behaviour interaction with patients infected with HIV/AIDS

Avoidance is defined as a conscious defense mechanism consisting of refusal to encounter situations, activities or objects that will produce anxiety or conflict, while avoidant is defined as moving away from negatively oriented things (Dorland’s Pocket Medical Dictionary, 2001: 97). People who lack support structures normally use this technique.

In this study nurses’ demonstrated difficulty in managing the overflowing wards with patients infected and suffering from HIV/AIDS opportunistic diseases. They applied avoidance-avoidant behaviour. The sub-categories of “avoidance-avoidant behaviour” are tabulated in Table 3.2.5 and discussed below:

TABLE 3.2.5 Sub-categories of avoidance-avoidant interactions with patients infected with HIV/AIDS

<table>
<thead>
<tr>
<th>Sub-categories of avoidance-avoidant interaction with the patients infected with HIV/AIDS</th>
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<td>• Avoidance-avoidance strategies</td>
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<td>• Isolation and loneliness</td>
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Crystal et al (1993:120) state that depression and anxiety is associated with “escape avoidance”. The nurses in this study were anxious and depressed about the environment in which they find themselves in providing care to AIDS patients, such as overflowing wards, slow response to treatment; dying patients and fear of infection. The ward environment lacked supervision and that had a negative impact on patient care. Failure to build relationships during early intervention of nursing care affected the whole process. The environment negatively influenced the interaction between the nurses and the
patients. In their study Severinsson and Hallberg (1996: 395) came to the same conclusions. Patients were very worried about the care they received and felt the pain of being avoided as stated below:

“Ba o fete-Feta” (They just pass you without concern).
“Ke ra gore: Ba o tlogela moo” (I mean they just leave you there).
“Ba re ke a boa but never come back o bone gore a ba ne lethabo” (They will tell you I will come and you see that she is not happy with you and the next thing she does not come).
“Ba o fa dihlare ba tloga” (They will come and give you treatment and go, just like that).
“Ge o ba bitsa ba a kwata e ne a ba buu le wena botse” (If you call them they become angry, and could not talk to you well).

The problems related to nursing care in the study conducted by Niven and Knussen, (1999:177) were found to be associated with lack of knowledge, discomfort and overload. These had placed tremendous stress on nurses, hence they avoided the patients. In this study nurses worked in a similar milieu and also avoided the patients. The stress contributed to negative attitudes, scolding, insulting and aggression. In the study conducted by Kalichman et al (1996: 589) it was found that nurses without support used avoidance–avoidant behaviour. Nurses in this study faced discomfort in caring for HIV/AIDS patients and did present with avoidance–avoidant behaviour. The statements confirm this:

“Ke gore every time ge o ya gae o tsamaya o na le stress, o tsamaya o le tired emotionally” (When you go home you are stressed and emotionally tired).
“I can’t adjust myself, it’s really stressing, you know,”

The nurses end up using avoidance-avoidant coping strategies. In their study Scanlon and Weir (1996: 296) found nurses faced Hobson’s choice, either to continue resorting to maladaptive and potential abusive coping skills to defend themselves against unavoidable anxieties or face the consequences of
becoming unbearably exposed to the dreadful vicissitudes of human suffering. The patients reported experiencing insults and being scolded. The patients needed support while nurses wanted security from the fear of infection. The patients suffered as a result. The nurses used abusive coping skills in order to avoid the HIV/AIDS infected patients who were suffering. This revealed unbearable anxieties as cited by the nurses:

“Ke dira mmerekwana waka ke fetse” (I do my work and finish).

Patients infected with HIV/AIDS are faced with multiple physical symptoms and complex psychological stresses and if they are avoided, this adds to the strain they have (Gibbs, Ellershaw & Williams, 1997: 60). The caregiver also faced multiple care problems and burnout (Bellani et al, 1993: 536, Pila & Chew 1993: 119 and Enzmann et al, 1993: 119). The behaviour has been seen as withdrawal from difficult situations. People, who withdrew from difficult situations instead of taking responsibility, are seen as people who are in a high level of psychological stress (Simon & Ng, 2000: 567). In this study nurses also withdrew from the patients. The nurses distanced themselves from HIV/AIDS patients. Pila and Chew (1993: 119) found that volunteers caring for AIDS patients separated themselves from the patients in order to protect themselves from further suffering.

- **Avoidance-avoidant strategies**

Avoidance is defined as a conscious defense mechanism consisting of the refusal to encounter situations, activities or objects that will produce anxiety or conflict, while avoidant is defined as moving away from negatively oriented things (Dorland’s Pockect Medical Dictionary, 2001: 97). People who lack support structures use this strategy.

The nurse-participants found it difficult to provide care and caring to patients infected with HIV/AIDS - hence avoidance-avoidant strategies were used. According to Kalichman et al (1996: 590) social support could reduce anxiety and depression; this was what HIV/AIDS patients and the nurses needed. The patients reported as follows:
“Ba a o fete-feta” (They just pass you without concern).
“Ba o tlogela moo” (They just leave you there).

The nurses found working with HIV/AIDS patients unbearable. According to the patients, nurses seemed to have no supervisors. It was considered that the supervisor might be assisting with the patient overload and had no chance of supervising the nurses. It was evident that all nurses were just working, and resorted to avoiding contact with the patients by being busy all the time. Severinsson and Hallberg (1996: 395) emphasised the influence the working environment has on the outcome of the services. It was important that the patients’ and nurses’ environment be managed in a way that the supervisor is visible to all groups. The patient–participants wished they knew who the supervisor was.

“Ba re ke a boa ‘but never come.’ ba tloga o sa bua” (They will say I am coming they will never come or if they come when you are still talking they will go and says they will come but they never do).

Nurses found themselves trapped in caring for the patients who were very sick with HIV/AIDS and responded slowly to the treatment. They coped by using avoidance mechanisms.

The nurses’ safety is considered in the nursing profession, thus they are taught to implement measures to prevent the spread of the infection by all means. It is surprising that these measures were not applied in caring for these patients rather than avoiding them. This implies that the nurses wanted to be away from the patients and that when they were with the patients they ended up avoiding them. Furthermore nurses are expected to assist the patients by teaching them how the infection is spread and the prevention thereof. Edwards (2000: 29) and Soul City (2002:10) put an emphasis on informing the partner about the infection and its spread and prevention. If patients are avoided, how will the patients know and understand that they should inform their sex partner about their status and that they should always wear condoms during sexual intercourse to prevent infecting the partner and
to avoid further exposure to the infection if the partner also is infected. The patient will be discharged without any knowledge and the problem of HIV/AIDS infection continues. UNICEF, WHO, UNESCO AND UNFPA, (1993:83) recommend that everyone should help in the worldwide effort to stop HIV from spreading to the new generation. If nurses avoid the patients they refuse them information to prevent the spread of this deadly disease. The nurses presented with unloving and unmerciful attitudes. Severinsson and Hallberg (1996:396) emphasised the clinical model for the psychiatric patients, which is based on caritative caring originated from the concepts of love, mercy and charity as the basis for caring. In this study patients also needed love and mercy but nurses could not offer that and remarked:

“Hey... HIV AIDS patients are stressing”
“Di paciente ga ba se no go bolwela gore ba na le bolwetse bo ba HIV/AIDS ba tenega, ba kwata” (The patients after being told about this disease of HIV/AIDS, they become irritable, and angry).

The nurses unconsciously avoided the patients by use of the following avoidance-avoidant strategies:

- Defensive avoidance: insulting and scolding the patients and presenting anger.
- Escape avoidance: They promised the patients they would come but never went back to them, keeping themselves very busy.
- Security avoidance: Fear of infection and difficulties in coming to terms with the fact that HIV/AIDS has no cure and seeing many young people dying.
- Hobson’s choice: Maladaption and abusive coping, protecting themselves from the pain experienced by the patients and overflowing wards.
- Total avoidance behaviour, absence of touch, communication, physical and social encounter (Crystal et al, 1993:125).
These strategies were followed as the nurses failed to deal with the HIV/AIDS epidemic and shortage of staff. The fact that patients could not respond well to treatment and not being able to face the death rate in the ward, left the nurses frustrated and with lost vision.

“Ke na le go utlwela bohloko, thata gore.. especially ba ba nnyane ke ipotsise gore ka ‘age’ tsa bona” (I feel hurt and sympathetic especially to young patients).

“My Lord, it hurts, it is painful to see people dying in front of you on a daily basis.”

“It is painful to work with these people who are very sick.”

“Every body got scared about this disease.”

“Moya wa gago o ya ko tlase, ga go easy go bona di patiente di hlokafala mo pele ga mahlo a gago” (Your spirit goes low, you feel sad, it is not easy to see patients dying in front of you).

The statements indicated that the nurses were under stress and frustrated, they needed support as well. In their study, Linsk and Mason (2004: 127) realised that HIV/AIDS caregivers experienced complex emotional and behavioural stressors. Nurses in this study were also caregivers and they were also affected. The nurses needed debriefing sessions, support and addition of staff to be able to manage the challenges of HIV/AIDS in the ward. It would be appreciated if the hospital authorities and all other health services leaders could realise the need for more resources, both material and human to support health workers and in the fight against HIV/AIDS.

- **Isolation and loneliness**

Isolation means the process of separating from others (Dorland’s Pocket Medical Dictionary, 2001: 447). Lonely means unhappiness because one is not with other people (Oxford Dictionary, 1999: 373). Patient-participants in this research experienced a sense of isolation and loneliness while in the hospital. They found themselves alone with pains and a lot of uncertainties.
It also happened in the study on the experiences and coping skills of the families of HIV/AIDS patients that the participants who cared for HIV/AIDS patients’ families coped by isolating and withdrawing themselves from society (Manamela, 2001: 40). Nurses isolated themselves from patients as a measure to avoid difficulties and infections. It seemed everybody was afraid of HIV/AIDS. Therefore the nurses jeopardised the patient’s health by neglecting the patients’ social needs and leaving the patients alone. The following statements confirm:

“Manurse ba be ba le kgole, busy ka mereko wa bona” (The nurses were far, busy with their work).

“My Lord, it hurts, it is painful to see people dying in front of you on daily basis”.

“It is painful to work with these people who are very sick”.

“Everybody got scared about this disease.”

Patients lacked social support while in the hospital. They were discharged without psychologically adapting to their illness, this affected their future means of reducing complications. The nurses blamed the working conditions. According to Colebunders (2001: 171), patients admitted in general hospitals were less satisfied with care than those who are admitted to the university hospital. This might be attributed by the fact that university hospitals are better staffed with students assisting in providing quality care. Simoni and Cooperman (2000: 297) and Siminoff et al (1998: 148) also mentioned that spending less time with the patients show patient neglect for their psychological care. It is obvious that nurses experienced internal and external stress, thinking about their own families, while some might be infected and trying to deal with their own status. This researcher’s study on the experiences of the family of people living with HIV/AIDS, (Manamela, 2001: 52) recommended that nurses had to come with ways of managing stress rather than becoming angry at the service user. According to Simoni and Ng (2000: 616) cognitive and behavioural efforts can help in managing the stress. Nurses in this study should have embarked on measures that could assist in
managing stress and helping them, not to use avoidance-avoidant strategies to avoid the patients.

- **Stigmatisation and discrimination**

  Stigma is a socio-cultural stressor – attitude or trait deemed by the social environment to be different and diverse. Discrimination refers to differentiation between individuals or groups not based on actual merit. People living with HIV/AIDS face double jeopardy: fighting for their life and often facing discrimination (Mndzebele, 2001:31)

  Dorland’s Pocket Medical Dictionary (2001:783) defines stigma as the act or process of negatively labelling or characterising people as different. These people were identified as possessed/infected by the HIV/AIDS, a virus that has moral connotations. In this study patient-participants perceived this as being stigmatised by the nurses.

  All participants perceived that they were rejected and stigmatised by nurses. Barraso (1999: 557) found that there was a stigma attached to the HIV/AIDS support network. UNAIDS (2000: 27) support the fact that HIV/AIDS is stigmatised. According to Doka (1997: 187) discrimination, avoidance and denial continue to be the ruling pattern of behaviour among nurses in dealing with HIV/AIDS patients. This caused more frustration and stress on the affected person and led to slow response to clinical treatment. Gaskin and Brow (1997) in Kemppainen (1998: 330) described the stigmatising comments as a sense of being contagious. It was the same in this study. Measures to reduce stigmatisation should be included in the nursing care plans and discharge plan which encourage family involvement, Chibamba (1993: 520) recommended that more involvement of the community in the care of AIDS patients would assist to reduce the stigma.

  During the interview sessions stigmatisation was realised in this community where one of the patients was in his bedroom with all his belongings like packets of Jungle Oats, pots and utensils, which is a sign of stigmatisation and discrimination. It is important to note that this disease also threatens
nurses; that they are part of the community and practise this even in the hospital where they are supposed to practise nursing according to the professional ethics and principles.

The nurses were in a state of helplessness and wanted the patient to be referred somewhere else and believed that others could give better care than themselves. This is a sign of inability to cope. Their statements:

“In township X a centre lady … gore go bane le batho ba ba kgonago go ba hlokomela,” (There should be other people that can take care of HIV/AIDS patients).

The nurses did not seem concerned that they were trained, developed and have skills to provide better care to these patients. They saw the social workers as the professionals that should play a bigger role in the care of the HIV/AIDS patients. It is important to note that this behaviour demonstrated discrimination against the patients by nurses.

The nurses indicated that social workers should look for the place for the patients to be taken to, thus they thought the social worker can do better in assuming their role; such remarks would encourage feelings of isolation and rejection in the patients.

The statement below demonstrated rejection and neglect of patients:

“Masocial worker le bona ba neda go lebelela di patients ko ba ka yang ko teng, mo ba tla dulang sebaka ba fiwe care e enough” (Social workers as well need to look for a place where the patients can go and stay for a time and be given enough care).

“Social work people should do more proper care and necessary referrals for these patients.”

The patient-participants experienced stigmatisation in the community and again in the hospital. Neither of the two environments gave them support they
needed. Heckman et al (1998: 368) state that lack of support in patients with HIV/AIDS was seen as the absence of awareness of mental health issues. In this study the nurses considered physical care and neglected mental health care.

- **The patients neglect and rejection**

Rejection refers to an act where a person or something is not accepted because it is not good enough while neglect means not giving important attention to something regarded as unimportant (Oxford Dictionary, 1999: 52, 417). Patient-participants reported they were not accepted and that the nurses demonstrated a lack of care and gave little attention to their needs. The patients felt not accepted and unimportant to the nursing team.

The nurses were reported to have insulted and scolded the patients. These are other forms of avoidance-avoidant strategies used by the nurses and the patients perceived that as ways of being left to die. Responses to positive nursing action diminish loneliness and bring an increased feeling of acceptance and early recovery while negative nursing care decreases chances of early recovery (Kemppainen et al, 1998:334). The avoidance of the patients results in gross negligence where patients reported swollen arms due to dry drips.

“Di drips di be di nkgobatsa, di goga madi” (The drips were so painful and dry that there was blood running back in to the drip from my veins).

“HIV patients are really stressing ehh…”

”Ke dira mmereko wa ka ka fetsa”(I just do my work and finish).

“As a person you don’t feel free always”

The nurses were also reporting to be afraid of infection. This is evidenced when they wished they could be given immunisation, therefore if the drips withdrew blood backwards the fear of infection would be high.
Positive behaviour nurses were identified and they were seen as the “health care service provider assets.” These nurses demonstrated the care and caring in a holistic manner. They considered the patients as whole with body, soul and spirit as emphasised in Theory for Health Promotion in Nursing (Rand Afrikaans University, 2002: 5).

Asset refers to anything that is useful, and of a very good value, it might be a person or material (Oxford Dictionary, 1999: 34). These nurses were described as great nurses with the wish that all nurses could be like them. These nurses were positive in the care of these patients and are referred as “health service provider assets.” These nurses managed to establish positive nurse-patient relationships that were positive and supportive in nature. The sub-categories of positive behaviour nurses, “health service provider assets,” are tabulated in Table 3.2.6 and discussed below:

TABLE 3.2.6 Sub-categories of positive behaviour nurses, “health service provider assets”

<table>
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<tr>
<th>Positive behaviour nurses, “health service provider assets”</th>
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<td>• Sympathetic and empathetic caring assets</td>
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<tr>
<td>• Moral support assets</td>
</tr>
<tr>
<td>• Hope enriching assets</td>
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<tr>
<td>• Helpful assets</td>
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These nurses demonstrated the positive behaviours which viewed the patients holistically and realised that the patients could not be treated in isolation; they presented positive attitudes when they interrelated, interacted, influenced and were influenced by the environment and others like systems functioning within the system as stated by Antai-Otong (1995: 35). These nurses helped the patients to learn new adaptive patterns of behaviours in
order to live with HIV/AIDS. They guided the patient-participants that they could still considered living life to the fullest (Tseng, 1999:158).

The patient-participants identified some nurses who provided caring rather than just care. They identified the nurses’ positive’ behaviour as indicated below:

“Tshomisano e be e le e botse for nna”(The interaction and care was good, for me).
“The others will treat you well while others were bad.”
“Because ba bangwe ge ba bona gore o a lwala ba o treata pila ba o fa dipilisi, ba o botsa gore o fila byang”(Because others when they see that you are sick they can help you, show you love and give you some pills and ask you how do you feel or what problems do you have)?

According to Johnson (1993: 304) patients need to be helped to accept themselves, and this can be possible if caregivers reach out, like the positive nurses did in this study.

“Ba ba all right ba dira gore o dume e ka all nurses nkabe ba swana le bona” (The positive ones made you to wish that all the nurses can be like them).
“Manurse ba be ba ntswere pila” (I was treated very well by the nurses).
“Byale ka ge ke o boditse be ba ntreata pila, a ba mpha problems” (And as I said they treated me good, they didn’t give me any problem).
“Nurses never treated me bad.”
“The care was not so bad, or so good, what can I say? I can say others were good to me while others were bad.”

The positive behaviour nurses were conscious of bias that might jeopardise caring for HIV/AIDS victims and quality care. These nurses were able to attenuate the impact of personnel attitudes on AIDS patients. They made more effort to be there for the patients, provided caring rather than just care as evidenced below:
“I don’t see these patients different from others.”
“Ngiya bafundisa ngalo kugula” (I teach them about this disease, medication, nokuhla abafanele uku ukuhla” (about food that they are supposed to eat).
“Male patients are very difficult, abafuni ukuphuza emithi yabo” (They do not want to drink their medication). They need encouragement,” you take time to talk to them, feel for them.
“Ufunale uthate isikhathi ukhulume nabo ubazwele” (It is important that you make time to talk to them).
“Ngicabanga ukuthi ama patient lawa a nida ama home visits (I think these patients need home visits) ukuthi kube ne (in order that there should be) continuation ya (of) therapeutic talk.”
“O ba ka mokgwa o mongwe, o ba bogale, o hwetse o utlwa bohloko e be o thome o morapele” (The patients become somehow, very much angry, you sympathise with them and end up begging them).

The positive nurses were professionals who demonstrated the ability to apply the skills they acquired during their education and training. They interacted with patients in a goal-directed way, to assist them to mobilise their environmental resources to facilitate the promotion of their mental health (Poggenpoel, 1994:54).

These were nurses who were not affected by the fear of infection as well as patient and family irritability. They were described as nurses with positive attitudes. They were observed as positive behaviour nurses, “health service provider assets,” because they assisted the patient and complimented care in the following aspects:

- **Sympathetic and empathetic caring assets**: These nurses presented empathetic acceptance of the patients by creating a caring relationship (Andrews, 1991: 267).
• **Moral support assets**: These nurses demonstrated the warmth, and accurate empathy and complied with the standards of care as emphasized by Stuart (2002: 95).

• **Hope enriching assets**: They contributed to the hope that HIV/AIDS is not a death sentence and that a person could still lead a healthy life.

• **Helpful assets**: They were described as helpful and they were never forgotten. A wish that all nurses should behave the same is encouraging to this profession.

According to Scanlon and Weir (1996: 295) nurses need to strive towards a more therapeutic relationship with their patients. These were the nurses who realised the importance of establishing therapeutic relationships with the patients regardless of the HIV/AIDS burden, overload and shortage of staff.

It is clear that these nurses practised the role of advocates for the patients because in cases where other team members were harsh to patients, the nurses were good to them.

These are nurses who fit the findings of Nikkonen (1994: 1186) who were referred to as expert carers. The patients who are HIV/AIDS infected need this type of nurse who put patients’ needs first and advocated for the patients and utter remarks such as:

*"Talking to a person is therapeutic. You need to sit and give more attention to the patient."

These nurses were seen by the patient-participants as able to support them psychologically in times when their mental health or mood seemed to be wavering, not knowing what to do as it was stated. They complied with what Kaplan et al (1994: 541) suggested about the importance of psychotherapy.

Even if there were environmental barriers, patient and family barriers, they persevered and remained to be there for these patients. They understood that
some illnesses that affect the body may indirectly affect and disturb the brain, metabolism of the brain cells and lead to mental health problems as cited by Maddison and Kellehear (1982: 136) and Martin et al (1995: 2).

The nurses managed to guide the patients and give them the support. The patients were relieved from the overwhelming anxiety that might have led to mental illness, (Kreigh & Perko, 1983: 75), therefore these patients saw these nurses as positive behaviour nurses who are like, “health service provider assets.”

3.5 CONCLUSION

The nurses interaction with the patients who were HIV/AIDS infected, portrayed the patient-participants anxieties, frustrations and uncertainties; the nurse-participants’ helplessness in the “busy nurse” syndrome and other strategies used by nurses such as avoidance-avoidant measures, emotional harassment of the patients, limited communication as a way of shielding from the stress and pain of seeing patients died at an early age. There is a dire need for nurses to improve in the care and caring of the patients, to improve communication and the adoption of the position of positive behaviour nurses who should be seen as “health care service provider assets”. The nurse-patient interaction interviews gave a picture on both the responses to HIV/AIDS in general and the care given to the patients who are affected.

Chapter Three concluded the research findings, incorporating literature. The research findings would assist in the development and the description of the model that aimed at assisting the nurses to facilitate constructive interaction, while caring for the patients who are HIV/AIDS infected and be able to assist the patients in the promotion of their mental health.
CHAPTER FOUR

A TENTATIVE MODEL FOR THE FACILITATION OF CONSTRUCTIVE NURSE-PATIENT INTERACTION IN THE PROMOTION OF MENTAL HEALTH IN PATIENTS WHO ARE HIV/AIDS INFECTED.

4.1 INTRODUCTION

In the last Chapter the discussion of the research findings, incorporating the literature control was presented. The aim of this chapter is to develop a model to assist the nurses to facilitate constructive nurse-patient interaction in the promotion of mental health in patients who are HIV/AIDS infected.

4.2 CREATING A CONCEPTUAL MEANING

Conceptual meaning for this study was created from the empirical experience, which is the result of the collected and analysed data. According to Chinn and Kramer (1995: 80) conceptual meaning conveys thoughts, feelings and ideas that reflect human experience more fully than definitions. Concepts in this study were created from the type of interaction between nurses and patients as reflected in the participants’ interaction experience of visual images, movement, sounds, behaviour and interaction; that is, the totality of what is perceived during their interaction. Conceptual meaning assisted to create awareness of the range of possible uses and meaning of the words and creating exactly what the concepts in this study are intended to, to avoid misunderstanding (Chinn & Kramer, 1995: 78). The explored experience of the interaction revealed the feelings, attitudes and values attached to interactions, which were used in creating conceptual meanings.

The process required that many sources of data be considered. Many dimensions of meaning were examined. The concepts were presented for testing and challenge; thus the model is termed tentative because it is open for revision of both criteria and definition. However, the process was deliberate and a disciplined activity (Chinn & Kramer, 1995: 80-81).
4.2.1 Selecting the concepts

Selecting the concepts began by identifying the word that communicates an image that approximates the idea one wished to convey. The concepts selected in this study may still be used as technical or professional terms (special meaning within a discipline) and/or used as common or general language, but the meaning needs to be defined (Chinn & Kramer, 1991: 83). Therefore various definitions were first explored before clarifying their meanings in this study. The purpose was to develop a model to assist the nurses to facilitate constructive nurse-patient interaction that will promote mental health in patients who are HIV/AIDS infected.

4.2.2 Data sources

Data sources provide information about the concepts meanings; provide definitions, word usage and professional or existing theoretical definitions (Chinn & Kramer, 1995: 82). In this study dictionaries were used and it assisted in providing synonyms, and antonyms that convey commonly acceptable word usage and existing theory definition. The meanings conveyed pertained to the discipline, from which the theory was developed (Chinn & Kramer 1995: 82-8).

4.2.2.1 Contrary cases

According to Chinn and Kramer (1991: 86) contrary data are those that are certainly not an instant of concepts and can represent something that most observers will recognise easily what one is not talking about. Analysis of collected data showed that the nurse practised the opposite in caring for the patients with HIV/AIDS. The outcomes of the analysed data presented below gave what was contrary to what was commonly expected by the patients and the nurses’ scope of professional code of practice as regulated by the nurses’ governing body:

- A “busy nurse” syndrome
- Care versus caring for the patients with HIV/AIDS
- Limited communication with patients with HIV/AIDS
- Emotional harassment of patients with HIV/AIDS
• Avoidance-avoidant behaviour with patients with HIV/AIDS

The model concentrated on was contrary to the above in the following dimensions of the main concepts:

• To assist the nurses to make themselves available to assist the HIV/AIDS infected patients in the promotion of their mental health.
• To assist the nurses to use constructive coping strategies while caring for the HIV/AIDS infected patients, to help the patients to promote their mental health.
• To implement open communication with the HIV/AIDS infected patients, to allow them to communicate their fears in order to promote their mental health.
• To provide emotional support to the HIV/AIDS infected patients, as a strategy to promote their mental health.
• To assist the nurses to balance care and caring of the HIV/AIDS infected patients, as a strategy to assist them to promote their mental health.

The model presents the five dimensions as indicated above. (See Figure 4.1)

4.2.2.2 Popular and classical literature

In this model conceptual meanings evolved from the popular and classical literature sources. They were used to provide meanings arising from the personal experiences of others and from literature (Chinn & Kramer, 1995: 86) and the nurse-participants’ and patient-participants’ interview results.

4.2.2.3 Professional literature

Chinn and Kramer (1991: 83) state that professional literature can be used to explore measures from within the context of the profession. The conceptual meanings of this model were also explored from the literature of the nursing profession.
4.2.2.4 People source

The model used hospitalised patients and nurses providing nursing services to provide valuable meanings. According to Chinn and Kramer (1995: 187) peers, workers and other hospital staff can provide valuable meaning.

4.3. DEFINITION OF CONCEPTS

The concepts emerged and were identified from the results of the completed fieldwork and analysed data. The four processes of theory development by Chinn and Kramer (1991:80-106) were utilised: creating conceptual meaning, structuring and centralising theory, generation of theoretical relationships and application. It gave clear conceptualisation of the identified concepts and provided guidelines for the model development.

4.3.1. Identification of the main concepts

The analysis of data showed that the nurses were unable to interact positively with patients who are HIV/AIDS infected in a goal-directed way and failed to facilitate the promotion of mental health in patients with HIV/AIDS. The nurses were affected by the fear of becoming infected from the patients, the health conditions in which HIV/AIDS opportunistic diseases affect our people; the problems of slow recovery, the anger and irritability presented by the patients and their families and overcrowded wards. These factors made their work difficult.

The patients were admitted in a general hospital for treatment of any of the HIV/AIDS opportunistic diseases. These patients needed health intervention programs, of which the nurses were important team members. These patients were engaged in the interaction with the nurses for 24 hours a day while the other team members were only involved periodically. The patients were to be treated holistically as whole persons with body, mind and spirit as emphasised in Theory for Health Promotion in Nursing (Rand Afrikaans University, 2002: 3).
The nurses are the first contact of the patients admitted in an institution and they all become engaged in an interaction, which contributes to the well-being of the patients. The interaction entails communication, both verbal and non-verbal (Okun, 1992: 47) and emotional support, which requires that the psychological well-being of the patient be considered in order for the medication to be effective. Therefore they have to develop intervention plans and call in the other team members. This shows that a nurse has a very important role to play. Most patients who are HIV/AIDS infected suffer physically, socially and mentally. The actual cause of the mental illness is unknown, but there are many contributory factors including HIV/AIDS. The nurses' interaction with these patients is reported to undermine the patients’ mental well-being. The patients were not properly cared for.

These patients described receiving lower quality services especially of mental health care while admitted in the wards. HIV compromised conditions present in very unappealing forms as reported by the nurses engaged with these patients. The nurses had difficulties in providing quality services to these patients. It was found that the nurses presented a busy nurse syndrome, providing care without caring about the patients with HIV/AIDS, used limited communication with patients with HIV/AIDS, unconsciously practised emotional harassment of patients with HIV/AIDS and present with avoidance-avoidant behaviors while interacting with patients with HIV/AIDS. A few presented positive behaviour in caring for patients with HIV/AIDS and this needs to be reinforced.

Therefore the main concept is: **THE FACILITATION OF CONSTRUCTIVE NURSE-PATIENT INTERACTION** with the aim of assisting patients who are HIV/AIDS infected and thus promoting their mental health. The process of the model for the facilitation of constructive nurse patient interaction has five dimensions as follows:

- To assist the nurses to make themselves available to assist the HIV/AIDS infected patients in the promotion of their mental health.
• To assist the nurses to use constructive coping strategies while caring for the HIV/AIDS infected patients and guide them to use their available resources to promote their mental health.
• To implement open communication with the HIV/AIDS infected patients, to allow them to communicate their fears in order to promote their mental health.
• To provide emotional support to the HIV/AIDS infected patients as a strategy to promote their mental health.
• To assist the nurses to balance care and caring of the HIV/AIDS infected patients as a strategy to assist patients to promote their mental health.

Figure 4.1 below depicts the five dimensions.
Figure 4.1 Five Dimensions for the facilitation of constructive nurse-patient interaction
4.3.2 Examination of the concept: Facilitation of constructive nurse patient interaction

The examination involves thorough examination of the words: “Facilitation of constructive nurse-patient interaction” by use of the dictionary, subject use of the words and the way in which the concepts develop.

4.3.2.1 Dictionary definition

4.3.2.1. (a) Examination of the concept: facilitation

The dictionary definitions of the word, facilitation, is presented below:

According to Dorland’s Pocket Medical Dictionary (2001: 321) facilitation means the hastening of or the assistance to a natural process.


According to Grove’ (1971: 813) to facilitate means:
- Make easy or less difficult.
- Free from difficulty.
- To lessen the work.
- To assist.
- To aid.

Fowler (1986: 183) states that facilitation means:
- To make easy.
- To operate.
- To lessen the difficulty of something.

Hawkins (1998: 229) defines facilitation as follows:
- To make something easy.
The Concise Oxford Dictionary (Fowler and Fowler, 1990: 419) defines facilitation as to make something easy, less difficult or more easily achievable.

According to the Mini Oxford School Thesaurus (Spooner, 1994: 270) the following words were identified to draw on their similarities:

- To promote means to rise; aid; assist; move; honor; graduate; pass; encourage and cultivate.
- Assist means help; aid; support; promote; speed and second.
- Operate means to lead; work; perform; function; power and produce
- Guide means to direct; lead; explain; provide; regulate; act; supervise; instruct; conduct; control; pilot and power.
- Perform means to complete; furnish; fulfill; accomplish; present; carry; act; function; give; meet; play; avail; clarify; strengthen; reorganise and intercede.


4.3.2.1. (b) Examination of the concept: constructive

Longman’s Dictionary (1995: 292) defines constructive as
- Intended to be helpful and suggest improvement rather than upset or offend people.
- Having effect or likely to produce results.

The Oxford Dictionary (1999:135) define constructive as:
- Useful and helping with the aim improvement.
- To build or improve.

The Mini Oxford School Dictionary (1996: 234) defines constructive as:
- Being helpful.
4.3.2.1. (c) Examination of the concept: interaction

Longman's Dictionary (1995: 743) define interaction as:
- Doing together.
- Working together.
- Talking to each other.
- Process by which two or more have an effect on one another.

The Oxford Dictionary (1999: 243) defines interaction as:
- Communication in a way that has an influence or effect on others.
- Mix.
- Cooperate.
- Involve.
- Allow direct two-way communication between the two.

The Mini Oxford School Dictionary (1996: 232) defines interaction as:
- Having an effect upon one another.

4.3.2.2. The subject definition of the words facilitation of constructive interaction

Nursing management, nursing education, community health nursing and psychiatric nursing have used the word facilitation as follows:

4.3.2.2. (a) Nursing education

Facilitation
In nursing education the word is used as a noun, meaning the role of the nurse educator as a facilitator. A facilitator is a person with the role of helping the participants learn in an experiential group.

- Coutts and Hardy (1995: 73) define facilitation as talking and listening in an empathetic, warm, non-directive and non-judgmental way.
• Mellish and Brink (1999: 47) define facilitation as coordination of activities and acknowledging each other.
• Quinn (1988:187) defines facilitation as a plan of activities to assist.

**Constructive**
• According to Ellis and Hartley (2000: 176) constructive is something that leads to improvement of performance.
• Booyens (1999: 299) defines constructive as an intervention in an unproductive situation in order to improve.
• I believe that constructive is an intervention that is non-judgmental, empathetic, accepting and allowing full involvement.

**Interaction**
• In Reilly and Obermann (1999: 2143) interaction is defined, as involving one-on-one, develop mutual respect and rapport, caring experience, emphasis on implementation of relationships, relationship encounter or act and is characterised in the provision of support, encouragement, reducing stress and facilitating communication.

**4.3.2.2. (b) Community health nursing**
Stanhope and Lancaster (1988:550) describe the role of the facilitator as the primary role of an internal consultant. This means that the facilitator has knowledge of available resources, is the person who assists nurses; groups; administrators and organisations, involving the needs of the client, staff and the organisation. Therefore, by performing the facilitation function, the consultant guides nurses in problem solving with respect to individual patients and family needs, the health needs of the group of clients or patients or professionals, their concerns and attitudes and also facilitates their interaction with others.
4.3.2.2. (c) Psychiatric health nursing

In psychiatric nursing the concepts start integrating and interacting. The psychiatric nursing uses communication skills to facilitate the promotion of their mental health and that of the mental health consumers.

4.3.2.2. (d) Nursing management

Facilitation

- Facilitation refers to the identification, institution, agency, clear articulation, zero tolerance for any discrimination, effective cross cultural communication, skill and commitment (Andrew & Boyle: 2003 398).

- Facilitation is seen as the nurses aid the individuals to identify, mobilise and develop their own strength (George, 1995: 364).

Constructive

- Constructive can be seen as something that will improve performance. (Booyens, 1999: 239).

Interaction

- Patients enter into and maintain nurse-patient relationship until they are discharged from the hospital (George, 1995: 104).

- Further associated with coordinating, providing, regulating, direct help, integrated nursing, responding to patients request, desire and needs; determining how the patient can be helped; entering into and maintaining nursing relationships with the patients, families and groups (George, 1995: 104).

- Performance of activities that individuals initiate and maintaining structural integrity and human functioning and contributing to human development of people (George, 1995: 101).

- According to Booyens (1999: 239) interaction is a key to group life, be it physical, verbal, non-verbal or emotional.
• Gillies (1989: 208) defines interaction as it denotes the words and behaviour and interpersonal transactions that refer to the exchange of words and/or behaviour between two people.

4.4 REDUCTION PROCESS OF IDENTIFIED CRITERIA

Reduction refers to the process of moving from the general to the specific (Chinn & Kramer, 1991: 196). In this research a list of definitions were sought, where meanings were clustered to form a list of essential criteria. These clusters were used to draw a conclusion for the final definition of the “facilitation of constructive interaction.” Related criteria were included as complimentary to the essential criteria.

4.4.1 Formulating criteria

Formulating criteria assisted in providing guidelines for recognising the empirical experiences that are represented on the model. Similar meanings or instances were differentiated. The criteria also guided in naturally refining the concepts so that the intended meaning was reflected. However the criteria are to be guided by the purpose of the model (Chinn & Kramer, 1995: 90-93). The Table 4.1 below describes the main concepts of the model:
Table 4.1 Describes the criteria for the main concepts the model:

<table>
<thead>
<tr>
<th>Concept</th>
<th>Essential criteria</th>
<th>Related criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitation</td>
<td>Promote</td>
<td>Operate</td>
</tr>
<tr>
<td></td>
<td>Assist</td>
<td>Perform</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Promote</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Guide</td>
</tr>
<tr>
<td>Constructive</td>
<td>Provide</td>
<td>Build</td>
</tr>
<tr>
<td></td>
<td>Be positive</td>
<td>Suggest</td>
</tr>
<tr>
<td></td>
<td>Be helpful</td>
<td>Have effect</td>
</tr>
<tr>
<td>Interaction</td>
<td>Initiate relationship</td>
<td>Coordinate</td>
</tr>
<tr>
<td></td>
<td>Maintain relationship</td>
<td>Involve</td>
</tr>
<tr>
<td></td>
<td>Communicate</td>
<td>Cooperate</td>
</tr>
</tbody>
</table>

4.5 DEFINITION OF MAIN CONCEPT: THE FACILITATION OF CONSTRUCTIVE INTERACTION

Facilitation of constructive nurse-patient interaction refers to the process whereby the nurses initiate and maintain trust relationships with the patients in providing quality health service, through demonstrating effective communication in a positive and helpful way, with the aim of assisting the patients in the promotion of their mental health.

The nurses are expected to initiate and maintain a helpful interaction with the patients, show positive attitudes, encourage two-way communication and motivate the patients with HIV/AIDS to take part in their care, deal effectively with the emotional effects of the opportunistic diseases, and on discharge guide them to mobilise the available resources to promote their mental health.
The main concept is: **THE FACILITATION OF CONSTRUCTIVE NURSE PATIENT INTERACTION**, with the aim of assisting patients who are HIV/AIDS infected to promote their mental health. The process of the model for the facilitation of constructive nurse-patient interaction has five dimensions as follows: (to be discussed fully in Chapter Five).

- To assist the nurses to make themselves available to assist the HIV/AIDS infected patients in the promotion of their mental health.
- To assist the nurses to use constructive coping strategies while caring for the HIV/AIDS infected patients and guide them to use their available resources to promote their mental health.
- To implement open communication with the HIV/AIDS infected patients, to allow them to communicate their fears in order to promote their mental health.
- To provide emotional support to the HIV/AIDS infected patients as a strategy to promote their mental health.
- To assist the nurses to balance care and caring of the HIV/AIDS infected patients as a strategy to assist patients to promote their mental health.

4.6 RESEARCHER’S MENTAL MAP

The mental map sketch was used to assist in identifying and categorising the related concepts and clarifying the process of defining the concepts. The map could further assist in guiding the nurses in the facilitation of the promotion of HIV/AIDS patients’ mental health. The researcher’s mental map is illustrated in Figure 4.2 below:
Figure 4.2 The researcher’s mental map (survey lists: Dickoff et al, 1968:437).
4.7 CONCLUSION

In this chapter a proposed model for facilitation of constructive nurse-patient interaction is presented. Chapter Five deals with the description of the structure and the process of the model. The guidelines for the operationalisation of the model will be discussed as well.
CHAPTER FIVE

DESCRIPTION OF THE MODEL FOR THE FACILITATION OF A
CONSTRUCTIVE NURSE-PATIENT INTERACTION.

5.1. INTRODUCTION

In Chapter Four a tentative model for the facilitation of a constructive nurse patient interaction was described based on the results of the fieldwork done. The aim of this chapter is to describe the model that will assist the nurses to facilitate constructive nurse-patient interaction in the promotion of mental health in admitted patients who are HIV/AIDS infected. A model is defined as a structural design consisting of organised and related concepts or a pictorial representation that shows the simplified details of a concept or concepts considered relevant to measure the specific outcomes of a discipline (Reihl-Sisca, 1989: 7). The structural form of the model will be described. This will include a brief overview, the goals, the purpose, the context, assumptions on which the model is based, definitions, relationship statements, structures and the process of the model. Lastly the guidelines for operationalising the model in practice, as well as its evaluation will be described.

5.2. BRIEF OVERVIEW OF THE MODEL

The model for the facilitation of constructive nurse-patient interaction in the promotion of mental health in admitted patients who are HIV/AIDS infected, is based on the belief that the nurses by virtue of being trained and developed in their profession, can assist the patients to promote their mental health and that the nurses can change their behaviour when interacting with patients. This can be easy and possible only if the nurses implement the professional standards and code of practice effectively (Searle, 2000: 98-99). The nurses are to take the leading role in their interaction with the patients. In order for them to facilitate the interaction the model suggests the five dimensions. The
model for the facilitation of constructive nurse-patient interaction and all its attributes or dimensions will be described as listed below:

- Availability of the nurse
- Caring by the nurse
- Open communication
- Coping by the nurse
- Emotional support

Facilitation of constructive nurse-patient interaction refers to the process whereby the nurses initiate and maintain trusting relationships with the patients in providing quality health service, through demonstrating effective communication in a positive and helpful way, with the aim of assisting the patients in the promotion of their mental health.

5.2.1 The facilitation of a constructive nurse-patient interaction

The nurses are expected to maintain a helpful interaction with the patients. It is important to demonstrate positive attitudes, encourage two-way communication and encourage the patients with HIV/AIDS to take part in their own care. The patients will then be able to deal effectively with the emotional effects of the opportunistic diseases and mobilise the available resources to promote their mental health.

The researcher provided the five dimensions that form the model for facilitation of constructive nurse-patient interaction. The dimensions are interrelated and it does not matter which one the nurses start with; they will end up with the desired outcomes in the promotion of the patients’ mental health. Therefore the model presents the five dimensions that when applied will assist in the promotion of the patients’ mental health. It will be difficult for the nurses to facilitate constructive nurse-patient interaction without being available, providing emotional support, encouraging open communication and using positive coping skills to provide nursing care to the patients with HIV/AIDS infection. The dimensions are outlined below:
5.2.1.1 The availability of the nurse

The availability of the nurse refers to situations where the nurses are required to be available for 24 hours a day. The nurses are to be available in the wards and for the patients in order to provide nursing care in a holistic way. They are to provide the nursing care for the patients as individuals with unique needs. Availability involves being there for the patients, not just being present in the wards, but having relationships, providing care, listening, assisting, encouraging and supporting the patients, families and friends who seek clarity on the patients’ progress (Taylor, 1986: 37 and Fisher, 1984: 389). Being available includes communicating, caring, giving care and providing emotional support.

5.2.1.2 Caring by the nurse

Caring is the most unifying, dominant and central intellectual and practical focus of nursing (Leininger in Green-Edelstein, 1986: 9). Nurses are to facilitate the caring aspect through the nursing process, which includes, assessment, planning, implementation of the nursing procedures, protocols according to the quality standards and code of care (Searle, 2000: 99) and continuous evaluation in an integrated manner (Rand Afrikaans University, 2002: 5). Therefore caring is seen as the process of facilitating patients’ health or wellness by implementation of the nursing process (Ward, 1993:14). The nursing process emphasises holistic care, which is patient-centered. Positive and supportive interaction provides a caring relationship, providing the information, resources and feedback the patients need to cope with the illness, promoting health either mental or physical and assisting the patient to deal with double jeopardy of dealing with ill health and stigma (Wilson, 19 May 2004: 18). These are what the HIV/AIDS patients will need the most. Each patient needs to be viewed and treated holistically, and not to be treated in isolation because a person is a complex organism who constantly interrelates, interacts interdependently, who influences and is influenced by the environment (Antai-Otong, 1995: 37). The nurses are to spearhead support and ensure that the patients are encouraged to realise their potential. Then
the patients through realising their potential can still live authentic and manageable lives. Jordaan and Jordaan (1989:33) state that this realisation can only occur if the nurses provide caring to the patients and are there for them. Caring does not only involve giving medications and performing nursing procedures, but calls for the nurse to be understanding, empathetic, showing concern for the health of the patients. Thus it means looking after people and their needs such as physical, mental, social, functional, economical and their spiritual interest.

5.2.1.3 Open communication
Communication is the foundation for all the interactions and personal relationships (Johnson, 1993:95). To live is to communicate.

Communication is a way of assisting people to reach some understanding of each other, assisting in beginning and ending the relationship. Communication encourages people to learn more about each other, about themselves and how others perceive them. The nurses are to create the opportunities for the patients with HIV/AIDS to communicate their concerns, uncertainties related to the illness and to learn more on how to prevent the spread of HIV and re-infection, delay occurrence of opportunistic illnesses and most importantly, to promote their mental health with the resources within their reach. The nurses are to apply the positive communication skills to facilitate constructive interaction with these patients. The ability to present positive verbal and non-verbal communication skills allows helping relationships and can assist the patients to open up. The nurses are to apply communication skills such as listening skills - using one’s eyes and ears in order to understand better (Kreigh & Perko, 1983: 237), clarifying – attempting to focus on or to understand the basics of the person’s statement. (Okun, 1992: 70), reflecting – to convey to the sender the expressed thoughts, paraphrasing –restating the message in similar words (Uys, Pieterson & Middleton, 1994: 133), checking – sharing how one perceives and responds to another, feedback - make others understand how their behaviour affects people and how people perceive their actions.
5.2.1.4 Emotional support

Emotions involve affective, cognitive and behavioural processes in a complex feedback-loop system. These interconnected components have an effect on a person as a whole. The person who is ill usually has emotional problems such as anxiety and fear and the nurses have to be able to assist them by providing emotional support. Emotional problems are best treated by the ventilation of suppressed feelings and therefore direct expression is encouraged.

The patients who are admitted due to HIV/AIDS compromised conditions need to be motivated to express their emotions so that at the end they can adapt to the reality of the infection and take care of themselves. It is important that the patients and the nurses should collaborate, so that they can also coach each other; thus patients are offered a chance to fully participate in their care. Then both will present a positive attitude and display the abilities that at the end assist the patients to mobilise the resources that will assist them to progress. The patients with HIV/AIDS need to adapt to the situation and learn new patterns of behaviour in order to lead their life happily even if they are infected.

5.2.1.5 Coping by the nurse

Coping refers to a dynamic process that involves the demands and restrictions on a person and the manner in which the person adapts and adjusts to these demands and restrictions as well as the utilisation of the resources available (Wilson & Kniesen 1996:76). The nurses need to fully understand the environment in which they are functioning, the era of HIV/AIDS, then the interaction can be constructive: for example, when a person is exposed to stress the person will move from functional equilibrium to disequilibrium and will present with symptoms of behavioural problems such as anger, arguing and depression. Nurses are like patients here and need to cope, they may need to be engaged in debriefing sessions, role-playing and music therapy (Fletcher & Fountain, 1991:117). In this manner
they will be able to help the patients with HIV/AIDS to communicate their thoughts, feelings and cope better. It will be possible for the nurse to identify the patients who are unable to cope and refer them to specialists who provide psychotherapy (Corsin & Weddin, 1995: 1).

5.3. GOALS AND PURPOSE OF THE MODEL

5.3.1. Goals of the model

- To ensure the application of the theory within the context of the practice with the aim of improving the nursing care of admitted patients who are HIV/AIDS infected.
- To develop sustainable empiric knowledge within the nursing profession that will facilitate constructive nurse-patient interaction.
- To provide knowledge and understanding to ultimately enhance the nursing discipline.
- Lastly to apply the theory into the practice.

5.3.2 Purpose of the model

The purpose of the model is to provide a theoretical framework that will assist the nurses to facilitate constructive nurse-patient interaction while taking care of the HIV/AIDS infected patients and to assist them to use their available resources to promote their mental health. The nurses are trained to create an environment that encourages early recovery and an understanding of the problem of HIV/AIDS will make their work easier. The model will assist the nurse to facilitate constructive nurse-patient interaction.

5.4 THE CONTEXT OF THE MODEL

The context of the model is the general health delivery system where patients are admitted in the hospital wards for treatment and recovery. The patients spend most of their time in the wards and are cared for by nurses who are expected to provide holistic care to all the patients.
5.5 ASSUMPTIONS OF THE MODEL

The assumption from the Theory for Health Promotion in Nursing, Rand Afrikaans University (2002) as well as the researcher’s personal assumption will be used as the basis for the model.

5.5.1 Meta-theoretical assumption

These are the assumptions about nurses and the patients infected with HIV/AIDS:

Chinn and Kramer (1995: 118) define assumptions as those basic given or accepted “truths” that are fundamental to theoretical reality; an assumption may take the form of the factual assertion or may reflect value position. The researcher used a value assumption which implies what is right, well, or ought to be; nurses are to treat the patients as human beings who need to be respected as people.

The nurses are to facilitate constructive nurse-patient interaction with the aim of promoting mental health in patients with HIV/AIDS. They are to ensure courtesy and present helping attitudes while interacting with these patients.

The nurses should understand the importance of facilitating constructive nurse-patient interaction with the aim of promoting mental health in patients with HIV/AIDS. They are to assure and demonstrate courtesy in their interaction with HIV/AIDS infected patients, to provide holistic nursing care to these patients and value patients’ involvement in managing their own care. The following assumptions are made:

- The nurses should learn to avoid presenting with the busy nurse syndrome by making themselves available for these patients.
• The nurses should learn effective coping mechanisms that will assist the patients to understand their condition and to cope with their condition as well.
• The nurses should learn to provide emotional support rather than harassing the patients with HIV/AIDS.
• The nurses can learn to use the opportunity to communicate openly with the patients during their stay in the hospital and be able to guide them in mobilising available resources in the community to promote their mental health when discharged.
• The nurses can learn to replace the avoidance-avoidant attitude by accepting the patients as they are and learn to use positive coping skills that will benefit the patients in the promotion of their mental health.
• Nurses are in the best position to provide the majority of direct patient care services in the hospitals and can contribute to a great extent in the HIV/AIDS prevention and care.

If the above are considered, the patients who are HIV/AIDS infected can understand their illness, clear uncertainties and become able to deal with the reality of infections and the consequences in a positive manner.

5.5.2. Assumptions in relation to the theory of health promotion
The assumptions from the Theory for Health Promotion in Nursing, (Rand Afrikaans University, 2002: 4, 11-12) will be applicable to the model:
The nurses and patients are seen as whole persons, embodying body, mind and spirit. They are to function in an integrated, bio-psychosocial and interactive manner with the environment to achieve the promotion of health including mental health.

The nurses interact holistically with patients; families; co-workers and the community at large. This may take place in the wards, which are seen as the external environment, consisting of physical, social and spiritual dimensions.
The nurses are to provide nursing care, which is an interactive process where the nurses as sensitive therapeutic professionals are to facilitate the promotion of health through mobilisation of the resources. The nurses have to demonstrate positive attitudes in the facilitation of constructive nurse-patient interaction with the aim of assisting in promoting mental health in patients with HIV/AIDS.

5.6 RELATIONSHIP STATEMENTS

The relationship of concepts is established based on the above definition and conceptualisation. The facilitation of constructive interaction needs to take place between the nurses and the admitted patients who are HIV/AIDS infected. Both the nurses and the patients are human beings or persons with body, mind and spirit and function within the environment in an integrated and interactive manner (Rand Afrikaans University, 2002: 4), therefore their interaction will affect each other, the internal and the external environment.

The interaction takes place in the wards where the nurses create a context for their interaction by creating the environment that promotes the patients’ mental health and empowers them to continue to mobilise available resources in the community after they are discharged.

Nurses are expected to establish a trust relationship with these patients and facilitate the constructive interaction throughout the patients stay in the wards. For the nurses to facilitate constructive interaction they need to understand the patients, show love and concern, accept the patients as they are and present with empathetic and sympathetic attitudes (Kreigh & Perko, 1983: 224).

The nurses can only manage to facilitate constructive interaction between the patients with HIV/AIDS if they are able to consider the five dimensions outlined in this model. Thus, they should be able to cope with the consequences of the HIV/AIDS epidemic such as overflowing wards, lack of treatment for HIV/AIDS, delayed response to symptomatic treatment and early death of the
younger generations. The nurses need to understand the importance of being available to these patients so that they can support them emotionally, allow open communication at all times and provide caring rather than just giving them medication and performing the nursing procedures.

5.7 THE STRUCTURAL FORM OF THE MODEL

The structural form of the model for the “facilitation of constructive nurse-patient interaction” is based on the nurses’ ability to facilitate constructive interaction. Constructive interaction needs to take place between the nurses and the patients who are HIV/AIDS positive and admitted in the ward due to opportunistic. For the nurses to facilitate constructive interaction they need to be available for the patients, provide caring rather than just care, encourage open communication, use effective coping mechanisms and provide emotional support to the patients who are HIV/AIDS infected. The nurses are also expected to defuse anger and aggressive behaviour in patients and families and to consider nursing the patients as individuals with unique needs.

Figure 5.1 below depicts the interaction between nurses and patients as part of the model for the facilitation of constructive nurse-patient interaction:
5.7.1 The meaning of the figure

The borders are like a fence ensuring security of the environment around the nurses and the patients. The green colour indicates that the nurses and the patients should work together to create a conducive environment that will enable early recovery and/or new ways to promote health including mental health even if HIV/AIDS has no cure. The square indicates that the nurses have a specific role (using professional skills to provide health services) to play to brighten the life of the patients to make it lively (green), thus, implement the five above-mentioned dimensions in order to promote the mental health of the HIV/AIDS infected patients, involve the patients in their own care, guide and educate them so that they will be able to mobilise their own available resources to promote own mental health when discharged from the hospital.
The orange arrows both sides show the importance of the facilitation of constructive interaction between the nurse and the patients, which should always be facilitated by the nurse and requires communication and shared responsibility in the care provided. The yellow arrow pointing downwards shows that when constructive interaction is facilitated the outcome will be the promotion of patients’ mental health.

Figure 5.2 below depicts the dimensions of the model for the facilitation of constructive nurse-patient interaction:
Figure 5.2 The five dimensions of the model for facilitation of constructive nurse-patient interaction
5.7.2 The interrelationships of the dimensions

Figure 5.2 describes the facilitation of constructive nurse-patient interaction whereby the nurses facilitate constructive interaction as they are interlinked by the five dimensions. The five dimensions promote the facilitation of constructive nurse-patient interaction.

The yellow arrows in the borders show that the dimensions are interlinked and each one supports each other and that if applied constructive interaction will be facilitated and as a result the patients’ mental health will be promoted.

The arrow outside indicates that the dimension need to be implemented all in order to be able to facilitate the constructive interaction for the promotion of mental health in patients who are HIV/AIDS infected.

The yellow arrow pointing downwards shows that when dimensions are applied constructive interaction is facilitated then the outcome will be the promotion of patients’ mental health.

Figure 5.3 below depicts the facilitation of constructive nurse-patient interaction: the meanings of the colours and the model will be discussed in detail:
Figure 5.3 Model for facilitation of constructive nurse-patient interaction
5.7.3 The meanings of the colour of the model

The green colour means that the environment where the nurses interact with the patients needs to be therapeutic. Green means life and peaceful and helping relationships.

Red stands for the nurses to be alert in applying the five dimensions within the professional standards, allowing therapeutic environment for recovery to take place and not to negatively affect the nursing environment, which results in delayed healing, complications and death.

Dark green resembles the need for the patients to be treated as unique, holistically and with dignity so that at the end of the care the patients will be satisfied, with their mental health promoted and discharged home to continue with life, having full ability to manage HIV/AIDS infection after discharge and promote their own mental health.

The orange colour indicates brightness, open communication and mutual understanding and involvement of the patients in the care rendered.

The yellow colour symbolises the interconnections of all the dimensions. Each one works together with the other and that can lead to effective and efficient nursing care. The arrows symbolise interconnection of the five dimensions and that the dimensions work together in one accord. As they are interconnected and applied in the nursing process they result in quality nursing care. The ordinary straight arrow indicates that each one gives effect to the other. Thus, constructive interaction needs that the five dimensions be applied. If they are implemented, constructive interaction will be facilitated and result in the promotion of the patients’ mental health.

The blue colour symbolises the clear sky and this means that if all the dimensions are applied the patient will understand the illness, take care to prevent further infections and spreading the virus, manage oneself and live healthier with HIV/AIDS as there is no cure at the moment and still have
brighter health and future in days after discharge. If the five dimensions are effectively and efficiently applied in giving patient care, the patients’ mental health will be promoted.

5.8 THE DESCRIPTION OF THE MODEL: THE PROCESS

The process for the model for the facilitation of constructive nurse-patient interaction in the promotion of mental health in patients who are HIV/AIDS infected is a continuous process, as long as the patients are admitted, and has positive consequences when the patients are discharged. The patients can be assisted to mobilise their own resources available in the community to promote their mental health.

The nurses are involved in the care of patients in the wards. Being involved means that the people are committed to their professional ethics, standards, codes, rules and regulations (Searle, 2000: 98). These nurses are trained in the basics of providing nursing care to all patients. Without interaction there will be no care. The interaction is the cornerstone in every area of care and requires availability of the nurse, being there for the patients, providing caring rather than just care and being involved in open communication with the patients, using effective coping mechanism because HIV/AIDS is a life threatening disease which is scary. Therefore it is important that the nurses should provide emotional support to the patients who are HIV/AIDS infected while they are admitted in the wards. The nurses need to clarify their values regarding HIV/AIDS so that they do not stigmatise and discriminate against the HIV/AIDS patients admitted in the wards.

The nurses need to promote a therapeutic milieu where the patients will feel welcomed, accepted and understood. These patients are devastated and need to clear up all the uncertainties related to HIV/AIDS infection and its consequences such as opportunistic diseases. The nurses are appointed and allocated to these wards because they were trained in the provision of nursing care. They may only need in-service education and debriefing on the
HIV/AIDS epidemic because the virus affects every individual in one way or another.

The process of the model for facilitation of constructive nurse-patient interaction requires the application of the five dimensions that will help the nurses to facilitate constructive interaction between themselves and the patients in the promotion of mental health in patients who are HIV/AIDS infected. It does not matter which dimension one starts with, but as the dimensions are all interrelated, they will promote the model for facilitation of constructive nurse-patient interaction for the promotion of mental health in patients who are HIV/AIDS infected.

5.9 GUIDELINES FOR THE OPERATIONALISING THE MODEL

In order to interact, a relationship should be established. All interactions form a cycle of sending and receiving messages. This takes place between two or more people. In this model the interaction will be between the nurses and the patients who are HIV/AIDS infected. Their families and friends may also be drawn in because they will interact with the nurses while visiting the patients. This includes perceiving what the other person is saying or doing then responding, either verbally, or nonverbally, and taking action and perceiving what the other person’s response is (Johnson, 1993: 3). The nurses are with the patients for 24 hours a day and they are also the first contact in the wards, therefore they are expected to facilitate the constructive interactions between the patients and themselves.

The guidelines also focus on the model for the facilitation of constructive nurse-patient interaction in the promotion of mental health in patients who are HIV/AIDS infected. The operationalisation of the model requires the application of the five dimensions as follows:
5. 9.1 Facilitation of the constructive nurse-patient interaction

The nurses take the leadership role in the facilitation of constructive nurse-patient interaction to encourage the promotion of mental health in patients who are HIV/AIDS infected. In order for the nurses to achieve this, they should be able to identify the objectives and strategies to be used as well as the proposed activities required in accomplishing their vision. The dimensions below will detail the guidelines:

- To assist the nurses to make themselves available to assist the HIV/AIDS infected patients in the promotion of their mental health.
- To assist the nurses to use constructive coping strategies while caring for the HIV/AIDS infected patients and to guide them to use their available resources to promote their mental health.
- To implement open communication with the HIV/AIDS infected patients to allow them to communicate their fears in order to promote their mental health.
- To provide emotional support to the HIV/AIDS infected patients as a strategy to promote their mental health.
- To assist the nurses to balance care and caring of the HIV/AIDS infected patients as a strategy to assist patients to promote their mental health.

5.9.1.1 Dimension one: the availability of the nurse

Objective:

- To assist the nurses to make themselves available to assist the HIV/AIDS infected patients in the promotion of their mental health.

Principles:

- **Self-definition** - the nurses need to define why they are in the ward, assess their own needs, understand their self-image and know themselves (Kaplan et al, 1994: 25,6 and Johnson 1993:30), then they will be able to understand and define others' needs. In this case they will understand patients' health needs as individuals.
• **Self-assessment** - nurses should be able to assess their feeling, needs and values, this will help them to understand themselves and then the patients.

• **Self-exploration** – the nurses need to be true to themselves, explore their own feelings and needs; frustrations and concerns related to HIV/AIDS then they will be able to manage the patients (Okun, 1992:214).

• **Self-understanding** - it is important for the nurses to know what is best for them, their needs, their values and belief systems and then it will be easy to understand the patients.

• **Self-realisation** - the nurses to be assisted to realise their fears, ability and need to develop and avoid negative aspects that influence their work negatively and retard their ability and skills to execute their duties.

• **Misconceptions** - they must deal with misconceptions and myths about sexuality and HIV effectively.

**Activities:**

• Establish trust relationships.

• If there is trust relationships, the nurses will always try to be there for the patients, without trust the nurse will always avoid the patients.

• Provide therapeutic touch.

• Be there for the patients always even if they have nothing to say, but just inform the patients they are there for them.

• Guide the patients on self-care such as on a balanced diet as the Minister of Health said: There is no cure for AIDS but one can stay healthy and strong by eating the right food, and the Minister of Health, Dr Tshabalalala Msimang commented further that HIV/AIDS is not a death penalty; if one complies with the right dietary plan one can remain healthy (Minister of Health Dr Tshabalala Msimang in Sowetan, 19.May 2004: 18).
• Implement the Departmental policy on the management of occupational exposure (National Department of Health, 2000: 5) after they have identified their fear of infection and spread.

5.9.1.2 Dimension two: caring by the nurse

Objectives:
• To assist the nurses to balance care and caring of the HIV/AIDS infected patients as a strategy to assist them to promote their mental health.
• To assist the nurses to provide nursing care in totality and holistically. Holistic care is central to caring for people living with HIV/AIDS (Gauteng Health Department, 2001:6).

Principles:
• Warmth, immediacy, empathy, respect, genuineness, love, sympathy, unconditional acceptance and understanding.

Activities:
• Provide a confidential environment.
• Share information on HIV/AIDS with the patients.
• Emphasises the role of the person living with HIV/AIDS in the fight against AIDS (North West Provincial Council on AIDS, October 2000:15).
• Protect the patients from discrimination.
• Provide nursing activities according to the specific and general needs of the patients as a result of the individual assessment, planning, monitoring and evaluation of care rendered.
• Involve team members according to the relevancy of the need.
• Involve the family and advise on referrals in the community.
• Provide psychological support as the need arises.
• Manage time effectively.
• Engage in HIV/AIDS in-service education and seminars, workshops and meetings.
• Caring is also teaching the patients on how to cope with everyday life.
• Use of occupational health nurses’ advice related to occupational safety (Otto & Botes 2001: 12).

• Provide nursing care according to the code of the profession; develop and implement ethical standards to guide nurses to provide quality-nursing care even to people with HIV/AIDS infection (Searle, 2000: 98-99).

5.9.1.3. Dimension three: coping by the nurse

Objective:
• To assist the nurses to use constructive coping strategies while caring for the HIV/AIDS infected patients and to guide them to use their available resources to promote their mental health.

Principles:
• Value clarification, self-confidence; determine self-esteem status and self-actualisation.

Activities:
• Manage own frustrations and anxiety effectively.
• Manage working life properly, thus time they spend at work.
• Engage in debriefing activities.
• Rest when necessary.
• The nurses to take seriously their need for professional support as they strive towards a more therapeutic relationship with their patients (Scanlon & Weir 1997: 295).
• Become engaged and participate on social support networks, as this appears to protect people from the harmful effects of stress.
• Learn more about the HIV/AIDS pandemic and its management.

Manage after work relaxation and actively become involved in the established employee assistance programs of the Department and institution.
5.9.1.4. Dimension four: open communication:

Objective:
- To implement open communication with the HIV/AIDS infected patients to allow them to communicate their fears in order to promote their mental health.

Principles:
- Trust, commitment, honesty, listening, non-judgment, approachable respect and confidentiality.

Activities:
- Development and maintenance of good verbal and non-verbal communication.
- Initiate and encourage communication.
- Listen and allow patients to ask questions then give honest answers.
- Give feedback where needed and as promised.
- Respond to calls with immediacy.
- Be there for the patients if there is an unplanned need.
- Involve others that can be of great help.
- Communicate and educate on healthy sexual lifestyles.

5.9.1.5 Dimension five: emotional support

Objective:
- To provide emotional support to the HIV/AIDS infected patients as a strategy to promote their mental health.

Principles:
- Love, compassionate, concern, understanding, unconditional acceptance, empathy and sympathy.

Activities:
- Allow the patient to cry and verbalise the frustrations and anger.
- Listen and provide therapeutic touch.
- Encourage crying if it happens.
• Offer a shoulder to cry on.
• Let the patient take responsibility and make own decisions.
• Open up for any guidance or advice.
• Provide support for any decision taken except when it may cause a threat to life.
• Make the patients aware of the danger of continuous exposure to the virus.
• Explore the patient’s feelings and assist the patients in the healing process.
• Refer those that are not coping for specialised mental care (Maland, Meadows & Catalan, 2001:413).

5. 10 EVALUATION OF THE MODEL

The panel of experts evaluated the model and feedback was provided. The experts hold Doctoral Degrees in Nursing Science and extensive experience in research and theory generation. Seminars and group discussion provided inputs on the model. Consultation and discussions around the interaction and dimensions assisted in refining the model. The evaluation process covered the following steps:

• How clear is this theory/model?
• How simple is this model?
• How general is this model?
• How accessible is this theory?
• How important is this theory (Chinn & Kramer 1995:127-137).

It is of the utmost importance to understand that the theory needs to have an impact on changing the nursing practice for the benefit of the profession and the people served. Thus it should offer new concepts with which to work on to facilitate constructive nurse-patient interaction in the promotion of mental health in patients who are HIV/AIDS infected.
5.10.1 How clear is this theory?

5.10.1.1 Clarity
Clarity refers to how well the model can be understood and how consistently the concepts are defined (Chinn and Kramer, 1995:127). In this study the main concepts of the model were defined and conceptualised. The sub-concepts or dimensions were also identified; definitions are clear and used consistently. The definitions were derived from general dictionaries, professional meaning in nursing, psychiatric nursing, community health and nursing education and management. All other factors that could obscure the clarity were excluded in the definition and conceptualisation of the concepts. The meaning was defined and used consistently.

5.10.1.2 Consistency
Consistency means that the concepts of the theory are used in ways that are consistent with their definition (Chinn and Kramer, 1995:129). In this study the key words are explicitly defined. The assumptions were used consistently and this enabled consistency. This was deliberate to avoid confusion. The purpose, goals, definition of concepts and relationships remained consistent throughout the process.

5.10.1.3 Structural clarity
Chinn and Kramer (1995:130) describe structural clarity as referring to how understandable the concepts connections, reasoning and relationships within the theory were clarified and defined. The concepts are interconnected and readily recognised and organised into a coherent whole. The major concepts and the dimension fit well within the model.

5.10.1.4 Structural consistency:
The model is formed around one predominantly structural form. Thus: “Facilitation of constructive interaction,” used as a central map. This provides a high level of structural consistency.
5.10.2 How simple is this model?

5.10.2.1 Simplicity
Simplicity requires that the number of the elements in each category, particularly the concepts and their relationship be minimal (Chinn & Kramer, 1995: 131). The theory is simple because the numbers of the elements in the model and within each concept are minimal; in total they are less than ten. Complexity was avoided and unimportant concepts were not included.

5.10.3 How general is this model?

5.10. 3.1 Generality
According to Tiffany and Lutjen (1998: 15) generality makes the theory useful and allows the applications of the theory into any appropriate situation. It means that the theory can be applied to broad arrays of the nursing practice (Chinn & Kramer, 1995:129), within non- and admission situations. The scope of concepts and purpose within the theory is general to nursing practice. To some extent other health professionals can also apply the model. The model addresses the broad aspects of individuals, society, health and environment. Therefore the theory is of a high degree of generality and useful for organising ideas about universal health care behaviours.

5.10.4 How accessible is this theory?

5.10.4.1 Empirical applicability
Empirical applicability addresses the extent to which empiric indicators can be identified within the concepts of theory and how attainable the projected outcome can be linked to the empiric indicators available in the practice through generating and testing the relationship and deliberately applying the theory, for an example, nurses make themselves available. The concepts were defined and this ensured that they were clear and enabled the theory to be more empirically précise.
5.10.4.2 Predictability
The predictability value has been inherent and can ensure that the theory can be easily influencing in knowing obstacles to constructive interaction. And this can be guarded against.

5.10.5 How important is this theory?
This theory concurs with what Walker and Avant (1995:144) state, that useful theory is helpful in providing understanding, insight, and explains better and helps in making predictions. The theory is closely tied to practical value, and it creates the situation of reality in nursing practice. Does the theory answer the question, does the theory create a reality that is important to nursing? This theory contains the concepts, definitions, purposes and assumptions that are grounded in practice (Chin & Kramer, 1995:134) and is also based on holism, which is emphasised in the execution of the nursing duties. Therefore this theory is of high importance to nursing services

5.10.5.1 Consequences
This theory is feasible to be used to operationalise the model in the nursing services. The evaluation revealed that the theory could guide research and nursing practice.

5.10.5.2 Meaning and logic
The theory used meta-theoretical and theoretical definition from the Theory of Health Promotion in Nursing, Department of Nursing Science (Rand Afrikaans University, 2002: 4-9). The constructs and the philosophy of the theory were used as a guide by the researcher and therefore the meaning and logic of the model for the “facilitation of constructive nurse-patient interaction” is considered valid in the theory of health promotion in nursing.

5.10.5.3 Operational adequacy
The model is easy to operationalise. The objectives are defined and the principles are identified and activities described. The guidelines for the
operationalisation of the model are also proposed. It is envisaged that the model is of operational adequacy.

5.10.5.4 Contribution to understanding
The theory contributed to the increase of understanding of the “facilitation of constructive interaction.” Almost all users of health services, not only the patients who are HIV/AIDS infected will benefit from applying the theory. Obstacles to facilitation of constructive nurse-patient interaction are identified and can be prevented.

5.11 CONCLUSION

This chapter dealt with the proposed model. The process of the model for the “facilitation of constructive nurse-patient interaction” in the promotion of mental health in patients who are HIV/AIDS infected is completed. The model is described in full and evaluated. The model was presented to the panel of experts and was refined and accepted. In the next chapter the researcher will examine, whether the objectives are met, provide a summary and conclusions as well as limitations and recommendations.
CHAPTER SIX

SUMMARY, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS FOR THE OPERATIONALISATION OF THE MODEL.

6.1 INTRODUCTION

The previous Chapter dealt with the structure, and the process of the model and the guidelines to operationalise the model for the facilitation of the nurse-patient interaction. This Chapter examines whether the objectives were met, describes the summary and conclusions, limitations and recommendations for the operationalisation of the model.

6.2 SUMMARY AND CONCLUSIONS

The thesis dealt with the nurses interaction with the patients who are HIV/AIDS infected with the purpose of the development of the model that will assist the nurses to assist the HIV/AIDS infected patients to mobilise the available resources in order to promote their mental health. A theory generation research design was applied during the conduct of this study. The research process was carried out in four steps of theory generation.

The first step considered concept analysis and covers the areas of identification of central concepts, and concepts definition. This was divided into numerous sub-categories. During this process a qualitative research strategy, which is explorative, descriptive and contextual following a phenomenological approach was applied to reveal the interaction of nurses with the patients who are HIV/AIDS infected. A purposive sample of seven nurses working in the general wards and eight patient-participants who are admitted in the wards and are HIV/AIDS infected were sampled from the total population of the two groups. Data were collected by the field worker and the main researcher and revealed that the nurse-participants experienced difficulties in caring for the HIV/AIDS infected patients and failed to facilitate
the constructive nurse-patient interaction. The patient-participants also revealed that the nurses were not coping with their illness but resorted to a "busy nurse syndrome" all the time with limited communication, poor coping and emotionally harassing the patients while unable to provide caring. It was clear that the nurses need assistance to provide holistic care to the patients who are HIV/AIDS infected.

Step two dealt with the model development and the main concepts of the model were identified as the facilitation of constructive nurse-patient interaction. The concepts were identified, defined and analysed fully by looking into dictionary definitions and subject usage; the attributes identified were synthesised to form a definition.

Step three dealt with the description of the model and covers the structure, definition of assumptions and the relationship statements.

Step four addressed the implementation of the guidelines for the operationalisation of the model for the facilitation of constructive nurse-patient interaction in the promotion of mental health in patients who are HIV/AIDS infected. This covers the main concepts of:

- Availability of the nurse
- Caring by the nurse
- Open communication
- Coping by the nurse
- Emotional support

The study contributed to nursing practice and knowledge, therefore the results should be considered when nursing the patient infected with HIV/AIDS in all sectors of the provision of health care.
6.3 LIMITATIONS

The research was conducted in the general wards of a general hospital. The general nurses do study general nursing care including the psychological care of the individual. However they study this in a more superficial way than psychiatric nurses. All nurses are to consider the psychological care of any patient who is in their care. However in every section there was at least one psychiatrically trained nurse.

There were some limitations that need to be highlighted as follows:

- Shortage of nursing staff lengthened the process of data collection.
- Very sick patients were unable to take part in the interview while still admitted.
- HIV/AIDS is still seen as stigma and some patients refused to take part.
- Nurses often needed emotional support immediately and that was only offered later and telephonically which cannot be guaranteed.
- Not all the family members had the privilege of being supported during the interview sessions, as there were no prior plans for that.

6.4 RECOMMENDATIONS

The recommendations are made in terms of the application of the model. The model can be operationalised in the general wards, psychiatric wards, and community health settings including the Non-Governmental Organisations and Community Based Organisations as well as Home Care. The research findings have benefit to the nursing management and the health authority leaders as well in that they are the planners for the nursing services, therefore they can also improve their systems in the resource allocation and this will assist them to manage the AIDS era effectively.

All other categories of health care services can apply the model in their sections.
6. 4. 1 Operationalisation in the general nursing profession

The nursing profession is a nurturing profession and deals with human beings. In order to operationalise the model effectively the socio-economic dynamics of the health environment and the health thrust should be taken into consideration. Therefore continuous monitoring and evaluation of nursing care is very important. This should be followed by feedback and measures to address any loop-holes in the nursing profession. The nurses in the general ward provide nursing care to people with different health problems and the admitted people are in most cases very ill. With HIV/AIDS epidemic even all the very ill that are not diagnosed but may yet be infected and the nurses need to be prepared to provide care to all the patients as if they are HIV/AIDS infected.

In operationalising this model the nurses will have to facilitate constructive nurse-patient interaction at all times. The concept of constructive interaction is applicable throughout the nursing discipline. The nurses need to be available for the patient, being there and providing a holistic nursing care. The AIDS era is a devastating era and the nurses can apply the strategies for coping as described in this model and will be able to manage themselves in the nursing environment. The application of this model will guide the nurses to value the importance of open communication in the nursing practice especially when providing care to the people affected by the stigmatised diseases such as HIV/AIDS. The emotional support of the people affected by HIV/AIDS requires that the nurses be able to clarify their values related to sexuality, and then they will be able to support and assist the patients effectively. If the model is applied in general nursing practice the nurses will be able to provide caring and care to the patients affected by HIV/AIDS.
6. 4. 2. Operationalisation of the model in the psychiatric nursing services

Psychiatric nursing considers the mental health as the cornerstone of its practice. The practice requires that in every encounter with the patient the aim should be to promote mental health. The application of this model in psychiatric nursing practice will benefit both the nurses and the patients. The nurses should note that any physical illness may contribute to mental health problems and HIV/AIDS is one of those illnesses. Applying the model will assist the nurses to ensure that they are always available for the patients, being there is very important in psychiatric nursing. Applying the proposed coping strategies, implementing open communication and providing emotional support to the anxious and worried patient will all contribute to the care and caring in a holistic way; the psychiatric nursing student will also be developed and realise the importance of facilitating constructive interaction in the psychiatric nursing field.

6. 4. 3 Operationalisation of the model in community health nursing services

Community health nurses doing home visits will be able to apply the model so that their nursing care will be effective and when they leave the patient the patient will be able to mobilise their available resources to promote their mental health. The nurse will be available as scheduled, use coping strategies, support the patient emotionally while ensuring open communication and all this will contribute to holistic caring.

6. 4. 4 Operationalisation of the model in general nursing research

The rational statements formulated in this model can be subjected to an ongoing research in order to determine whether they are valid or not. They may be formulated into testable hypothesis such as: “there is high level of satisfaction among patients infected with HIV/AIDS cared for by the nurses who facilitate constructive interaction.” The proposed guidelines can also be
researched in a descriptive case study. Qualitative research methods can still be used to evaluate the application of the model in the clinical field and journals can be kept as a reflective strategy. The nurses can always evaluate themselves based on the results of this study.

6.4.5 Operationalisation of the model in the nursing management

The management can apply the model in developing plans and strategies that will help the nurses to cope with the HIV/AIDS era and the phase of dying. The management can also consider the need for more resources and development in the treatment of patients infected with HIV/AIDS to ensure that the nurses will always be available to assist the patients. At the end the patient will be receiving holistic nursing care.

6.4.6 Operationalisation of the model in the non-governmental organisations, community based organisations and other professions

Non-governmental organisations, community based organisations and other professions can operationalise the model and their organisation can benefit from the model. All sectors that are affected by HIV/AIDS can apply the model and provide quality care to the patients infected with HIV/AIDS.

6.5 CONCLUSION

In this chapter it was established whether the research purpose and objectives were met. The conclusions and limitations were identified and recommendations for the operationalisation of the model in general, psychiatric, community health nursing and the related researches were outlined, including the benefit for the nursing management and the health sector authorities; non-governmental organisations; community based organisations; home care and any other health professionals providing care to HIV/AIDS infected patients.
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8. ANNEXURES

ANNEXURE A

An interview guide on exploration and description of nurses-patients interaction.

Nurse-patients interaction

Tell me how it is to interact with nurses in this ward (directed to the patients)

or

Tell me how it is to interact with patients who are HIV/AIDS positive (directed to the nurses)
Request for consent to conduct research

I Makgabo Johanna Manamela, am a D. Cur. Student of Rand Afrikaans University, Johannesburg. I am engaged in a research project entitled “Nurses interaction with the patients who are HIV/AIDS infected,” under the supervision of professor Marie Poggenpoel and Dr Madré’ Oberholster of the Department of Nursing Science, and professor Chris Myburg of the Department of Educational Science of the Rand Afrikaans University.

The aim of the research is to explore and describe the interaction of nurses with the patients who are HIV/AIDS positive in the institution. Your experiences in the interaction will assist on what is perceived to be helpful during the interaction. The findings will be implemented in order to improve the nursing practice and raise awareness on patient ‘side.

You will be interviewed and verbally present your interaction. The process will be audio taped for verification of finding by the independent experts and will be kept confidential. You will give your informed consent to these proceedings and reserve the right to cancel it at any stage of these proceedings. You are under no obligation to participate in this project.

I undertake to guard your anonymity by omitting the use of names and places. Confidentiality will be assured by destroying the taped recorded material on completion of analysis thereof.

Research results will be made available for your perusal if you need. I avail my cell phone number as 0824460313 if you wish to contact me.

Signed at-------------------------------------this -------------------day of--------
----------2003
PARTICIPANTS

MJ MANAMELA. M.CUR. RN
D.CUR. (PSYCHIATRIC NURSING) STUDENT RESEARCHER

MARIE POGGENPOEL. RN. PH. D PROFESSOR: NURSING SCIENCE (PROMOTER)

CHRIS MYBURGH. HED, BSC, (HONS, M COM D. ED. PROFESSOR: EDUCATIONAL SCIENCES. (CO-PROMOTER)

DR MADRÉ OBERHOLSTER. D. CUR, RN. NURSING SCIENCE: (CO-PROMOTER)
ANNEXURE C

A REQUEST TO CONDUCT THE STUDY IN YOUR INSTITUTION

269 De Boulavard Street
605a Overton Flats
SILVERTON
2003/06/10

The CEO
Mamelodi Hospital
Private Bag x0023
P.O Rethabile
Pretoria
0001

Dear Sir /Madam,

A REQUEST FOR PERMISSION TO CONDUCT A RESEARCH

I am hereby request to be given a permission to conduct a research study in your hospital.

I am Makgabo Johanna Manamela, a doctoral (D Cur) student with the Rand Afrikaans University. My promoters are Professors M Poggenpoel and CPH Myburgh AND Dr M Oberholster. It is one of the requirements that I conduct a research in order to complete my studies.

My research topic is as follows: Nurses’ interaction with the patients who are HIV/AIDS infected.

The objectives of the study are as follows:

- To explore and describe the nurses’ interaction with the admitted patients who are HIV/AIDS infected.
To develop and describe a model that will assist the nurses to facilitate the promotion of mental health in patients who are HIV/AIDS infected.

The Rand Afrikaans University Ethical committee will approve the study, and ensure that the ethical principles are complied with and will also be subjected to your ethical committee’s examination. Consent to participate will be obtained in writing from the nurses taking care of the admitted patients who are HIV/AIDS infected and the same patients. The participants will be informed about the purpose of the study. They will be informed that participation is voluntary and that they can withdraw from the study without any penalties. They will be informed that the study carries no physical risk and that privacy.

ETHICAL CONSIDERATIONS

Ethics refers to a science or study of morals and morality, of which is the standard of behavior followed by individuals or groups. As this research involves human beings I will ensure that participants’ rights are protected. Therefore the following principles will be adhered to:

**Respect for human dignity**
This indicates that the participants have the right to self-determination and the freedom to participate or not to participate in the research. The researcher will explain to the participants that they have the right to respect for human dignity, whatever information they will give will not be used to undermine their dignity. The participants have the right to withdraw without penalties during the process if they can realise that the cost and benefit associated are not worth it.

**The Right To Privacy**
The right to privacy involves issues around the private information given by the participants; this may include the feelings, beliefs, attitude, behavior and opinions. Research information will be destroyed immediately after the
research results is published, the right to privacy will be adhered to, there will be no mention of names.

**The right to anonymity and confidentiality**
Anonymity requires that the participants’ identity not be linked to their responses. Confidentiality requires that information shared by participants should not be linked to the participants and real names will not be used. The researcher will ensure that no unauthorised person will gain access to the data. Data will be kept safe and destroyed on completion of the study.

**Informed consent**
Informed consent refers to the participants’ documented agreement to participate in the study. The participants are given the opportunity to be explained and clarified about what the study is all about and voluntarily choose to take part. The researcher will explain about the background of the study, the purposes and the objectives of the study, research designs and method to be followed, ethical considerations and reporting systems. The participants will be allowed to ask questions for clarity. The researchers will ensure that the participants understand all the details of the study and request them to sign an informed consent documents. The right of the participants will be highly protected as indicated above.

Hoping that my request will be considered.

Yours faithfully

Makgabo Johanna Manamela

STUDENT’S SIGNATURE________________________________
PROMOTER’S SIGNATURE______________________________
CO-PROMOTER’S SIGNATURE__________________________
ANNEXURE D

A SOLEMN PROMISE

• To keep data confidentially, under lock and key.
• To ensure that no one other than the already mentioned supervisors will get access to data.
• To destroy the audiotapes as soon as the study is complete.
• To leave my contact address and telephone number in case you want to contact me in matters related to the study.
• To provide a summary of research findings should you wish so.

STUDENT’S SIGNATURE

_________________________________________________

SUPERVISOR’S SIGNATURE

_________________________________________________
ANNEXURE (E)

UNIVERSITY ETHICAL CLEARANCE
ANNEXURE (F)

HOSPITAL /SETTING'S AUTHORITY'S APPROVAL
ANNEXURE (G)

REQUEST TO IDENTIFY PARTICIPANTS THROUGH NGO
ANNEXURE (H)

APPROVAL FROM THE NGO
ANNEXURE (I)

ENGLISH EDITING CERTIFICATE
Annexure (J)

Nurse-participant interview

Interview number One
I: Good-day P.
P: Good day I.
I: I’m here for the purpose of the interview as arranged with the research student. The purpose of this study is to look at how you, as a nurse interact with HIV/AIDS patients. The interview will last for 45-60 minutes. Whatever, we discuss in this interview will be confidential. Do you agree to participate in this research interview?
P: Yes, kulungile, but uwa bona nawe ngu busy la e wardini. (Yes, it's okay but you can see for yourself it is busy in the ward.)
I: Mmm...ngiya bona (Yes, I can see). Singacala nge interview (Can we start with the interview.)
P: Yebo. (Yes).
I: Tell me how is it for you to interact with patients who have HIV/AIDS.
P: Ngubuhlungu (it is painful) ngoba (because) we are at a stage were it affect most young people who are dying. Nawe uya saba ngoba una abantwana aba lingana nama patients wakho. (You’re scared because you have children of the same age as your patients.) Uya zibuza ukuthi (you ask yourself) what if it was my child, bengizo kwenza kanjani (what will I have done?) Uyazi, lendaba ye HIV/AIDS inzima ugu sebenza ngayo (You know this issue about HIV/AIDS it is heavy/difficult to work with). Uya zibuza ukuthi, wena as a nurse, are you safe? (You ask yourself, as nurse that, are you safe?) There are preventative measures laid down for us as a nurse, but then there is still that “thing” that hangs behind the back of your head, that you can become infected at any time. Ma ucala ugula, ukohlela (When you start getting sick, coughing) you start wondering, did I get it from the hospital. You have to wear protection gloves, but a person, a nurse you don’t feel free always to use these things because la bantu bafana nawe, nami (these people are just like you and me). Psychologically, to work with these patients uya kathala (you get tired). If HIV/AIDS ivakashela edlini yakho, uza yenzani mara (if HIV/AIDS
visits your home what will you do, what is it that you can do?) I blame the
government, if they started early education bafundisa abantu (teaching
people), nge (about) HIV/AIDS like other diseases such as diabetes and
hypertension, testing of HIV/AIDS should not have been allowed. Uma
umuntu uyagula, (if a person is sick) you should be treated as having any
diseases. It should have not be kept a secret, closed because now ngenye i
nto ehlile emama thele (stigma). Luka kugula kwe HIV/AIDS (this sickness of
HIV/AIDS) has become the worst enemy of South Africa. Modimo wa ka (My
Lord), it hurts, it is painful to see people dying in front of you on daily basis. E
khaya ngiyashumayela evangeli kubantwana bami ngaluku gula (At home I
preach a sermon to my kids about this disease) I see my patients, I relate the
situation outside. Kuswiza ubuhluungu uku sebenza na la bantu aba gulayo
ka khulu (it is painful to work with these people who are very sick.
I: How do you interact with them?
P: Ngiba thatha nje ngabanye ama patients. (I treat them as equal to other
patients.)
I: What do you mean about equal?
P: I don’t see these patients different from others. Ngiya bafundisa ngalo
kugula (I teach them about this disease), medication, nokuhla abafanele uku
ukuhla (about food that they are supposed to eat). Male patients are very
difficult, abafuni ukuphuza emithi yabo (they do not want to drink their
medication). They need encouragement, ufunale uthate isikhathi ukhulume
nabo ubazwele (it is important that you take time to talk to them, feel for
them). It is important as a nurse not to lose hope. After being discharged most
of these patients lose hope and become very ill. Ngicabanga ukuthi ama
patient lawa a nida ama home visits (I think these patients need home visits)
ukuthi kube ne (in order that the should be) continuation ye (of) therapeutic
talk.
I: Mmm… therapeutic talk. What will therapeutic talk mean to you?
P: Ukukhuluma nomuntu (Talking to a person) is therapeutic. You need to sit
and give more attention to the patient. La bantu ba ya gula phela and ba ba
confused (these people are sick and become very confused). Therapeutic
means to motivate, encourage the patients. Kufanele ukuthi uma uyi nurse
unikeze ama patients ama example we themba, impilo nokufa (it is right that
when you are a nurse you should give patients examples of hope, life and
death). Give them hope that they are not alone in these situations, sonke
siyofa ngelinye ilanga (we are all going to die one day). Ukubalulekile ukuthi
ama patients fanele athate ama precautionary measures (what is important is
that these patients must take precautionary measures). Ukubalulekile (talking with these patients is very important).

I: How will communication assist these patients with HIV/AIDS patients?

P: Ama patients bane i nto yo kuthi aba nabo abantu aba ngakhuluma nabo
(Patients have a thing that they do not have anybody to talk to). Thina singa
ma nurse (we as nurses) should make it easier for them, encourage them to
drink their medication, keep them busy in the ward. Noma begula kanjani
bazaphola (No matter how sick they are, they will get healed. Stigma is a
query, yenye yezinto ukuthi thina (it is one of the things that) as nurses
sikhulume ngazo nama (talk to about it) patients and family zabo(patients and
their families). Akuna isikhathi, ama patients siya ba nanazela ukuthi bahlale
bacoce namanye ama patients, ba bonge nempilo e banayo (time is limited,
patients are encouraged to socialise with other patients and appreciate their
lives).

I: Tell me more about time being limited.

P: Rehabilitation is necessary for these patients. Time is needed to give
individual attention to these patients. Social work people should do more
proper care and necessary referrals for these patients. La ewardini akuna
isikathi for ukuhlala no kukhulama na lama patients, ama admissions maningi
(in the ward there is no time to sit and talk with these patients, admissions are
overflowing).

I: What makes it difficult not to give “proper care” to these patients?

P: Umsebenzi mniki lana, ukuna ama nurse, ishortage yasi bulala. Noma
uyenza ihistory taking during admission, a kuna isikhathi so ngena phakathi
kwe history yo kugula kwe patient (there is overload of work here, there are
not enough nurses, this shortage of nurse is too much. Even when you do an
admission of a patient there is no time to go into detail of the patients’ history).

I: What would you like to have best done for HIV/AIDS patients?

P: Ukuba khuthaza (to comfort these patients). Ukuba siza ukuthi ba
ko amukele luka gula ba nako (to assist them to accept the disease),
ukuba tshela ukuthi ukuya ngesikhathi kuza lunga (to tell them that in time things will be okay). Ukusiza ama patients ukuthi le langa ba phuma ngalo e wardini, ba phume ngomoncondo wethemba (to help patients that the day they are discharge from the ward, they must walked out with a thought of hope). Ukuba nanakezela ukuthi bakhulume ngezinto ezaba phethe kabuhlungu (to encourage them to talk about what is bothering them), ukuthi uma befika ekhaya bangla fike bahlale nje ba bodwa, akusi kahle, bafanele ukuthi bazame ukuhla nabanye abantu (when they are at home, they should not sit alone, it is not right, they should stay with others.

I: What message can you give to other nurses on how to interact with HIV/AIDS patients?

P: Bakhulume nabo, ba encourage ama grupu ema patientini ukuthi bakhulume bonke, uku khuthazana, ukuba na manye ama prayer meeting for amanye ama patients a weak (to talk to them, to encourage groups among patients to talk to each other, to comfort each other, to have more prayer meetings for other patients who are very sick). I nto yo kucala ukuthi thina asinga manurse sikhuthazane, ngoba ngeke siyazi ukuthi kusasa izoya kwabani iHIV/AIDS (the first thing is that we as nurses we need to comfort each other, because we don’t know when will HIV/AIDS visit our houses).

I: What other thoughts do you have about this topic?

P: Ugulumente ufanele ukusiza kakhulu (the government must help a lot) more than think they are doing. Bafanele ba size ngokususa le stigma isikhona ngalo kugula lokhu, ba itrite nje nga manye a ma diseases (they must help by eradicating the stigma of this disease, to treat it like any other disease). Loko kuza siza ukuthi abantu bangla sayenzi isecret, ngoba abantu bacabanga ukuthi lo kugula kwa Bantu aba hamba ba lala konke la (this will assist that people do not keep this disease a secret, because people think this disease is of people who are promiscous). And nale diflucane igovernment ayi sebenzi makuba ama patients are full blown (and this diflucane the government gives does not help if the patients are full blown). Luku gula kubulala umoya (this disease, kills your spirit. Kuba lulekile ukuthi sezi ama patients wethu (it is important that we assist our patients).

I: Is there anything to you would like to add, P?
P: Akukho (no there is nothing). Kufunale ukuthi ngiyo siza ewardini iMonday ne Tuesday zibizi ka khulu nga maddmission (I need to go and assist in the ward, Monday and Tuesday are busy with admissions).
I: Ngiya bonga kakhulu isiskhathi sakho, P? (Thank you very much for your time, P?)
P: Ngu bonga mina (I thank you)
I: Goodbye
P: Bye for now.
Annexure (K)

Patien-participants interview

Interview number four

R: Dumelang, (Good morning) Mam.
P: Dumelang (Good morning).
R: Ke leboga nako e le wena. Ke kopa o mpotse ka botlalo tshomisano ya gago le bonurse ge o robetse sepetlele. (Thank you for your time that you we have, together. I request that you tell me about your interaction with the nurses in the ward).
P: Hoo... The nurses, we ... in the hospital, ge o le mo sepetlele bangwe ba o swara botse, bangwe ka moo ba ratago ka gona, (when we visit, they do not treat us well, the others will treat you well, while the others will treat you the way they want) ba o fotlela, ba o roga. (They scold at you).
R: When you say ba a o fotlela Mam, (they scold at you) o ra bjang, e o swara byang taba ye? (I will like to find out how does this affect you?)
P: Ge ba thoma ba o fotlela, (Immediately they scolded at you), pelo ya ka e ba bohloka, a ke sa lokologa. (my heart become painful I don't become free) ke re ka gore ba tseba status sa ka or seo ke sa se tsebego, (and when they scolded me it is may be they know my status or what I don't know) ka gore ge ba bona gore o a lwala, o positive, (because if they can hear that you are sick, you are positive) they treat you ka mo ba ratago (as they like) ga ba o sware pila, (they do not treat you well).
R: In this way when they treat you the way they want, a wa gopola go dula le bona la bolela gore why ba o swara bjale? (didn’t you think of sitting down with them and ask why are they treating you as they like).
P: Aowa, a ra dula fase , batho ba a ba bonale, ke no re may be ke tla ba isa pele, court. A ba re sware botse ka mo re lebeletsego. Fela ke e lesitse moyeng. (No I didn’t sit down with them and ask, I just think may be this people need to be taken to the law sections, they do not treat people well as expected but I just leave it in the air).
R: Ke a kwa mma …. Tswelapele (I hear mam... continue).
P: O, k , o dula mola , bona ba ya godimo le fase, ba se na taba le wena.
(O.K, when you sit there waiting for the nurses they will just pass you there moving up and down, they don’t just care about you). Gore o kwa di pain, very pains, ba ya godimo le fase, mola e le kgale ke gona ba o thusa (the fact that you feel pain, you feel very much pains, they really don’t care about you). they will just move up and down as they wished, after a very long time they will assist you, ka nako yeo o painelwa e bile o lapile, ge ba tlo o thusa e tla no ba wa pelo e botse a botsisa gore go reng (by that time you will be in pains and tired, even when they finally help you they will be someone with good heart who will ask them what is this person waiting for, why is this patient here, le mo thusitse or why a sa thuswa? Ba tla re a wa thuswa fela go se lebaka. (have you assessed her if so why was she still here, they will say she is not yet assisted without giving any good reason for not checking you).

R: Ge o le bjalo wena o ikwa byang? (In these instances how do you feel about this treatment? You as a person).

P: Mme..ke kwa bohloko kudu, ke a kgopisega, ka gore ke motho , ene ge re ka thoma go Iwa go ka se be botse (I ... feel very bad and hurt about this because we are people and they are also people if you start fighting it is not so good, it will not be nice to fight. Ke a tshoga, ka boifa (This makes me to be afraid, I become frightened).

R: Ge o le byalo o tshoga, o tshosa ke eng? (In these incidences if you become afraid, what makes you to be afraid)?

P: O.k, a ke re ba tla be ba nkgadimola, (In this instances when they scolded) (Kgadimola) ke nagana fela gore a ke sa tlo tla mo, ke ye go gongwe ka gore batho ba ba RaFO. A ba o sware ga botse (it will lead you to think of never coming to this hospital anymore, but go to other hospitals because these people are (RAFO) they do not treat you well. Le ge o ba bona kwa ntle o a gopola gore sister o, a a ntswara botse ge ke robotse sepetlele, (When you meet then by mistake in the street you start to think that this sister did not treat me well when I was admitted). And this also affects other sisters bao ba o swarago botse, (who treated you well). They are all labeled as bad.

R: Ma, o ra gore ruri a ba o swara botse? O ka hlalosa ka botlalo? (do you say indeed they were not treating you well, can you explain that in detail, on how they cared for you)?

P: They were not treating us well because ge o tsena (when you enter) a ba o
thuse, go no ba le ba bangwe ba ba ka o thusang ka pela, ba lebelela faele ba o thusa ka lerato. (they could not help, though there are others who can help you earlier, when you arrive, they took the file and help you, these ones can give and show you love and) ka nako tse dingwe o hwetsa ba babe ba go hloka kwelobohloko, (at times you meet the bad one who will never show sympathy or value you).

R: O ra byang ka go bontshwa lerato? (What do you mean by being shown love)?

P: Ka gore bao ge ba o bona ba bontsha lerato, ba o fa dihlare ka lerato ba tla ba botsisa gore o byang, a o na le bothata naa? (Because others when they see that you are sick they can help you, show you love and give you some pills and ask you how do you feel or what problems do you have)?

R: Byalo se se o swara byang? (Then how does this make you feel)?

P: The good ones o duma e ka ka moka ba ka be ba le byalo (made you to wish that all the nurses can be like them), ka gore bangwe ba dira gore moya o be o moso (because the others make your spirit to become black) moya o ba o montsho. O a sulafaletswa (you become sad).

R: O ra byang?( What do you mean by the black spirit)?

P: Moya o ba o moso, ge o bona gore a ba o dire motho, o byalo ka phasela, le wena o a inyatsa. (The spirit.... the spirit become black when you see the person because it seems you are not a person, you think why is this person is treating me like this, like I am not a person. O a inyatsa. (You look down upon yourself).

R: Hmm.. ke a kwa mma…(I can hear mam ..........).

P: Ge moya o le byalo o ipona o le selo fela, a ba na taba le wena, ba o feta-feta. Ba a Fete-Feta, they just pass by. (When your spirit become black/ is low, it seems you are not a person anymore, you are just a thing, an object, they do not care about you. They just pass you without concern)

R: Ke na le wena mma, o ra gore a ba bolela le wena, ba o reasura, go go homotsa? (I am with you Mama...are you saying they can’t talk to you and reassure you or come to you and talk to you and counsel you), ge ba tloga ga o tle ba bangwe ba o thusa? (but when they leave, are there no others who will come and assist you )?

P: Aowa, ga o tle motho, ba berekela kgole le nna, (No, they work far from
R: Se se o swara byang? (Then how does this affect you?)
P: Ke kwa bohloko, ba dira gore o ... o a ‘HLAKAHLAKANA’ (I feel bad because this person makes you confused and makes your spirit black).
R: O ra eng ge o re ‘HLAKAHHLAKANO’? (What do you mean by confusion?)
P: O kwa ba re ... ba re: Ai.... O o be a ya kae ... o inyakela di AIDS, o be a dira eng, (You will hear them saying: You will hear them saying: What was she doing, she got herself into this AIDS), di a nyamisa, (this type of commends are hurting) DI A SULAFATSA’ (IT HURTS).
R: Aowa, ba ka na ma ba re yalo? (Really, do you say nurses can say that?)
P: Eng, ba bolela byalo, ba re le se mmone a e byalo o na le AIDS, (Yes they say that, they just say that,... say ..... as you see her she has AIDS.(P looked so sad)
R: E se gore o kwa ge ba fa report go ba bangwe ba tshaisa, o re kgane ba ra wena? (Is it not maybe you hear them when they give each other reports you think they are talking about you?)
P: Heee ...ga o tsebe mama.. (you do not know ...) ba a bolela, o kwe o swabile o sa tsebe gore o reng, ba bolela ga mpe, ba somisa faele. (they talk mam, you find yourself very sad not knowing what to do or say, they read your file and use the information very bad).
R: O na me o dire eng? Ge ba usa le file? (In this case what do you do? if the file is used badly))?
P: O no kwa bohloko o sa tsebe gore o dire eng. (You just feel bad, you are hurt, you do not know what to do).
R: Ge o le byalo, hlokomelo yona e byang? (In this case mam when they talk like that how was the care)?
P: Hlokomelo...hlokomelo ga e go, (Care .. care is not there), o tla no dula koo, ge ba fa dijo le dihlare go kaone, ka nako engwe bao ba tla semaela, (you will just stay there but those who give us meals and treatment are better, they will smile at you.
R: Ba tle ba dio bolela le wena, goba ge o bitsa? (Did they...ever talk to you or when you call)?
P: Ba bangwe ba a tla, ba re go byang, fela bontshi a ba di tsene tseo. Hee.. a ba o botsise gore o byang, a ba na taba ba dira ka mmo ba ratago, o ka re a
o phele (others will come and even ask how do you do, how do you do, care for yourself while others ... hee they do not care, they treat you like you are not alive or a person).

R: Ge o setse le bao o dira byang? (when you remain with those ones what do you do)?

P: O no tseba gore a ba ne taba le motho, ba no dula ba bolela, they don’t care, ge e le group go gongwe ba bane ba ka semaela fela the rest a ba bone gore o a lwala. (When you are with this ones you just know that they do not care about patients, this people mam they sit in their table and talk and in this group only four can smile at you the rest are not for that, they can’t even think that that person is sick).

R: Bjale mama (Now mama) in general hlokomelo ebe e le byang? Tshomisano le bo nurse? (How does you rate the care, your interaction with the nurses?)

P: E be e sa kgotsofatse for nna, (The interaction and care were not satisfactory to me), ke ile ka nagana go sepela/ tshaba ke ye sepeltele se sengwe go ba clinic ka gore ba ka ba kaone.(I even thought of running to other hospital or at least the clinics because at the clinic they give good care).

R: Ge o nagana go tshaba, go be go se se se ka dirwang ka gore sepeltele se ke sa lena. (If you want to run away, didn’t you think there could be something that might be done that you do not run away because this hospital is for you)?

P: Be ke tla reng, mo gongwe ge ba ka oketsa manurse go ka ba kaone, ba ka re kgona ra se nagane ga tloga. (What would I have done? Or if they can increase the nurses and ensure that they work properly, in that way we may not think of going to other hospitals).

R: Eee... go be go se ka moo o ka bonago ba bagolo? (Were there no other ways you could use to inform the hospital leaders)?

P: Ga o ba botsisa ka ba bagolo, ba re a ba go, ba tshaisetse, o tla reng, (When you ask about them they just tell you they are not available, they have gone off, what will you say? O tla no dula (You just stay).

R: O ra gore ge o na le complain a o tsebe gore o dire eng? (Does this mean that if you have complains you do not know where to complain)?
**P:** The complain, a re tsebwe gore re dire eng ka gore ge o re superintendent o kae ba re a ba tsebe, (we do not know were we should take them because if you ask about the superintendent they tell you he/she is not here we do not know where he/she is).

**R:** Ka tsela ye o ra gore poledisano le bo nurse e be e se botse? (So in this way you mean your communication with nurse was not good)?

**P:** Go byalo mma (Yes mama).

**R:** Ke eng se o naganag gore ba bagolo ba ka se dira go improver? (What do you think the authority should do to improve the situation)?

**P:** A ke tsebe, mo gongwe o be le o mogolo ka warding, a hlokomele, goba the security ka gore le di visitors ga di swarwe botse, ge o latelewa ka five minutes ga ba o dumelele o tsena, (I don't know unless if there can be someone in the ward with authority to take care of things in the ward or the security because even the visitors are not treated well, if you arrive late even with five minutes they will not allow you).

**R:** O ra gore a o tsebe motho o mogolo ka warding? (Do you say you do not know there are those in authority in the ward)?

**P:** Aowa, a re ba tsebe, a ke re ba apara go swana, (No we cannot distinguish them because they all wear same type of uniform).

**R:** Ke a kwa mma… a o sa na le se sengwe, pele re fetsa? (I hear mam... is this the only information that you wanted to discuss with me? Are there others things that you want to present before we end this meeting)?

**P:** Ke di boletse ka moka, (there are all I wanted to say mam).

**R:** Ke a leboga nako e botse ye, ge o ka ba le se sengwe o ka somisa cellphone number yeo yaka. (I thank you, for this good time, if there can be anything that you want to talk about I am just a cellphone away use it).

**P:** ke a leboga (I thank you).

**R:** Ga botse, (Good bye).

**P:** Ga botse. (Good bye).
REQUEST FOR CONSENT TO CONDUCT RESEARCH

I, Mampato Jokwana Mamesela, am a D. Cur. Student at Rand Afrikaans University, Johannesburg. I am engaged in a research project entitled "Nurses interaction with the patients who are HIV/AIDS infected," under the supervision of professor Marie Ploeggenpohl and Dr. Jackie Oberholster of the Department of Nursing Science, and professor Chris Myburgh at the Department of Educational Science of the Rand Afrikaans University.

The aim of the research is to explore and describe the interaction of nurses with the patients who are HIV/AIDS positive in the institution. I invite you to participate in this research. Your experiences in the interaction will assist us in understanding what is perceived to be helpful during the interaction. The findings will be implemented in order to improve the nursing practice and raise awareness on patient care.

You will be interviewed and video-taped your interaction. The process will be audio taped for verification of finding by the independent experts and will be kept confidential. You will give your informed consent to these proceedings and reserve the right to cancel it at any stage of these proceedings. You are under no obligation to participate in this project.

I undertake to guard your anonymity by omitting the use of names and places.
Confidentiality will be ensured by destroying the taped recorded material on completion of analysis thereof. The benefits for you to participate in this research is that you are provided with the opportunity to verbalise about your experiences of interaction with patients who are HIV/AIDS infected.

Research results will be made available for your perusal if you need. I will my cell phone number as 021-4420313 if you wish to contact me.
Signed at 2000

IJ MANAMELA M.CUR. RN
D.CUR. (PSYCHIATRIC NURSING) STUDENT
RESEARCHER

Mare Poggendorf
MARI POGGENDORF. RN PH.D
PROFESSOR: NURSING SCIENCE
(PROMOTER)

Dr. PHADRA GEBEKHOLSTER D.CUR. RN
DEPARTMENT OF NURSING SCIENCE
(CO-PROMOTER)

Chris Myburgh
BSc., HONS, M.COM, D. ED
PROFESSOR: EDUCATIONAL SCIENCES
CO-PROMOTER
DEPARTMENT OF NURSING SCIENCE
Telephone: (011) 496-3090

The CEO
Mamelodi Hospital
Private Bag X0023
P.O. Radiokwane
PRETORIA
0001

Dear Dr. Assistant,

A REQUEST TO CONDUCT THE STUDY IN YOUR INSTITUTION

I am hereby request to be given a permission to conduct a research in you hospital. I am
Johnson Mabamala Mzimela, a doctoral (D Car) student at the Rand Afrikaans University.
My project is: "Interaction of patients who are HIV/AIDS infected.

My research topic is as follows: Interaction of patients who are HIV/AIDS infected.

The objectives of the study are as follows:

- To explore and describe the nurse's interaction with the admitted patients who are
  HIV/AIDS infected.
- To develop and describe a model that will assist the nurses to facilitate the
  promotion of mental health in patients who are HIV/AIDS infected.

The study will be approved by the Rand Afrikaans University Ethical committee which
ensures that the ethical consideration and will also be subjected to your ethical committee's
consideration.

Consent to participate will be obtained in writing from the nurses taking care of the
admitted patients who are HIV/AIDS infected and the same patients, the participants will
be informed about the purpose of the study. They will be informed that participation is
voluntary and that they can withdraw from the study without any penalties. They will be
informed that the study carries no physical risk and that privacy.

Ethical considerations

Ethics refers to a science or study of morals and morality, of which is the standard of
behavior followed by individuals or groups. As the research involves human beings, I will
ensure that participant's rights are protected. Therefore the following principles will be
achieved in:

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Respect for human dignity
This indicates that the participants have the right to self-determination and the freedom to participate or not to participate in the research. The researcher will explain to the participants that they have the right to respect for human dignity, whatever information they will give will not be used to undermine their dignity. The participants have the right to withdraw without penalities during the process if they can realize that the cost and benefit associated are not worth it.

The Right To Privacy
The right to privacy involves issues around the private information given by the participants; this may include the feelings, beliefs, attitude, behavior and opinions. Research information will be destroyed immediately after the research results is published, the right to privacy will be adhered to, there will be no mention of names.

The right to anonymity and confidentiality
Anonymity requires that the participant’s identity not be linked to their responses. Confidentiality requires that information shared by participants should not be linked to the participants and real names will not be used. The researcher will ensure that no unauthorized person will gain access to the data. Data will be kept safe and destroyed on completion of the study.

A solemn promise
- To keep data confidentially, under lock and key.
- To ensure that no one other than the already mentioned supervisors will get access to data.
- To destroy the audio tapes as soon as the study is complete.
- To leave my contact address and telephone number in case you want to contact me in matters related to the study.
- To provide a summary of research findings should you wish to.

Informed consent
Informed consent refers to the participant's documented agreement to participate in the study. The participants are given the opportunity to be explained and clarified about what the study is all about and voluntarily choose to take part. The researcher will explain about the background of the study, the purposes and objectives of the study, research designs and method to be followed, ethical considerations, and reporting systems. The participants will be allowed to ask questions for clarity. The researcher will ensure that the participants understand all the details of the study and request them to sign an informed consent documents.
The right of the participants will be highly protected as indicated above.

My address is:
299 De Boulevard Street
866a Overton Flats
SILVERTON
0184

Hoping that my request will be considered.

Yours faithfully,

MJ MANARELA  M.CUR. RN
D.CUR. (PSYCHIATRIC NURSING) STUDENT
RESEARCHER

MARIE POGGENPOEL  RN, PHD
PROFESSOR: NURSING SCIENCE
PROMOTER

DR MADRA OBERHOLSTER (D CUR, RN)
DEPARTMENT OF NURSING SCIENCE
CO-PROMOTER

CHRIS MYBURGH (HED., BSc., Hons., M Com., D Ed.)
PROFESSOR: EDUCATIONAL SCIENCES
CO-PROMOTER
DEPARTMENT OF NURSING SCIENCE
Telephone: (011) 439-2452
Fax: (011) 439-2257
Reference Number: 02/06/05

TO WHOM IT MAY CONCERN

TITLE OF RESEARCH PROJECT: “Nurse’s interaction with patients who are HIV/AIDS infected”.

RESEARCHER: M. J. Macavaney

SUPERVISORS: Prof. M. Foggens
Prof. C. H. Myburgh
Dr. M. Oberholster

The Committee for Academic Ethics of the Faculty of Education and Nursing of the Rand Afrikaans University evaluated the research proposal and received letters of the above research proposal and confirmed that it complies with the approved Research Ethical Standards of the Rand Afrikaans University. Permission was granted for research to continue on 6 September 2005.

The study supervisor and researcher demonstrated their intent to comply with the approved Ethical Research Standards during conduct of the research project.

Yours sincerely,

[Signature]

MARIE FOGGENS (PROF)
CHAIRPERSON: FACULTY’S COMMITTEE FOR ACADEMIC ETHICS
DEPARTMENT OF HEALTH
MAMELODI HOSPITAL

21 October 2003

Addressee: Ms MJ Mamanele
Chief Executive Officer
Mamelodi Hospital

Dear Ms Mamanele

RE: REQUEST TO CONDUCT STUDY AT MAMELODI HOSPITAL

The Research Committee of Mamelodi Hospital has considered your request.

We are glad to report that it has been approved on the following requirements:

- The research must be conducted in such a way that it has no impact on the services and duties of the staff in the wards.
- That it has no financial implications on the hospital budget.
- The protocol must be adhered to.
- A report must be completed at the end of the study and forwarded to the management of the hospital.

Thank you.

[Signature]

Dr MJ Haysiek
Chairperson: Research Committee
GAUTENG HEALTH SERVICES
DEPARTMENT
MAMELODI HOSPITAL
F/BAG X0032
P.O.RETHABILE
0122

Enq: Ms M.J. Manamela
Tel: (012) 841 8302
Fax: (012) 841 8412

ATT: Tetani
NGO

Dear Sir/ Madam,

I am a D Cur student with Johannesburg University (RAU) and one of my requirement for my Doctorate with Johannesburg University (RAU) is to conduct research. My topic is nurses intervention with patients who are HIV/AIDS infected. I am hereby making a request to interview the HIV/ AIDS infected patients who were once admitted in the Mamelodi Hospital and now follow Rehabilitation programmes in your organization.

The problems I encountered is that patients admitted in this hospital are very sick, unable to talk. My promoter agreed that I follow them up in the community hence- I have realized that you can be able to assist me.

Attached receive my letter of request as approved by my Promoter.

Thank you,

Ms M.J. Manamela
Chief Executive Officer

2002 05 14
5 December 2003

TO WHOM IT MAY CONCERN

This is to certify that I have read the dissertation on NURSES' INTERACTION WITH PATIENTS WHO ARE HIV/AIDS INFECTED, handed to me by Mrs. M.J. Mmaneola.

I have corrected errors of spelling and syntax. I looked at the issue of congruency between titles in the text and in the index and pointed out all discrepancies. I also paid attention to the numbering of sections and sat with Mrs. Mmaneola so that she could see where she went wrong.

As far as possible I checked the references quoted and saw to it that the spelling was corrected. I also tried to ensure that all references quoted were taken up into the bibliography and where they were not, I pointed that out to the author.

[Signature]

Williams S. Bothe
BA (Hons), B.Ed, STD.
25th May 2023

Ms Ml Menezela
Mamelodi Hospital

Dear Ms Ml Menezela

RE: YOUR REQUEST TO IDENTIFY STUDY PARTICIPANTS

We are glad to inform you that your request to identify participants through our organization is being granted to you; therefore someone will be designated to accompany you in identifying study participants.

Kindly note the following:
- That there will be no financial implications on our budget.
- The protocol must be adhered to (ethical principles such as confidentiality, patient rights etc).

It will be highly appreciated that at the end of the report a copy thereof must be submitted to us.

Wishing you well in your study.

Thank you.

[Signature]

Ms S Rbine
Acting CEO
TO WHOM IT MAY CONCERN

This is to certify that I have read the dissertation on NOBLES' INTERACTION WITH PATIENTS WHO ARE HIV/AIDS INFECTED, handed to me by Mrs. M.J. Mammosa.

I have corrected errors of spelling and syntax. I looked at the issue of congruency between titles in the text and in the index and pointed out all discrepancies. I also paid attention to the numbering of sections and set with Mrs. Mammosa so that she could as when she went wrong.

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Willa B. Beita
BA (Hons); B. BSc; STD.