NURSES’ OWN PERCEPTIONS OF THEIR THERAPEUTIC RELATIONSHIP IN PROVIDING CARE TO PATIENTS WITH MENTAL HEALTH DISORDERS

By

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MINOR DISSERTATION

submitted in fulfilment of the requirements of the degree

MAGISTER CURATIONIS

in

PSYCHIATRIC AND MENTAL HEALTH NURSING SCIENCE

in the

FACULTY OF HEALTH SCIENCES

at the

UNIVERSITY OF JOHANNESBURG

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August 2012
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DEDICATION

For their belief in me, I dedicate this dissertation to my daughters, Suné and Michelle.

ACKNOWLEDGEMENTS

I am sincerely grateful to God for the ability to complete this project.

My gratitude and appreciation to the following people:

To my supervisors, Prof. Marie Poggenpoel and Prof. Chris Myburgh: thank you for your support and patience. Without your expert knowledge and skilful assessment of my work, this project would not be possible.

Thank you to the managers and nursing staff of the private general hospitals who willingly allowed me to use their time and their perceptions to add to the body of nursing knowledge.

To Catherine Bell who assisted me with the technical support.
ABSTRACT

The facilitation of a therapeutic relationship is an essential skill in nursing, and particularly in mental health care. The emotional effects of illness and the increase in admission of patients with mental health challenges in private general hospitals has made the facilitation of a therapeutic relationship a vital component of modern healthcare. While working in a private general hospital, the researcher dealt with numerous incidents in which nurses displayed a lack of awareness and misunderstanding during interactions with patients.

The objectives of this study were: to explore and describe nurses’ perceptions of facilitating a therapeutic relationship; to examine differences in nurses’ perceptions of facilitating a therapeutic relationship by comparing various categories of nurses; and to propose recommendations concerning the facilitation of a therapeutic relationship.

A quantitative, descriptive, contextual and deductive design was followed in the study. Categories of nurses and care workers from three private general hospitals in Gauteng were involved. Self-administered questionnaires (n=184) were used for nurses and care workers to rate their perceptions of facilitation in relation to the dimensions of a therapeutic relationship namely: empathy, positive regard, genuineness, concreteness and self-exploration. Specific hypotheses were tested to identify whether statistically significant and substantial differences existed between the perceptions of two or more groups of nurses.

The results indicated that the mean scores on the deeper reflective levels of facilitation of a therapeutic relationship were lower than expected. Nurses in the caring profession should have an awareness of a therapeutic relationship; however, the majority of nurse-participants rated their perceptions of facilitation to a lower level than the researcher expected. The lower levels showed lack of concern for the patient’s feelings, were superficial or neither hindered nor facilitated a nurse-patient therapeutic relationship.

The higher mean scores obtained on responses pertaining to general nursing tasks demonstrated that nurses were more aware of the patient’s physical needs. This result was not surprising when considering that there seems to be non-therapeutic environment and medical model of care in private general hospitals.
When groups were compared, no statistically significant and/or substantial differences were found between the perceptions of various categories of nurses. Although professional nurses seemed somewhat more aware of how patients should be treated, age, experience and previous interpersonal skills training did not impact perceptions of therapeutic relationships.

In conclusion, the findings of the study showed general insensitivity of nurses towards patients’ emotional needs. The larger percentage of younger, inexperienced and sub-professional nurses in the sample has training and cost implications for private general hospitals. The researcher therefore highlighted the need for nurse self-awareness, additional and continued interpersonal skills training. Sensitising as well as support to equip all nurses with the necessary skills to facilitate a therapeutic relationship at a deeper and reflective level of understanding is recommended.

Key dimensions: Therapeutic relationship, mental health disorders, nurses, perceptions, and private general hospitals.
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CHAPTER 1 RATIONALE AND OVERVIEW

“The more complex our technology and the more bureaucratic our hospitals have become, the less have respect and positive regard been communicated to patients” (Aiken & Aiken, 1973:864).

1.1 INTRODUCTION

Empathy, positive regard and respect have always been cornerstones of a nurse-patient relationship, but many professional helpers are simply not as helpful as they ought to be (Reynolds & Scott, 2008:232). While working in a private general hospital, the researcher experienced a lack of awareness amongst nurses concerning the mental health needs of patients.

In South Africa various psycho-social, cultural and economic conditions have a major effect on mental health. As a consequence of the changing profile of patients in private general hospitals, and a non-therapeutic environment, interpersonal challenges are increasing for those who work in private general hospitals.

Most patients who are admitted into a hospital for surgical or medical procedures experience some level of anxiety. Depression, for example, presents in multiple overt and covert forms and is often disguised as a physical or stress related symptom, or develops as a consequence of a physical disease, trauma or pain (Moyle, 2003:103). Mental health care is a human right and the Mental Health Care Act (No. 17 of 2002), therefore makes provision for patients with mental health disorders to be admitted into private general hospitals as well as designated psychiatric facilities.

Health professionals generally then require a more complete set of skills to deal with the additional challenges. Nurses are also expected to have the necessary skills to deal with the physical, emotional and/or mental health challenges of all patients.
1.2 RATIONALE OF THE STUDY

A therapeutic environment is created largely by the therapeutic attitudes of the staff and should promote changed behaviour and improve the mental health of patients. The nurse therefore is the instrument of care and is specifically trained to facilitate relationships with patients (Uys & Middleton, 2004:227). A therapeutic relationship includes self-knowledge and knowledge about the necessary dimensions of therapeutic communication. These dimensions include unconditional acceptance of the patient, the ability to listen and to hear, constructive non-verbal skills and constructive communication techniques. The use of rapport and alliance enables this process to happen by providing support, consistency and reliability in patient care (Gilbert, 2009:298-308). The nurse, therefore, needs to be actively and personally involved.

Mental health challenges however have a negative influence on nurses’ attitudes. Patients who have mental health disorders are perceived as dangerous (Mavundla, 2000:1574). Such stigmatisation of patients with mental health challenges could interfere with the nurses’ ability and willingness to facilitate a relationship. A study conducted in the United Kingdom by Harrison and Zohhadi (2005:473) revealed that it was apparent that nurses did not fully understand their role in mental health care and the provision of emotional care. In Australia, Reed and Fitzgerald (2005:251) explored the mixed attitudes of nurses in caring for people with mental illness in a rural general hospital. They found that when demands were high, mental health care was often left till last and was only carried out if there was still time, and only by those who perceived themselves as able to do it.

In contrast to the therapeutic environment of hospitals that specialise in mental health care, private general hospitals focus on physical illness. Financial considerations dictate the care and duration of stay of patients, the staff levels and engagement with patients. Treatment tends to be driven by the policies of medical aid funds, which emphasise shorter periods of admission. Nurses have less time to spend with patients and tend to focus on the medical and curative model of healing that is often task orientated. There is also an increasing trend to employ sub-professional staff to work within a demanding and changing health care environment of private general hospitals (Hanrahan & Aiken, 2008:215). Sub-
professional nurses and care workers often do not have the necessary skills and experience, but nevertheless provide patient care.

Nurse participants in the study by Reed and Fitzgerald (2005:215) believed that their lack of knowledge and fear of saying the wrong thing resulted in people receiving limited mental health care from nurses working in a general hospital. The negative effects of these shortcomings on nurses and patient outcomes have been described by several authors (Moyle, 2003:103; Vythilingum, 2009:450). They also recognised that nurses who were not specifically educated and experienced in psychiatric nursing found it difficult to attend to the patients’ mental health needs.

To address these intense anxieties, nurses (and patients) may result to defence mechanisms such as denial or suppression of feelings. Nurses may further adopt socially structured defence mechanisms such as focusing on paperwork, or often to ignore patients and their needs. The subconscious use of these mechanisms protects nurses from internal painful reality, conflict and external stresses of illness and suffering (Frisch & Frisch, 2011:105). They could also be used to hide from responsibility or to blame the system for one’s own deficiencies.

A nurse-patient relationship is essential in nursing irrespective of the challenges faced by nurses today. The changing patient profile in general hospitals increasingly requires nurses to be equipped with the necessary interpersonal skills, knowledge and attitudes to deal with these challenges.

1.3 RESEARCH PROBLEM

As a manager in private general hospital wards, the researcher often dealt with complaints from patients. The most concerning example occurred when a patient accused a nurse of being rude or of saying something in a way that either caused the patient to cry, become very angry or even to refuse further treatment. The nurse in question then seemed surprised, defended herself by saying that she did not mean to be insensitive and denied being rude to the patient.
The researcher realised that the incident seemed to be based on mutual feelings of disregard and apparent misunderstanding. The patient expected that the nurse should be friendly and understanding of his needs, while the nurse was unaware of the effect that her response had on the patient. Although this was a single incident, it is a typical one and illustrates the research problem highlighted by the researcher.

The following are examples of interactions (Appendix 2) reported to the researcher in 2009, while working in a private general hospital and involved nurses from all categories.

“I called the nurse and she just rubbed over the toe and said: ‘ay shame I’ll bring you something for the pain.’”

“I realised after a while that the other patient was in hospital for depression. … clerked by a nurse with only a curtain between my bed and her bed. I heard every single word of her history.”

The above responses showed disregard for the one patient’s pain and disrespect for the other patient’s privacy. The researcher consequently wondered at which point or stage of the conversation with the patient did the apparent misunderstanding occur, and if some nurses could be more aware of the patients’ emotional distress. If so, then what made the difference in how nurses perceived such an interaction with the patient?

Communication with patients who are admitted with mental health challenges is complex. Most patients in private general hospitals are not only physically affected, but also psychologically vulnerable. When in a crisis, most patients undergo physical or psychological changes. Pain, anxiety or fear can cause patients to deal with their problems differently from when they are healthy and in a familiar environment (Erchul & Martens, 2010:85). Nurses should not only be aware of these needs but also able to deal with them.

As early as the 1970’s, Cormack (1976:87) found a discrepancy between what nurses were expected to do and what was actually happening. He found that in interaction with patients all grades of nurses exhibited the following trends: on average, interaction was very short – 30 seconds to 4 minutes – entering into the relationship at a superficial level and generally avoiding prolonged patient contact. Some of these findings are still relevant today (Reynolds, 2000:1), and despite research showing a positive relationship between empathy
and patient outcomes, low levels of empathy are reported across all the health professions. Findings of earlier studies by Squier (1990:230), Sloane (1993:270), and Wheeler and Barrett (1994:230) were echoed by Reynolds and Scott (2008:232) who concluded that many professional helpers were simply not as helpful as they ought to be.

To problem is exacerbated by the fact that patients with mental health challenges or impaired cognition and communication skills are often emotionally vulnerable. Nurses therefore need to be especially skilled in communicating with patients and need to spend more time understanding them (Kutney-Lee & Aiken, 2008:1467; McEnhill, 2008:157). Patients who are treated with respect and empathy feel enlightened and accepted as a person; in a safe and understanding relationship, the patients experience a sense of being able to deal with their challenges (Edward, Welch & Charter, 2008:592).

1.4 RESEARCH PURPOSE

The purpose of the study was to explore and describe nurses’ perceptions of facilitating a therapeutic relationship with patients in private general hospitals in Gauteng.

1.5 OBJECTIVES OF THE STUDY

The study objectives were:

- To explore and describe nurses’ perceptions of facilitating a therapeutic relationship when caring for patients with physical, emotional and/or mental health challenges.

- To examine differences in nurses’ perceptions of facilitating a therapeutic relationship empirically by comparing groups according to gender, age, years’ experience, qualifications and interpersonal skills training.

- To propose recommendations concerning the facilitation of a therapeutic relationship for nurses working in private general hospitals.
1.6 PARADIGM

In the paradigm of the study the following aspects were considered of importance: basic dimensions of a therapeutic relationship, personal attributes influencing nurse-patient interaction and a supportive therapeutic environment.

1.6.1 Metatheoretical assumptions

Nursing is a caring profession. The expectation is that nurses have the necessary training and experience to be competent. Nurses, therefore, need to have knowledge, skills and a caring attitude to render wholistic nursing care.

The patients, on the other hand, are the receivers of care, and the assumption is that their physical, social and mental health needs will be met when they present with health challenges. Patients are vulnerable to emotional and mental health challenges as a consequence of illness. Patients assume that the environment where care is provided should be therapeutic and healing.

1.6.2 Theoretical assumptions

Social sciences are known for theoretical concepts or constructs used by the researcher to define and describe the dimensions of a therapeutic relationship. The conceptual framework was based on the person-centred model of psychotherapy of Carl Rogers (1975:100), and the systematic approach to the evaluation of interpersonal relationships (Aiken & Aiken, 1973:863). The conceptual framework is discussed in detail in chapter two.

The research focused on the way nurses perceived the facilitation of a relationship with a patient, and it is thus important to define key dimensions that were central to this investigation, namely therapeutic relationship, perception, mental disorder and or challenge and private general hospitals. Categories of nurses who participated in the study are: registered-, enrolled-, auxiliary nurses and care workers.

1.6.2.1 Therapeutic relationship

This involves self-awareness and knowledge of the necessary dimensions of therapeutic communication. These dimensions include an unconditional acceptance of the patient, the
ability to listen and to hear, constructive non-verbal skills and constructive communication techniques. The use of rapport and alliance enables this process to happen by providing support, consistency and reliability in patient care (Gilbert, 2009:298-308).

1.6.2.2 Perception
In this study perception refers to a state of being: the ability to see, hear or become aware of something or yourself through the senses (Bozarth 2001:1).

1.6.2.3 Mental health disorder
This is a condition affecting the mental state of a person to such an extent that it causes significant distress to the person, and/or challenges the person’s ability to function socially, occupationally and in terms of his self-care (The Mental Health Care Act, No. 17 of 2002).

1.6.2.4 A private general hospital
A private general hospital, according to the National Health Act (No. 61 of 2003:12), is defined as an institution, facility, building or place where persons receive care, treatment, and rehabilitative assistance, as well as diagnostic or therapeutic interventions at a regulated fee for service.

1.6.2.5 A registered nurse (RN)
This is a professional person who is qualified and competent to practice comprehensive nursing independently in the manner and to the level prescribed, and who is capable of assuming responsibility and accountability for such practice, and is registered with the South African Nursing Council (No. R. 2598 of 30 November 1984).

1.6.2.6 An enrolled nurse (EN)
An enrolled nurse is educated to practice basic nursing in the manner and to the level prescribed by a health care professional registered with the South African Nursing Council (No. R. 2598 of 30 November 1984).

1.6.2.7 An enrolled nurse auxiliary (ENA)
Enrolled nurse auxiliaries provide elementary nursing care in the manner and to the level prescribed by a health care professional as regulated by the South African Nursing Council (No. R. 2598 of 30 November 1984).
1.6.2.8 A care worker (CW)

Hospitals and care homes increasingly employ care workers to assist with elementary care of patients. A care worker has no formal education as a nurse and is not registered with the South African Nursing Council.

1.6.3 Methodological assumptions

The functional approach includes the planning, method and structure of the research. In this study the research process was logical, systematic and justifiable while the researcher remained objective and ensured validity of the study (Babbie & Mouton 2001:75).

1.7 RESEARCH DESIGN AND RESEARCH METHOD

A quantitative, descriptive, contextual and deductive design was used for the study. A quantitative research design, amongst other things, refers to a structured, statistical analysis (Burns & Grove, 2005:346). The researcher assessed nurses’ perceptions of the levels of facilitation when facilitating a therapeutic relationship in private general hospitals. Facilitation ranges, according to Aiken and Aiken (1973:863), from lack of concern and disregard of a patient’s feelings, to reflection and understanding of the patient’s feelings.

An empirical investigation further revealed possible differences between nurses’ perceptions of facilitation across groups in relation to the characteristics of a therapeutic relationship (empathy, positive regard, genuineness, concreteness and self-exploration).

The population from which the sample was selected (Babbie & Mouton, 2001:258) for this study comprised all nurse categories employed by the three accessible private general hospitals of a healthcare group in Gauteng.

A purposive sampling method was used to select a sample of registered, enrolled and auxiliary nurses and care workers working in the selected private general hospitals.

For data gathering, a two part self-administered questionnaire (Appendix 1) was used. Part A comprised five questions on biographical data, and Part B comprised 25 possible responses relating to the dimensions of a therapeutic relationship and the levels of
facilitation thereof. The adapted questionnaire was based on the theoretical framework, the dimensions of a therapeutic relationship (Rogers, 1957:100) and the levels of facilitation originally described by Aiken and Aiken (1973:865). The questionnaire was brief, and was developed to be easy to understand by the nurses who consented to participate, and also easy to code and interpret by the researcher, as advocated by De Vos (2001:82). The questionnaire is discussed in greater detail in chapter three (see Appendix 1).

**Validity and reliability:** According to Botes (2005:190), content validity implies that all core characteristics of a concept are identified in the literature and reflected in the research study. Reliability refers to whether a particular technique, applied repeatedly to the same participant or groups of participants, would yield the same results (Babbie & Mouton, 2001:119). In this study, reliability was investigated cursorily. The investigation used a descriptive contextual design, in which the self-perception of the participants of their own therapeutic relationship was investigated. A Cronbach Alpha Test (Polit & Beck, 2008:751) was used to conduct these reliability assessments.

The steps in the research process are presented herein as rationale to justify the decisions and findings of the study. Internal consistency was maintained by using the same version of the questionnaire for all participants (Creswell, 2008:170), and the researcher ensured consistency with data collection at all times.

**Data analysis:** The data collected from the questionnaires were inputted and captured on a spreadsheet. Hypotheses were formulated using the biographical data as independent variables, with respect to the facilitation of a therapeutic relationship (dependent variable). The differences between nurse group perceptions of the level of facilitation of a therapeutic relationship were identified using descriptive statistics and comparative statistical tests. The independent (biographical data) and dependent variables (perception of facilitation) and differences between categories will be discussed in chapter four.
1.8 ETHICAL CONSIDERATIONS

Generally accepted ethical guidelines of Dhai and McQuoid-Mason (2011:14) were used during the data gathering process and in the research process as a whole. Permission to conduct the research was obtained from the Ethics Committee of the University as well as the relevant hospital authorities (Appendices 3 and 4).

Participants' human rights were protected by applying:

- **Right of self-determination (Autonomy):** informing participants about the proposed study and allowing the choice to participate and the right to withdraw from the study at any time, without penalty.

- **Non-maleficence:** ensuring that no harm would come to the participants by means of discrimination as a result of their participation in the study.

- **Anonymity:** was based on the right to assume that data collected would be kept confidential by not using names or staff numbers to identify participants.

- **Justice:** there would be no discrimination on the basis of race, culture or social class and participants would be treated fairly.

- **The participants as well as the hospital authorities would have access to the published results of the study.**

These measures are discussed in greater detail in chapter three, paragraph 3.6.
1.9 CHAPTER OVERVIEW

In this chapter, an introduction, rationale and overview of the study were provided. The purpose, objectives, research methods as well as validity and reliability of the study were described.

Chapter two: The conceptual framework is discussed with reference to the literature review.

Chapter three: Research design and research method, including the research instrument used to collect data.

Chapter four: Statistical analysis and discussion of results.

Chapter five: Conclusions in relation to the findings, contribution to the knowledge of nursing and limitations of the study. Recommendations for practice and training as well as further research are proposed.
CHAPTER 2 CONCEPTUAL FRAMEWORK: FACILITATION OF A THERAPEUTIC RELATIONSHIP

2.1 INTRODUCTION

In chapter one, an introduction and overview of the study were presented. This chapter will present and expand upon the conceptual framework for facilitation of the nurse-patient therapeutic relationship. The first section of this chapter will cover the dimensions of a therapeutic nurse-patient relationship and facilitation thereof. In the second section, the researcher will present the personal attributes of nurses that could influence their interaction with patients. An environment that supports the facilitation of such a relationship will further be explained in the context of a private general hospital. The terms mental health disorders and/or challenges, nurse and patient will be used in the context of this study and she or he is used with no gender preference or relevance.

2.2 NURSE-PATIENT THERAPEUTIC RELATIONSHIP

Although interpersonal and communication skills form a vital part of nurses’ training courses (Arnold & Boggs, 2011:191), not all nurses working in private general hospitals benefit from similar training or experience. The challenge for hospitals and for nurses is nevertheless still to promote the health and mental health of all patients despite any shortcomings in training or experience.

In the healthcare context, the diversity of communication needs of patients, who are themselves dealing with their own fears of illness, death and dying, are often overwhelming and a nurse therefore needs a special set of therapeutic communication skills. These include active listening and constructive verbal and non-verbal affective techniques. Of the beneficial communication skills of warmth, understanding, respect and concreteness along with the helper’s expression and transparency all contribute to self-exploration of feelings and a therapeutic relationship based on trust (Gilbert, 2009:45; Frisch & Frisch, 2011:102; Arnold & Boggs, 2011:19).
The significance of establishing a therapeutic relationship is acknowledged by various authors (Rogers, 1957:100; Aiken & Aiken, 1973:865; Peplau, 1992:15; Frisch & Frisch, 2011:103; Arnold & Boggs, 2011:178) and was adapted for the purpose of this study (see Figure 2.1).

**Figure 2.1:** Dimensions of a nurse-patient therapeutic relationship
2.3 DIMENSIONS OF A NURSE-PATIENT THERAPEUTIC RELATIONSHIP

The dimensions of a therapeutic relationship described by Carl Rogers (1957:100) and the levels of facilitation thereof formed the conceptual framework and basis for the current study. Rogers (1957:100) identified three “helper” characteristics essential to the development of client-centred relationships: empathetic understanding, unconditional positive regard, and genuineness. Aiken and Aiken (1973:865) then later added concreteness and self-exploration as five core dimensions of a facilitative therapeutic nurse-patient relationship which were included by the researcher for the purpose of this study.

There is an expectation that nurses and other healthcare professionals should behave in a certain way that is “to be congruent in the brief relationship with the patient by presenting unconditional positive regard and empathic understanding of the client” (Bozarth, 2001:1). These primary curative factors are promoted in the perception of patient and nurse of each other. An open and trusting relationship is established when the patient is treated as an equal human being, which consequently facilitates growth and actualisation.

The interactive nurse-patient relationship could be facilitated on any one of five levels. At a lower level of facilitation, the nurse requires basic concern and empathetic understanding for the patient’s feelings, while at the higher levels the nurse requires awareness of the patients’ deepest emotions allowing them to explore their illness and experience respect as individuals (Aiken & Aiken, 1973:865).

Nurses’ perceptions were examined in relation to these dimensions of a therapeutic relationship. These levels of facilitation that were operationalised in the research questionnaire (Appendix 1) will be discussed in chapter three.
2.3.1 Empathetic understanding as contributing dimension of a therapeutic relationship

Empathy has been studied extensively, and is a key component of a therapeutic relationship. The attention is thus focussed on unconditional acceptance of the patient’s experiences rather than only talking to him (Bozarth, 2001:11). Empathy exists when the nurse, to some extent, experiences what life is like for the patient as if she is looking through his eyes - her ability to put herself in his shoes. With empathetic understanding, the nurse communicates that she understands what the patient is actually saying, and shows a willingness to listen. According to Rogers’s theory (1975), empathy is also a way of thinking with the patient and not for or about him. By allowing the patient to express his feelings and deeper emotions, the nurse needs to put herself aside and enter into the world of the patient.

There are barriers to empathetic understanding: language, biological factors, socio-economic factors, and cultural factors can affect how some people perceive others (Dolan & Fullham, 2004:1093-1102; Blair, Mitchell & Blair, 2005:81). Nurses should overcome these barriers and learn to reflect on messages from the patient.

2.3.2 Unconditional positive regard as contributing dimension of a therapeutic relationship

Unconditional positive regard was reconsidered by Wilkens (2000:24), who wrote that this condition implies unqualified respect for one another. Concern for the patients as individuals allows them to express their own feelings, irrespective of how painful, defensive or pleasurable those feelings might be.

Wilkens (2000:26) distinguished between three types of positive regard:

1) **Conditional positive regard**, where warmth, respect and acceptance are only offered when the other person fulfils some particular expectation, requirement, or as a reward.

2) **Unconditional negative regard** is the root of racism, homophobia and sexism and may be experienced at an unconscious level. One person conveys the message that the other will be hated or denigrated, no matter what is said or done.
3) **Conditional positive disregard**, or denying a person’s rights, occurs when one person refuses to enter into a relationship of any kind with another (2000:26).

Each of these conditions amounts to the withholding of love or care, and the absence of **unconditional positive regard** is therefore seen as harmful (Wilkens, 2000:26) particularly in a healthcare context. The need for self-regard may also be culturally variant because the constructions *self* and *regard* themselves differ across cultures (Heine, Lehman, Markus, & Kitayama, 1999:766).

### 2.3.3 Genuineness as a contributing dimension of a therapeutic relationship

Genuineness can be seen as a basic attitude of openness towards one’s self and others. A genuine and authentic response can be communicated when a nurse has the ability to identify differences and similarities between the facial expressions and behaviour of the patient. At the same time, for patients to be able to trust a nurse they should be able to relate to what the nurses say. A constructive honest and congruent response from the nurse enables the patient to manage uncertainty and make decisions about his challenges (Epstein & Street, 2007:17).

When there is incongruence between a person’s self-concept and what he experiences in a relationship with another, the person is in a state of ‘vulnerability’ and experiences a degree of anxiety (Wilkens, 2000:27). Responses used by a nurse which are perceived by a patient as being consistent with his own self-concept are therefore more likely to be heard and internalised. Messages which are inconsistent and incompatible with nurses’ self-image may prevent a trusting nurse-patient relationship from developing. A person’s beliefs about himself and the world, as well as spiritual and moral-ethical conduct, are closely linked to genuineness (LaSala, 2009:423).

A non-genuine response at a minimal level could, according to Aiken and Aiken (1973:863), be destructive and negative. At a higher, reflective level of facilitation, genuineness allows the nurse to be open to all experiences both pleasant and hurtful. Nurses often have a great need to be “nice” to patients even when they do not feel like being nice in response to a patient’s behaviour; but sadly, patients do become aware of the incongruence between verbal and non-verbal communication which affects the way they
perceive one another. An honest and sincere smile from the nurse, while showing genuine pleasure in being with the patient, builds trust in the relationship and has a healing effect.

2.3.4 Concreteness as a dimension and reality in a therapeutic relationship

Most patients seek compassionate feedback and expect understanding of their situation and life experiences. Arnold and Boggs (2011:191) consider that the timing of the feedback is of importance. Vague and abstract feedback hinders communication. Whether or not feedback is appropriate depends on the answer to the question: “Does the feedback advance the goals of the relationship?” To meet this requirement the patient needs an opportunity to reflect, ask questions and clarify his understanding of a message in a trusting relationship. It was noted in a study done by McEnhill (2008:157-164) that only one person, from a sample of 12 people with mild intellectual disabilities, had received and understood the bad news given by a doctor about his own terminal cancer.

Nurses are primarily responsible for breaking the bad news to patients. In avoiding ‘bad news’ the use of ‘they say’ messages or using unfamiliar terminology can develop anxiety and fear in the patient, which further hinders communication and healing. Reed and Fitzgerald (2005:251) also found that nurses working in general hospitals believed that their lack of knowledge and fear of saying the wrong thing resulted in limited care for patients with mental health challenges.

Concreteness in a discussion is experienced as specific, accurate information, and can help the patient to focus on the problems at hand. Responses at a lower level are vague and abstract in relation to personally relevant material (Aiken & Aiken, 1973). In this study, nurses’ perceptions of responses that either facilitate or hinder feedback of information were explored.

2.3.5 A dimension of awareness and self-exploration in a therapeutic relationship

Nurses and patients require self-awareness of their personal prejudices and stereotypes in relation to each other (Arnold & Boggs, 2011:178). Patients are able to explore and share personally relevant information or feelings only when they feel understood, respected and accepted. The ability to share these feelings is therapeutic and healing for the patient and
sometimes even the nurse can benefit, depending on the nurse’s self-concept and therapeutic use of communication skills and herself as a person.

For nurses, however, self-concept usually reflects their personal worldview – the way they see themselves and the world of nursing. It includes the physical, cognitive, emotional and spiritual aspects, and a philosophy that provides a broad and global explanation of the world. Everyone’s world and personal perceptions are influenced primarily by this philosophy and only then by knowledge and experiences (Burns & Grove, 2005:12). A healthy self-concept reflects attitudes, emotions and values that are consistent with a meaningful purpose in life. In self-exploration the nurse allows or encourages the patient to make discoveries about his feelings and his world that enable him to disclose personally relevant material (Aiken & Aiken, 1973:865).

The dimensions of a therapeutic relationship namely, empathetic understanding, unconditional positive regard, genuineness, concreteness and self-exploration, are interlinked. This wholistic understanding formulates the basis for the desired nurse-patient relationship in the context of this study (Figure 2.1).

2.4 PERSONAL ATTRIBUTES THAT INFLUENCE FACILITATION OF A NURSE-PATIENT RELATIONSHIP

Not only are the dimensions of a nurse-patient therapeutic relationship interlinked, but many factors could have an influence on the facilitation of a relationship and the environment of private general hospitals.

The nurse-patient relationship is theory guided (Arnold & Boggs, 2011:17) and therefore nurses need the necessary knowledge, skills and attitude to be competent in effective communication (Boyatzis, 1982:102; McLagan, 1996:65). All these aspects are embedded in a relationship and there should be a link between the competency level in healthcare and the actual performance of these skills in practice.
2.4.1 Self-awareness and perceptions of each other in a therapeutic relationship

Negative attitudes towards patients with mental health challenges and their environment could affect nurses’ perceptions of themselves, their social life, and cause physical exhaustion, and emotions of fear, guilt and despair. Such negative self-perceptions and despair amongst registered nurses working in general wards were highlighted by several studies from Australia (Reed & Fitzgerald, 2005:254), United Kingdom (Harrison & Zohhadi, 2005:473), America (Hanrahan & Aiken 2008:215) and South Africa (Mavundla, 2000:1574). Organisational problems and quality care issues caused psychiatric nurses, for example, to develop a negative attitude to their work environment when caring for people with mental health challenges.

A primary curative factor in healthcare is promoted in the perceptions of the caregiver and recipient of each other (Bozarth, 2001:1), in other words, the ability to see, hear or become aware of something through the senses. How people perceive each other is closely related to attitude. In their study, Schwartz, Chambliss, Brownell, Blair and Billington (2003:1033) found that professionals were much quicker to stereotype and pair, for example, “fat” with “lazy”, and other negative traits. People interpret stimuli or characteristics into something meaningful to them based on prior experiences even if this perception substantially differs from reality (Pickens, 2005:11).

Attitude refers to the mental approach a nurse uses; the perception or opinion she holds towards patients, hospitalisation, caring, colleagues, life and death; a mindset and a tendency to act in a particular way due to both her individual experience and temperament (Pickens, 2005:11). Vulnerable patients may feel stigmatised by the choice of words used by nurses and care workers who have a negative approach or attitude towards their mental health challenges.

Although the expectation is that nurses treat all patients equally and with positive regard, non-verbal communication, such as facial expressions and body language, can expose negative thoughts and attitudes to patients. Patients experience these incongruent verbal and non-verbal reactions as threatening and not genuine, and often delay medical care and treatment for their mental health needs because of stigmatising attitudes displayed by healthcare professionals (Andrews, Henderson & Hall, 2001:145).
2.4.2 Training and experience

A lack of skills, knowledge and inadequate access to training and supervision amongst nurses working in general wards were identified by Harrison and Zohhadi (2005:476) and Mavundla (2000:1574). In South Africa nursing education is controlled by the South African Nursing Council (SANC), and all categories of professional and sub professional nurses are registered or enrolled with SANC. The council is required to ensure minimum standards of nursing education and the practice of nurses to safeguard care of all patients. The following are descriptions of training and qualification requirements for nurses:

- A four-year degree or diploma from one of the institutions approved by SANC is necessary to become a registered professional nurse (RN). The RN is responsible for the scientific nursing process by assessing the patients’ condition; planning and implementing care; keeping legal records thereof and continuously evaluating the outcomes as part of a professional team. The four-year degree or diploma course includes a qualification in psychiatric nursing and midwifery. Most professional nurses in South Africa are thus also registered psychiatric nurses.

- To qualify as an enrolled staff nurse (EN), a two-year certificate is required. Staff nurses work under the supervision of a professional nurse and assist in the execution of the nursing care plan. The EN assists with admissions, pre- and post-operative care, wound care, handling of medication and promoting health. The enrolled nurse is allowed to do a bridging course that will qualify her as a registered nurse (RN).

- An enrolled auxiliary nurse (ENA) has a one-year certificate and is responsible for care as initiated by the registered nurse, and spends most of the time performing allocated tasks such as vital observations, admissions, pre- and post-operative and basic nursing care. The entry requirement for enrolled nurses and auxiliary nurses is Grade 10.

- Care worker: A number of institutions also offer three- to six-month courses in home-based care for healthcare workers. Due to the increasing non-availability of nurses in South Africa, the demand outnumbers the supply and therefore these care workers are employed in private hospitals to assist with elementary care, and
clerical tasks in the ward. They are, however, performing mainly bedside activities and inevitably have to communicate with patients on an emotional level.

Legally, registered nurses, according to the South African Nursing Council regulations and the Nursing Act (No. 33 of 2005) remain accountable for all nursing care given to patients in the hospital. The Nursing Act further makes provision for education, training, research, registration and practice of nurses. A professional nurse (unit manager) manages a unit, while a nursing services manager is responsible for managing the nursing function of the facility.

2.5 FACTORS THAT INFLUENCE FACILITATION OF A RELATIONSHIP IN PRIVATE GENERAL HOSPITALS

A supportive therapeutic environment is naturally a critical component in facilitating a therapeutic relationship. The therapeutic environment in psychiatric designated units is geared towards the mental health needs of the patients and a qualified, multi-disciplinary team is supportive of the mental health nurse.

In contrast, private general hospitals in Gauteng, South Africa also admit patients with mental health disorders in general wards. The therapeutic environment in those hospitals and wards is influenced by various factors that may support or limit the facilitation of a therapeutic relationship, and will be discussed in the following paragraphs.

2.5.1 Mental Health Care Act No. 17 of 2002

In terms of the Mental Health Care Act (No. 17 of 2002), it is possible for provincial health departments to designate any hospital with adequate facilities to admit involuntary mental health care users for 72-hour assessments in South Africa.

The implications of this clause have drastically changed the profile of patients being admitted to private general hospitals. Inpatient units serve as environments for addressing crises that cannot be handled in community settings, such as that of posing a danger to one’s self or others. Consequently, present-day inpatients are often suicidal, homicidal, or
unresponsive to many treatment modalities (Benson, Secker, Balfe, Lipsedge, Robinson & Walker, 2003:920). In South Africa, drug abuse, alcohol use, domestic and public violence, suicide attempts and the prevalence of HIV/AIDS pose major management problems for private general hospitals with constrained resources. In addition, a diagnosis of mental illness itself could have an effect on how patients perceive a relationship with a nurse (Bjorngaard, Ruud & Friis, 2007:804).

2.5.2 A Changing patient profile

With increasing admissions of people with mental health challenges into private general hospitals, the burden of care is aggravated by not only the diagnosis and case mix, but worsened also when the primary and secondary diagnosis or co-morbidities are not always clearly defined. Contrary to the popular opinion that psychiatric patients may be less ill than other patients, previous studies have demonstrated that they experience the same kind of adverse patient outcomes that have been a source of concern in medical-surgical patients (Hanrahan & Aiken, 2008:210-217).

Research indicates that three-to-five adults per 1000 will experience depression annually, whilst more than 15% of the population will suffer from depression and co-morbidities at some point (Murphy, Laird, Monson, Sobol & Leighton, 2000:505). Furthermore, children and adults are equally prone to emotional distress in hospitals. Delusional memories and hallucinations were five times more common among children who had been in intensive care or had been on common sedatives for more than two days, which raised their risk of post-traumatic stress symptoms (Colville, 2008:7).

As far as therapeutic communication and nursing is concerned, knowing the diagnosis and co-existing symptoms of mental health disorders is vital in understanding the patient’s behaviour and frame of reference. The primary diagnosis, co-morbidities and mental illness are often blurred in patients with other medical conditions, for example, a patient who has HIV/AIDS can present with confusion. Patients with cardiovascular disease or diabetes could be depressed and anxious, and a mother who has given birth in the maternity ward may develop post-natal depression or psychosis (Owe-Larsson, Såll, Salamon & Allgulander, 2008:119; Vythilingum, 2009:450).
2.5.3 Shortage of competent staff

There is a shortage of professional nurses, and specifically trained psychiatric nurses, in South Africa (Weltman, 2008:7). A common cost-containment strategy, consequently, in the private healthcare field, is to hire unlicensed personnel to staff inpatient units who then provide direct patient care previously done by registered nurses. Nurses who participated in a survey (Hanrahan & Aiken, 2008:215) agreed that the quality of hospital care had deteriorated since the hiring of unlicensed personnel.

The trend to replace registered nurses with less educated and less experienced, unlicensed staff needs careful consideration, because inpatient psychiatric care is human resource intensive and, therefore, expensive. Hanrahan and Aiken, (2008:215) suggest that administrators must carefully consider the best staff mix of professional and support staff to care for acutely mentally ill persons admitted to inpatient units.

Better nurse staffing and higher education levels of nurses reduce poor patient outcomes in highly vulnerable patients with serious mental illness when compared to surgical patients without mental health challenges (Kutney-Lee & Aiken, 2008:1467). The strategic policy in South Africa to admit psychiatric patients in general hospitals further challenges the skills mix and competencies of nurses who are working with medical, surgical and mental health challenges.

No specific evidence could be found of studies done in South African private general hospitals on the skills of mental health nurses, but other studies found that, due to the task environment and the particular skills mix in private hospitals, mental health care of patients was often delegated to sub-professional staff. Reed and Fritzgerald (2005:251) observed that sub-professional staff always played a key role in the provision of direct nursing care to patients. McDonald, Frakes, Apostolidis, Armstrong, Goldblatt and Bernardo (2003:226) supported these findings and found that nurses who provided care for patients with a psychiatric diagnosis delegated more patient care activities to auxiliary staff, who might lack the requisite experience and necessary training.

According to studies by Dor, Ehlers and Van der Merwe (2002:103) and Mavundla (2000:1574), healthcare workers in general practice have a poor concept of and very little
knowledge of how patients with mental health challenges should be managed. The researcher expects, therefore, that improving understanding of the patient’s needs through additional training or education would improve the relationship with patients, and could consequently lead to a better overall healthcare offering.

2.5.4 Structural factors detracting from a therapeutic environment

The operational parameters of private general hospitals are set by a range of non-therapeutic considerations. The focus of care is on the medical and curative model of healing and task allocation. Basic care is rendered mainly by sub-professional nurses, supervised by professional nurses.

In South Africa, such a non-therapeutic environment in private general hospitals is influenced by financial constraints that directly and indirectly have an effect on the quality of the nurse-patient relationship. Medical aids play a major role, and funding for patients with mental health disorders is limited in comparison with other medical and surgical authorisations.

2.6 SUMMARY

In this chapter, the conceptual framework was discussed and the literature was examined in relation to the dimensions of a therapeutic relationship. Factors which could have a direct or indirect effect on the facilitation of a therapeutic relationship in the context of private general hospitals were explored. In the next chapter the researcher will discuss the research design employed to examine nurses’ perceptions of facilitating a therapeutic relationship in private general hospitals in Gauteng, South Africa.
CHAPTER 3 RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The problem identified by the researcher while working in a private general hospital was that patients expressed unhappiness as a result of interactions with nurses. Some nurses viewed these interactions as inadvertent ‘misunderstandings’ of each other (paragraph 1.3). From the literature review in chapter two it is evident that the quality of nurses’ interactions with patients is crucial in a therapeutic relationship. This chapter explains the research design and methodology employed to assess nurses’ perceptions of facilitating such a therapeutic relationship. The research instrument which was used to collect the data is described in detail. The research instrument, the sampling method, ethical principles that guided the data collection and validity and reliability are also discussed.

3.2 RESEARCH METHODOLOGY

In this study a quantitative, contextual and deductive design was used. A quantitative research design is an objective and systematic process that lends itself to precise measurement and quantification of data, as well as to describe relationships between variables (Burns & Grove, 2005:346; Polit & Beck 2008:763).

The design was appropriate as it allowed the analysis of numerical data obtained from a rating scale. The researcher proposed to investigate and describe nurses’ perceptions of the levels (as described in paragraph 3.7) of their facilitation of a therapeutic relationship in a private general hospital.

A descriptive and inferential approach was followed. Quantitative approaches are said to use deductive methods, often testing hypotheses and deducing the results by using inferential tests (Watson, Mckenna, Cowman & Keady, 2008:16). A descriptive approach was used to portray accurately the characteristics of nurses or groups of nurses, while inferential statistics were utilised to make inferences on whether results observed in a sample were likely to occur in the larger population of nurses in private general hospitals.
(Polit & Beck, 2008:752). However, it is important to bear in mind that the sample was a purposive sample. This will restrict direct transferability of the findings to the population.

During statistical analysis the data obtained were used to describe nurses’ perceptions of facilitation of a therapeutic relationship. Based on the objectives of the study the following univariate hypothesis was tested:

Ho (null hypothesis): There is no statistically significant difference between specific groups of nurses’ perceptions of the levels of facilitation of a therapeutic relationship.

Ha (alternative hypothesis): There is a statistically significant difference between specific groups of nurses’ perceptions of the level of facilitation of a therapeutic relationship.

To enable the researcher to provide recommendations for practice and training of nurses, a number of statistical tests were used to compare and describe differences between various categories of nurses’ perceptions of facilitating a therapeutic relationship. Sub groups were compared with regard to the characteristics of a therapeutic relationship; empathy, positive regard, genuineness, concreteness and self-exploration. The possible differences between nurses’ perceptions are discussed in relation to the averages obtained on the specific aspects.

3.3 RESEARCH INSTRUMENT

A questionnaire was constructed to examine nurses’ perceptions in relation to the facilitation of a therapeutic relationship as described in the conceptual framework of the study. Existing instruments could not be used in this study as they were not applicable to nurses, but to other health professionals. (Cole & McLean, 2003:38; Hojat, Gonnella, Mangione, Nasca, Veloski, Erdmann, Callahan & Magee, 2002:523).

The questionnaire developed for this study (Appendix 1) consisted of two parts. Part A of the questionnaire consisted of five questions regarding biographical data: gender, age, nursing qualifications, years’ experience as a nurse and interpersonal skills training
courses attended. Part B of the questionnaire comprised scenarios and proposed responses to a patient’s question or concern, based on the dimensions empathy, positive regard, genuineness, concreteness and self-exploration of a therapeutic relationship. Facilitation of a therapeutic relationship, according to Aiken and Aiken (1973), varies with respect to the level on which the nurse-patient interaction occurs and will further be discussed in the next sections.

3.3.1 Part A of the questionnaire: Biographical data

In part A of the questionnaire the following independent variables of the population under investigation were identified: gender, age, years of experience, qualifications and interpersonal skills training courses attended. It was expected to identify whether those attributes played a role in how nurses perceive a therapeutic relationship.

3.3.1.1 Question one: Gender

Gender differences have been reported in relation to qualities that can contribute to better empathetic understanding (Hojat et al., 2002:523), where women performed better than men on emotional intelligence scales. The healthcare profession is thus more attractive to women (Wilson & Eagles, 2006:321). Despite attempts to attract male nurses to the profession and to increase the number to be trained, few male nurses are entering this still dominantly female profession in South Africa’s geographical distribution (South African Nursing Council, 2010).

3.3.1.2 Question two: Age in completed years

Life experience contributes to an appreciation of the therapeutic aspects of a relationship (Scanlon, 2006:319) while Hunter (2008:318) suggests “as one ages, the self develops and becomes a more unique entity formed by personal experiences and personally developed values and beliefs”. Some nurses enter the profession directly from school at a young age, while others choose to become a nurse at a later stage in their lives. The question was included to identify if age influenced how nurses perceived a therapeutic relationship.

3.3.1.3 Question three: Number of years’ experience as a nurse

Nurses gain clinical experience during and after their academic training. Some nurses start working as auxiliary nurses and then register to study further from within the hospital and
affiliated colleges. Knowledge and skills gained by attending lectures are applied to nursing practice in a clinical setting, and can be perfected with years’ experience under professional guidance and supervision. Cole and McLean (2003:47) suggested that with more experience occupational therapists become more efficient in their use of skills in developing therapeutic relationships. The number of years’ experience could play a role in the way nurses perceive a therapeutic relationship.

3.3.1.4 Question four: Professional qualifications

Nursing qualifications and training requirements were discussed for registered nurses (RN), enrolled nurses (EN), auxiliary nurses (ENA) and care workers (CW). Incidences of misunderstanding raised in paragraph 1.3 involved nurses from all categories, irrespective of their qualifications. Kutney-Lee and Aiken (2008:1467) found that higher education levels for nurses reduced poor patient outcomes in highly vulnerable patients. The researcher, therefore, expected that a qualified and registered nurse (RN), with or without a psychiatric qualification, had the relevant professional training and was competent in facilitating a relationship.

3.3.1.5 Question five: Interpersonal skills training courses attended

Communication and interpersonal skills form an essential part of nursing and other healthcare professions. The results of a study done by Scanlon (2006:319) indicate that the process of developing therapeutic relationships is a combination of learned experience through the acquiring of interpersonal skills and retaining those skills in practice over time. Scanlon shows that these skills become redundant if the individual has not acquired sufficient life experience to appreciate intuitively the therapeutic aspect of the relationship.

The fifth question therefore examined whether nurse participants had previous interpersonal skills training and how their perceptions of a therapeutic relationship were influenced by the training courses they attended.

The above independent variables were assessed by nurse participants in the empirical investigation and used as different variables. The dimensions of a therapeutic relationship were used as dependent variables.
3.3.2 Part B of the questionnaire: Levels of facilitating a therapeutic Relationship

Part B of the questionnaire (Appendix 1B) assessed the dimensions of a therapeutic relationship and the level of facilitation thereof.

Carl Rogers (1957:96) argues that constructive interpersonal relationships between two persons will be possible during short-term encounters if warm concern and empathy is developed. The level on which these encounters occur in a therapeutic relationship is described by Aiken and Aiken (1973:866) as the extent to which a response facilitates reflection, or distracts from what the patient is actually experiencing or saying. In part B of the questionnaire each of the levels was measured against a characteristic of a therapeutic relationship.

The levels of facilitation were operationalised in the questionnaire by means of responses to patients as described in interactive scenarios related to the characteristics of a therapeutic relationship (Appendix 1B). The levels range from lack of concern for the patients’ feelings, superficial responses, average responses, responses that add deeper meaning to what the patient is saying, and to a level of facilitation where the nurse reflects at the deepest level on the patients’ feelings. On this level the nurse and the patient have full awareness of themselves as individuals and each other (Aiken & Aiken 1973:866).

For each concept of a therapeutic relationship a scenario was used to examine a nurse-patient interaction on various levels of facilitation. The scenarios included fictitious names and diagnoses of patients, but also reflected the reality of everyday nursing life in a private general hospital as experienced by the researcher. The various levels of facilitation as identified by Aiken and Aiken (1973) formed the basis for the responses in five scenarios. Part B of the questionnaire was constructed as follows.

3.3.2.1 Empathetic understanding as a dimension of a therapeutic relationship

The extent to which a response was experienced as empathetic understanding was explored. The participating nurse was requested to assess the likelihood of using each response on a scale of 1 “not at all” to 5 “to a large extent”.

Scenario one: Mr Tim repeats the same question many times: “When does the doctor come to see me? I need to go home before 5 pm.”
1.1 Level I: Lack of concern: No concern for the patient’s feelings and insensitive way of communicating: “Please do not ask me that again – he will come sometime today, he is a busy man.”

1.2 Level II: Superficial response: Does not show emotion and does not answer the patient’s question: “I have told you before that I do not know; we have also been waiting for him all day.”

1.3 Level III: Average response: Basic concern and willing to interact but does not hinder or facilitate a relationship: “As I explained before, Sir, I do not know, but is there something I can do for you while you wait?”

1.4 Level IV: Response adds deeper meaning to the patient’s expression of feelings: “You wanted to see the doctor Mr Tim, and the traffic is getting worse later – shall I phone him?”

1.5 Level V: Reflective facilitation of feelings: Full awareness and empathetic understanding that allows the patient to express his deepest emotions: “You seem anxious about not knowing when he will discharge you; I will remind the doctor, Mr Tim.”

3.3.2.2 Positive regard as a dimension of a therapeutic relationship
This scenario examined positive regard and the extent to which the patient is perceived and respected as an individual.

Scenario two: The patient is in a busy 6 bed ward and has a urinary catheter as well as ECG leads connected to his bare chest. He says: “It hurts ‘down there’ but I do not want the ‘whole world’ to look at me again.”

2.1 Level I: Lack of concern: Total lack of concern and understanding for the patient’s privacy: “The whole world will not see it; only the staff in ICU and they have seen everything by now.”
2.2 Level II: Superficial response: Communicates superficial concern and disrespect of the patient as an individual: “If you have a problem with us Madala, I will ask the doctor to have a look, he is also a man.”

2.3 Level III: Average response: Shows basic concern and regard for the patient’s overt need for privacy: “Don’t worry Sir; I will make sure that the curtain is drawn when we check it out.”

2.4 Level IV: Response adds deeper meaning: Deeper respect for the patient is expressed: “I apologise for being insensitive Sir, what can we do to make you feel less exposed?”

2.5 Level V: Reflective facilitation of feelings: Communication which expresses the very deepest respect for the patient’s worth as a person: “You sound upset about being treated in a disrespectful way Mr Dube; you would feel less exposed if we cover you appropriately.”

3.3.2.3 Genuineness as a dimension of a therapeutic relationship
Honesty and genuine responses to a patient were assessed in the third scenario.

Scenario three: A bed-ridden woman in despair asks of you: “Will I ever go home and be able to walk again?”

3.1 Level I: Lack of concern: Response is unrelated, negative and with destructive effects: “Many people like you have walked again; you can also do that with a bit of effort.”

3.2 Level II: Superficial response: Does not form the basis of a relationship: “Of course you will, as long as you work harder with the physiotherapist and the nurses.”

3.3 Level III: Average response: No positive or negative cues to indicate a genuine response to the patient’s feelings: “It is difficult to say in your situation Mum but you need to stay focused and do not lose hope.”
3.4 Level IV: Response adds deeper meaning: Demonstrates genuine concern and understanding: “It seems impossible at this stage, what do you and your family think about your progress?”

3.5 Level V: Reflective facilitation of feelings: Response is spontaneous and open to all experiences both pleasant and hurtful: “I hear how difficult is for you to be hopeful Mrs French when you do not see improvement; it seems to be a slow process.”

3.3.2.4 Concreteness as a dimension of a therapeutic relationship
Expression of concreteness in feedback to the patient was explored.

Scenario four: The patient expresses concern about her sudden reaction to chemotherapy: “Why am I feeling so sweaty and hot today after the chemotherapy?”

4.1 Level I: Lack of concern: Response to the patient is vague and anonymous: “Do not worry; it will settle down; there is medication prescribed for you. The sister keeps the keys.”

4.2 Level II: Superficial response: Conversation is vague and abstract in relation to personally relevant material: “People feel like that sometimes after chemotherapy – we see it all the time; they do not always need medication for it.”

4.3 Level III: Average response: Neither hinders nor facilitates clear communication: “Your temperature rose in reaction to the treatment; I will bring your medication and check your temperature again later.”

4.4 Level IV: Response adds deeper meaning: Enables the patient to express concerns in specific and concrete terminology: “You did not react by having a temperature the previous times my dear, would you like me to phone the doctor rather?”

4.5 Level V: Reflective facilitation of feelings: Enables the patient to express concerns in concrete and specific terms that indicate reflection, touch and awareness: “You sound anxious about this reaction to the treatment and your face does feel warm. Why is it different for you today Mrs Polly?”
3.3.2.5 Self-exploration as a dimension of a therapeutic relationship

Facilitation of self-exploration of the patient by means of therapeutic relationship was explored.

Scenario five: “My wife will be ok while I am in hospital; after all, my best friend is looking after her because she does not drive, you know?”

5.1 Level I: Lack of concern: Response does not allow the patient to disclose personally relevant feelings but rather discourages interaction: “It is good to have someone else to look after her; at least you do not have to worry about her.”

5.2 Level II: Superficial response: Nurse responds without affect and does not allow the patient to enter into a discussion: “Most people are not so fortunate to have friends who are willing to help them; many patients have that problem.”

5.3 Level III: Average response: Allows the patient to voluntarily disclose some personal feelings: “Your wife seems to rely on you to get around; being in hospital for such a long time is difficult for her also.”

5.4 Level IV: Response adds deeper meaning: Allows the patient to disclose his feelings: “It is frustrating to depend on others to do what you usually do Sir, but it is also kind of your friend to help her.”

5.5 Level V: Reflective facilitation of feelings: Response allows the patient to make discoveries about his feelings and his world: “You sound relieved about the support from your friend, and also worried and disappointed that you are not there for her.”

3.3.3 Rating scale

Participants were asked to rate each of the responses on a scale with the objective of assessing their perception of facilitating a therapeutic relationship. Self-assessment was used for practical reasons and because nurses should know themselves and the situation best. The rating scale ranged from “not at all” (marked as 1) to “to a large extent” (marked as 5). A total of 25 response items were assessed (five levels x five scenarios, see Appendix 1).
The data obtained from the questionnaire were then quantified and described. If the nurse marked number five on the scale, she perceived the response as being used “to a large extent”. On the other hand, if she marked number one on the scale, it indicated that she perceived the response to be used “not at all”.

For statistical purposes, all the responses on each of the levels of facilitation were analysed together and were labelled and presented in chapter four, as follows:

Level I response items (1.1; 2.1; 3.1; 4.1; 5.1) referred to a “lack of concern”

Level II response items (1.2; 2.2; 3.2; 4.2; 5.2) were without affect and “superficial”

Level III response items (1.3; 2.3; 3.3; 4.3; 5.3) indicated “average responses” that neither hindered nor facilitated a therapeutic relationship

Level IV response items (1.4; 12.4; 3.4; 4.4; 5.4) “added deeper meaning” to what the patient expressed

Level V response items (1.5; 2.5; 3.5; 4.5; 5.5) were “reflective of feelings” and self-exploration on the deepest level of facilitation.

3.4 VALIDITY AND RELIABILITY

In general, the concept of validity refers to the extent to which an instrument measures what it is supposed to measure (Burns & Grove, 2005:211). In the case of this study (2006:319), the focus was on content validity which was reasoned in chapter two and also paragraph 3.3.

Content validity refers to the extent to which the questions in the questionnaire and the scores obtained from the participants on the questions are representative of the possible questions that a researcher could ask about the content or dimensions being measured (Creswell, 2008:172). The content validity of the questionnaire in this study was based on the fact that the questions were formulated based on existing literature. The level of facilitation in relation to the dimensions of a therapeutic relationship was then given to participants to assess the possibility of them using the response. Each of the questions
was based on theory and formulated in view of the literature. The researcher has many years of experience and knowledge gained in the field of nursing, and content validity was further ensured by experienced specialists in the fields of nursing and educational research who examined the measuring instrument (Botes, 2005:191).

According to Polit and Beck (2004:30) threats to the internal validity of a study due to extraneous factors can invalidate the results of the research. If threats to validity are not controlled or minimised, a researcher could mistakenly attribute the differences between the compared groups (independent variables) as an effect on the dependent variable (Polit & Beck, 2004:30). Under such circumstances the differences could actually be as a result of an extraneous event, which is especially true for a purposive sample. During the planning stages of the study, factors that could have influenced internal validity were considered, and the following measures were taken:

- Selection bias was minimised by selecting nurses on all the possible shifts that they might work from all three selected hospitals. The reason for this was to enable nurses from a week day and night shift as well as weekend day and night shift to have an equal chance of being selected (Creswell, 2008:308). Further, prospective participants were invited without any prejudice or bias.

- The completion of the questionnaire by the participants was conducted over two months from August to September 2011 to accommodate historical events such as shift changes and staff returning from holidays (Creswell, 2008:308).

- To test further the research questionnaire, a pilot study was conducted with fifteen nurses from another hospital of the same hospital group before the actual study took place. This was done to enhance the understanding of the information letter and the questionnaire. The pilot study formed part of the process to ensure that the questionnaire was suitable, and to identify difficulties with data collection. It also served to check the length of time it took to complete the questionnaire and to check clarity and understanding of the statements. Ambiguous and unclear questions were identified and other issues raised were addressed. The limited time that nurses were allowed to spend away from patients, for example, and a lack of a quiet space in the ward environment to complete the questionnaires were mentioned. In an attempt to
manage such foreseen difficulties, the researcher liaised with the nursing managers and was well prepared to deal with the instrument and data collection process.

- Internal consistency was maintained by using the same version of the questionnaire for all participants (Creswell, 2008:170). The subscales on the questionnaire were designed to facilitate assessment of the self-perception of participants (Polit & Beck, 2004:418). The researcher further ensured consistency with data collection by conducting the research herself and by following the same procedures at all three selected hospitals.

A goal of scientific research is to have measures that are reliable. Reliability is the extent of consistency with which the questionnaire facilitates the assessment of the self-perceptions of nurses’ facilitation of a therapeutic relationship. The higher the reliability of a questionnaire, the lower the extent of errors in the obtained assessment scores (Polit & Beck, 2004:416). The Cronbach’s Alpha, a reliability index, was used to estimate the internal consistency of a measure composed of several subparts (Polit & Beck, 2008:751). Because of the explorative nature of the investigation, perceptions were consistently assessed, but it was expected that reliability could be low. The researcher would therefore withstand with the reasoning on content validity. In the case of this investigation no attention was given to aspects such as concurrent and constructs.

### 3.5 POPULATION AND SAMPLING

#### 3.5.1 Population

The population represented all individuals who share similar characteristics with respect to the investigation (Creswell, 2008:151). The population of nurses in this study included all the nurses working in three general hospitals of a private hospital group in Gauteng, South Africa. A preliminary enquiry from the three hospitals in February 2010 indicated that 282 nurses were employed at the time.
The three hospitals were purposively chosen because they were in one province, were of the same size and turnover. All three private general hospitals are required to admit psychiatric patients under the Mental Health Care Act (No. 17 of 2002).

3.5.2 Sampling
Sampling refers to the process of identifying and selecting a portion of the population that could be considered representative of the population, in other words, it must represent the target population as closely as possible (Burns & Grove, 2005:343). A purposive sampling method was used to obtain a large enough sample of nurses from all categories that was representative of the larger population. Purposive sampling is a non-probability technique (Burns & Grove, 2005:747) which allowed the researcher to consciously select certain participants or elements to include in the study, such as registered nurses, enrolled nurses, auxiliary nurses and care workers.

3.6 DATA COLLECTION
During the planning stages of the research, approval was obtained from the Faculty of Health Sciences Academic Ethics Committee of the University of Johannesburg. On receipt of approval from the participating hospitals' nursing managers, arrangements were made to conduct the study during August and September 2011. The following method was used to collect the data.

Data collection was done by the researcher, who followed the same procedure at all three selected hospitals. Questionnaires were completed by nurses from all shifts, for example, day and night shift on a weekday as well as weekend days.

- Nurses from all categories on duty were invited to participate in the study. Arrangements were made with the hospital management to allow all nurses from all the general wards to go to a designated private area to complete the questionnaire.

- Emergency patient care is a priority and had to be considered at all times. All nurses, therefore, could not leave a ward at the same time. Nurses working in
operation theatres and intensive care units were excluded for the purpose of this study.

- In accordance with the ethical measures described in chapter one (Dhai & McQuoid-Mason, 2011:14) nurses were given the opportunity to withdraw from participation in the research if they chose to. The procedure was explained and an opportunity was given to read the covering letter and to consider agreeing to participate. They were reassured that their names or staff numbers would not be used and that the questionnaires would be treated confidentially.

- It took the nurses 20 to 30 minutes to complete the questionnaire.

- Participants were asked to place the questionnaires in a sealed box after completion and the researcher collected the box after 2 hours.

Anonymity and lack of personal contact with the researcher were ensured in order to obtain the highest possible completion rate (Babbie & Mouton, 2001:523). The researcher, however, remained in the hospital to oversee the process and to assist management with any queries regarding the study. The process was repeated by the researcher at each hospital and on every shift. A total of 240 questionnaires were distributed.

### 3.7 DATA ANALYSIS

The data analysis phase of the research design entailed displaying and organising the raw data in such a way that the results could be used to answer the research question. After the questionnaires were returned, each one was carefully checked for obvious errors. The data were captured onto a data base by the statistical consulting team of the University of Johannesburg. Various levels of data analysis were undertaken by applying the Statistical Package for Social Science (SPSS) program to the data.

Firstly, descriptive statistics were used to generate a simple summary report using frequency analysis to describe the number of participants who answered each option in each question. The data obtained from the biographical section were used to assign potential groups, for example, age groups, groups with more or less experience as nurses,
qualification categories, and groups who had attended interpersonal skills training courses (independent variables).

For statistical purposes, all the responses on each of the levels of facilitation were analysed together and the results are presented in chapter four. The data concerning the dependent variables consisted of the self assessment of the participants on the five scenarios (paragraph 3.3). Participants were requested to mark their personal assessment from “not at all (1) to “to a large extent” (5) (see paragraph 2.3 and paragraph 3.3.3).

A variety of statistical tests were then applied to analyse the data. The Kolmogorov-Smirnov test was firstly used to determine whether two independent samples had been drawn from the same or different populations (Gaddis & Gaddis, 1990:144). No assumptions were made about the nature of the data distribution in the population of nurses sampled.

The specific hypotheses were tested to identify whether statistically significant and substantial differences existed between two or more groups’ perceptions of facilitating a therapeutic relationship. The groups of independent variables (gender, age, experience, qualifications and interpersonal skills training) were used to form the comparison groups.

Because no assumptions of a normal distribution could be made, a set of non parametric tests were used for the analysis of ordinal data or interval data. The means between two samples of possible unequally sized nurse groups (age, gender and experience) were compared with the following two-tailed tests because no direction of difference was assumed. A Student t-test was applied to investigate differences between the age groups and the groups of nurses with different years of experience.

The Mann-Whitney U test of ranks was used to test specific hypotheses of differences in perceptions between professional and sub-professional groups. Rather than using the values of observations themselves, rank tests involved ranking data from the lowest to the highest followed, by the calculation of an appropriate statistic (Gaddis & Gaddis, 1990:820; Howell, 2004:380).

The null-hypothesis is rejected or accepted by determining how probable it is that the observed results are due to chance, however, there is always a risk for error. Two types of
statistical errors can be made: rejecting a true null hypothesis or accepting a false null hypothesis (Polit & Beck, 2008:588). The risk was controlled during statistical analysis by selecting a level of significance (referred to as alpha=p) on the 5% (p=.05) and the 1% (p=.01) levels of significance. The hypothesis was rejected when the compared groups’ self assessments differed significantly as well as substantially on the 5% (p-value is less than 0.05) or 1% (p-value is less than 0.01) level of significance.

Where three groups of nurses’ self-assessments of the perceptions were compared, the Kruskal-Wallis one–way test was applied to analyse the variance by rank between three groups. Significant differences identified by the Kruskal-Wallis test were followed by the Mann-Whitney U test (with Bonferonni adjustment) to determine the difference between two pairs in the identified groups (Howell, 2004:381).

3.8 SUMMARY

In this chapter the researcher explained the research design that was selected to meet the study’s purpose and objectives appropriately. The research methodology and a description of the questionnaire used for data collection (Appendix 1) were discussed. Although the proposed statistical tests were explained in chapter three, the data analysis and description of results will be discussed in chapter four.
CHAPTER 4  DATA ANALYSIS AND DESCRIPTION OF RESULTS

4.1  INTRODUCTION

In chapter three the research design and methodology of the study were discussed. The research instrument was explained with reference to the conceptual framework of a therapeutic relationship (see chapter two). Part A of the questionnaire (Appendix 1) included biographical information, while Part B explored nurses’ perceptions of facilitation by means of responses based on the dimensions of a therapeutic relationship (empathy, positive regard, genuineness, concreteness and self-exploration). Validity, reliable as well as the sampling method and statistical tests used in the analysis of data were discussed.

In this chapter, the analysis and findings of the data are summarised and the meaning of numerical information is analysed, described and interpreted (see Figure 4.1).

Figure 4.1:  Summary of the statistical analysis
Questionnaires were distributed to 240 nurses employed by three private general hospitals in Gauteng during August and September 2011. Nurses of all categories, including care workers, were purposively sampled. Of the 240 questionnaires distributed, 200 were returned and 184 (76%) were analysed with a statistical package, SPPS-18, at the University of Johannesburg.

4.2 ANALYSIS OF BIOGRAPHICAL DATA

In the first section of the questionnaire (Appendix 1A) the biographical data was solicited with items relating to gender, age, years’ experience as a nurse, qualifications and interpersonal skill training courses attended.

4.2.1 Gender

The first item on the questionnaire determined the gender of the participants. It was found that of the 184 nurse participants, 92.4% were female (n=170) and 7.6% were male (n=14). This finding is not surprising, and is consistent with the profile stated by the Geographical Distribution (SANC, 2010) that 92% of the total population of nurses in South Africa are female. No hypothesis on the significance of differences on the perceptions between males and females was tested, because of the small number of males in the sample.

4.2.2 Age

In the second item participants were asked to state their age in completed years. The ages recorded vary between 20 and 67 years with a mean age of 38.58 years and standard deviation of 9.95 years. For the purpose of further statistical analysis, it was decided to divide the nurses into two age groups. Group (a) consisted of nurses younger than 40 years of age (n=103; 56.3%), and group (b) consisted of nurses who are 40 years and older (n=80; 43.7%).

The sample taken from three private general hospitals consisted of a larger number of nurses younger than 40 years of age (56.3%), which is contrary to the geographical
distribution (SANC, 2010), which reported that 36% of nurses in South Africa are younger than 40 years of age and 64% are 40 years and older.

### 4.2.3 Experience as a nurse

In the third item the participants were asked: “How long have you been working as a nurse?” The experience recorded varied between one and 48 years with a mean of 9 years. For statistical purposes the results were collapsed into two groups: (a) nurses who had less than 10 years’ experience (n=96; 52%), and (b) those that had 10 years’ or more experience as a nurse (n=87; 47.3%). A larger number of nurses had less than 10 years experience as a nurse (52%).

### 4.2.4 Qualifications

The fourth item explored nursing qualifications of the participants represented in the sample (Table 4.1). Four categories: Registered nurse (RN), Enrolled nurse (EN), Enrolled nurse auxiliary (ENA) and care workers (CW) are relevant to the employment profile in private general hospitals and to professional training of nurses applicable to the context of the study. Registered nurses are qualified general nurses with or without other qualifications, for example, psychiatric nursing.

#### Table 4.1: Distribution of nursing qualifications in the sample

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurse (RN)</td>
<td>62</td>
<td>33.7%</td>
</tr>
<tr>
<td>Registered Nurse with a Psychiatric Qualification</td>
<td>20</td>
<td>10.9%</td>
</tr>
<tr>
<td>Enrolled Nurse (EN)</td>
<td>40</td>
<td>21.7%</td>
</tr>
<tr>
<td>Enrolled Nurse Auxiliary (ENA)</td>
<td>32</td>
<td>17.4%</td>
</tr>
<tr>
<td>Care Worker (CW)</td>
<td>30</td>
<td>16.3%</td>
</tr>
<tr>
<td>Total</td>
<td>184</td>
<td>100%</td>
</tr>
</tbody>
</table>
For analytical purposes, the qualification categories were grouped together to form two larger groups consisting of: (a) professional nurses with or without a psychiatric qualification (n=82; 44.6%), and (b) sub-professional nurses (EN, ENA and care workers, n=102; 55.4%). Only 10.9% of the sample had a qualification in psychiatric nursing, and the larger number of the nurses in the sample was a mix of sub-professional nurses (55.4%).

4.2.5 Interpersonal skills training courses attended

In the last item of the biographical data the participants were given three options for interpersonal skills training courses attended. A basic training course was attended by 51.1% (n=92); an advanced training course was attended by 18.3% (n=33) and 30.6% (n=55) of participants had no previous interpersonal skills training. A larger proportion (69.4%) of nurses in the sample had interpersonal skills training in some form or another.

4.3 ANALYSIS OF THE THERAPEUTIC RELATIONSHIP

In the second section of the questionnaire (Appendix 1B) responses to the characteristics of the therapeutic relationship were assessed, according to the levels of facilitation described by Aiken and Aiken (1973:865). Self-assessment of the extent to which the nurses perceived each level of facilitation of a therapeutic relationship was used for the purpose of analysis of the data in this section.

4.3.1 Descriptive overview: perceptions of all nurses in the sample

The nurses’ own perceptions of their therapeutic relationship were assessed with respect to empathy, positive regard, genuineness, concreteness and self-exploration (paragraph 3.2). The basis for self-assessment of the levels of facilitation as well as the dimensions of a therapeutic relationship was given in chapter three. For statistical purposes all the response items on each level of facilitation were analysed together:

Level I response items (1.1; 2.1; 3.1; 4.1; 5.1) “lack of concern”
Level II response items (1.2; 2.2; 3.2; 4.2; 5.2) “superficial responses”

Level III response items (1.3; 2.3; 3.3; 4.3; 5.3) “average responses”

Level IV response items (1.4; 12.4; 3.4; 4.4; 5.4) “adds deeper meaning”

Level V response items (1.5; 2.5; 3.5; 4.5; 5.5) “reflective facilitation of feelings”.

Reliability was not investigated in depth in this study. This was due to a number of challenges. Firstly, there were five scenarios, each with a different focus. This made the logic of applying a Cronbach alpha, for example, difficult as five different aspects need to be investigated. Further, the explorative nature of this study also acted against such an investigation. Nevertheless, Cronbach alpha coefficients were calculated for all the five items (5) on a specific level. Concerning a lack of concern (Level I), the Cronbach alpha was 0.688; on a superficial level (Level II) it was 0.673; on an average level (Level III), 0.571; the level that adds deeper meaning (Level 1V), 0.591, and concerning a level reflective of feelings (Level V), the Cronbach alpha was 0.695. It was expected that the Cronbach alpha values would be low because of the few items in each level (only 5). Nevertheless, these findings are promising. However, in view of the explorative nature of the investigation further discussion of this will not be done. It is recommended that this aspect should be further researched.

The frequencies and distribution of the ratings on the 25 response items (5x5) to the facilitation of a therapeutic relationship for each level is presented in Table 4.2 (n=sample size; $\bar{x}$=mean/average; SD=standard deviation). The total mean scores obtained by all the participating nurses (n=184) per level of facilitation vary between $\bar{x} = 2.35$ (lack of concern) and $\bar{x} = 3.63$ (average response) on a scale of 1 “not at all” to 5 “to a large extent” (see Table 4.2). The highest mean scores were recorded on the average level of facilitation. Responses on the average level are therefore rated “to a larger extent” by most nurses on a scale of 1 to 5 (item 1.3 $\bar{x} = 3.59$, item 2.3 $\bar{x} = 4.26$, item 3.3 $\bar{x} = 3.36$ and item 4.3 $\bar{x} = 3.92$). This is an indication that most nurses’ perceptions were at a level that neither facilitated nor hindered a therapeutic relationship.
Table 4.2: Summary of response rating of all nurse participants

<table>
<thead>
<tr>
<th>Item</th>
<th>Response</th>
<th>n</th>
<th></th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Please do not ask me that again – he will come sometime today, he is a busy man</td>
<td>183</td>
<td>1.53</td>
<td>1.12</td>
</tr>
<tr>
<td>2.1</td>
<td>The whole world will not see it; only the staff in ICU and they have seen everything by now</td>
<td>182</td>
<td>1.85</td>
<td>1.31</td>
</tr>
<tr>
<td>3.1</td>
<td>Many people like you have walked again; you can also do that with a bit of effort</td>
<td>181</td>
<td>2.70</td>
<td>1.52</td>
</tr>
<tr>
<td>4.1</td>
<td>Do not worry; it will settle down; there is medication prescribed for you. The sister keeps the keys</td>
<td>180</td>
<td>2.36</td>
<td>1.54</td>
</tr>
<tr>
<td>5.1</td>
<td>It is good to have someone else to look after her; at least you do not have to worry about her</td>
<td>181</td>
<td>3.35</td>
<td>1.52</td>
</tr>
<tr>
<td></td>
<td><strong>Total lack of concern responses (Level I)</strong></td>
<td>183</td>
<td>2.35</td>
<td>0.94</td>
</tr>
<tr>
<td>1.2</td>
<td>I have told you before that I do not know; we have also been waiting for him all day</td>
<td>183</td>
<td>1.74</td>
<td>1.18</td>
</tr>
<tr>
<td>2.2</td>
<td>If you have a problem with us Madala, I will ask the doctor to have a look, he is also a man</td>
<td>183</td>
<td>2.02</td>
<td>1.46</td>
</tr>
<tr>
<td>3.2</td>
<td>Of course you will, as long as you work harder with the physiotherapist and the nurses</td>
<td>182</td>
<td>3.24</td>
<td>1.51</td>
</tr>
<tr>
<td>4.2</td>
<td>People feel like that sometimes after chemotherapy – we see it all the time; they do not always need medication for it</td>
<td>180</td>
<td>2.18</td>
<td>1.34</td>
</tr>
<tr>
<td>5.2</td>
<td>Most people are not so fortunate to have friends who are willing to help them; many patients have that problem</td>
<td>181</td>
<td>2.76</td>
<td>1.48</td>
</tr>
<tr>
<td></td>
<td><strong>Total of superficial responses (Level II)</strong></td>
<td>183</td>
<td>2.38</td>
<td>0.92</td>
</tr>
<tr>
<td>1.3</td>
<td>As I explained before, Sir, I do not know, but is there something I can do for you while you wait?</td>
<td>183</td>
<td>3.59</td>
<td>1.42</td>
</tr>
<tr>
<td>2.3</td>
<td>Don't worry Sir; I will make sure that the curtain is drawn when we check it out</td>
<td>184</td>
<td>4.26</td>
<td>1.17</td>
</tr>
<tr>
<td>3.3</td>
<td>It is difficult to say in your situation Mum but you need to stay focused and do not lose hope</td>
<td>181</td>
<td>3.63</td>
<td>1.43</td>
</tr>
<tr>
<td>4.3</td>
<td>Your temperature rose in reaction to the treatment; I will bring your medication and check your temperature again later</td>
<td>180</td>
<td>3.92</td>
<td>1.33</td>
</tr>
<tr>
<td>Item</td>
<td>Response</td>
<td>n</td>
<td>$\bar{x}$</td>
<td>Std. Dev.</td>
</tr>
<tr>
<td>------</td>
<td>---------------------------------------------------------------------------</td>
<td>-----</td>
<td>-----------</td>
<td>-----------</td>
</tr>
<tr>
<td>5.3</td>
<td>Your wife seems to rely on you to get around; being in hospital for such a long time is difficult for her also</td>
<td>180</td>
<td>2.73</td>
<td>1.52</td>
</tr>
<tr>
<td></td>
<td><strong>Total of average responses (Level III)</strong></td>
<td><strong>184</strong></td>
<td><strong>3.63</strong></td>
<td><strong>0.83</strong></td>
</tr>
<tr>
<td>1.4</td>
<td>You wanted to see the doctor Mr. Tim and the traffic is getting worse later – shall I phone him?</td>
<td>182</td>
<td>3.26</td>
<td>1.49</td>
</tr>
<tr>
<td>2.4</td>
<td>I apologise for being insensitive Sir, what can we do to make you feel less exposed</td>
<td>182</td>
<td>3.58</td>
<td>1.53</td>
</tr>
<tr>
<td>3.4</td>
<td>It seems impossible at this stage, what do you and your family thinks about your progress?</td>
<td>181</td>
<td>2.17</td>
<td>1.34</td>
</tr>
<tr>
<td>4.4</td>
<td>You did not react by having a temperature the previous times my dear, would you like me to phone the doctor rather?</td>
<td>180</td>
<td>3.11</td>
<td>1.58</td>
</tr>
<tr>
<td>5.4</td>
<td>It is frustrating to depend on others to do what you usually do Sir, but it is also kind of your friend to help her</td>
<td>182</td>
<td>3.19</td>
<td>1.49</td>
</tr>
<tr>
<td></td>
<td><strong>Total of responses that add deeper meaning (Level IV)</strong></td>
<td><strong>182</strong></td>
<td><strong>3.06</strong></td>
<td><strong>0.92</strong></td>
</tr>
<tr>
<td>1.5</td>
<td>You seem anxious about not knowing when he will discharge you; I will remind the doctor, Mr. Tim:</td>
<td>184</td>
<td>3.44</td>
<td>1.44</td>
</tr>
<tr>
<td>2.5</td>
<td>You sound upset about being treated in a disrespectful way Mr. Dube; you would feel less exposed if we cover you appropriately</td>
<td>182</td>
<td>3.68</td>
<td>1.39</td>
</tr>
<tr>
<td>3.5</td>
<td>I hear how difficult it is for you to be hopeful Mrs. French when you do not see improvement; it seems to be a slow process</td>
<td>181</td>
<td>2.94</td>
<td>1.50</td>
</tr>
<tr>
<td>4.5</td>
<td>You sound anxious about this reaction to the treatment and your face does feel warm. Why is it different for you today Mrs. Polly?</td>
<td>180</td>
<td>2.90</td>
<td>1.44</td>
</tr>
<tr>
<td>5.5</td>
<td>You sound relieved about the support from your friend, and also worried and disappointed that you are not there for her</td>
<td>181</td>
<td>3.25</td>
<td>1.45</td>
</tr>
<tr>
<td></td>
<td><strong>Total of responses that reflect on feelings (Level V)</strong></td>
<td><strong>184</strong></td>
<td><strong>3.25</strong></td>
<td><strong>0.97</strong></td>
</tr>
</tbody>
</table>

The total number of responses (n), means ($\bar{x}$) and standard deviations (SD)
4.4 HYPOTHESES WITH RESPECT TO VARIABLES OF THE STUDY

In this section the significance and substantiality of differences between groups with respect to nurses’ perceptions of facilitation of a therapeutic relationship will be described. In using the biographical data (independent variables), the following groups have been defined: nurses younger than 40 years and nurses 40 years and older; nurses with less than 10 years’ experience and those with 10 years’ and more experience; professional and sub-professional nurse groups and three groups who attended either a basic or advanced course or did not attend any interpersonal skills training courses.

According to Burns and Grove (2005:169), the dependent variable is the response, behaviour or outcome that the researcher wants to predict or explain. The dependent variables in the following sections are therefore discussed as nurses’ perceptions of the levels of facilitation of a therapeutic relationship, which were conceptualised by Aiken and Aiken (1973) and Rogers (1957).

To identify statistical differences between the perceptions of the various nurse groups, a number of statistical tests were applied. The Kolmogorov-Smirnov test was initially used to determine whether two independent samples had been drawn from the same population (Howell, 2004:382). Because Ho is rejected in favour of the alternative hypothesis (p-value <0.05), the derivation is that the sample is not normally distributed. With the alternative hypothesis (Ha) in mind, statistical tests were applied on the data obtained from each group and analysed with non-parametric techniques, and no assumptions of normally distributed samples were made (Burns & Grove, 2005:445).

4.4.1 Hypothesis testing with regard to age groups

Two groups of nurses were defined: one group was younger than 40 years and the other group was 40 years and older. The hypothesis was tested with a Student t-test. A p-value of smaller than 0.05 was taken as a significant difference, on the 5% level of significance, between the perceptions of the two groups. A p-value smaller than 0.01 was taken as a significant difference on the 1% level of significance.
In accordance with the general hypothesis in paragraph 3.2, the specific hypothesis to be tested with the Student t-test is:

**Ho1:** There is no statistically significant difference between the means tested with a t-test between the perceptions of therapeutic facilitation of nurses younger than 40 years when compared to the perceptions of nurses 40 years and older.

**Ha1:** There is a statistically significant difference between the mean perceptions of therapeutic facilitation of nurses younger than 40 years when compared to the perceptions of nurses 40 years and older.

The results of the statistical analysis are presented in Table 4.3. From inspecting the size of the mean scores obtained on a scale of 1 “not at all” to 5 “to a large extent”, the lowest mean is on response item 1.1 \( \bar{x} = 1.52 \) (lack of concern) and the highest is on item 2.3 \( \bar{x} = 4.37 \) (an average response); no specific trend could be observed in this regard.

From Table 4.3 it is clear that Ho1 is rejected in favour of Ha1 with regard to items 5.2 (5% level), 4.3 (5% level), 3.4 (1% level), 5.4 (5% level), 1.5 (1% level), 3.5 (1% level), and 5.5 (1% level) at the stated level of significance (p-value <.05 =5%; p-value <.01= 1%). In spite of the statistically significant differences identified between the two age groups, it seems that these differences between the means of the two compared age groups are relatively small. It was therefore concluded that age did not play a role in how nurses perceived the facilitation of a therapeutic relationship.
Table 4.3: Perceptions of age groups younger than 40 compared to those 40 years and older tested with the Student t-test

<table>
<thead>
<tr>
<th>Response items</th>
<th>Younger than 40 years</th>
<th>40 years and older</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>( \bar{x} )</td>
<td>SD</td>
</tr>
<tr>
<td>Lack of concern (I)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Please do not ask me that again – he will come sometime today, he is a busy man</td>
<td>102</td>
<td>1.52</td>
<td>1.14</td>
</tr>
<tr>
<td>2.1 The whole world will not see it; only the staff in ICU and they have seen everything by now</td>
<td>101</td>
<td>1.82</td>
<td>1.30</td>
</tr>
<tr>
<td>3.1 Many people like you have walked again; you can also do that with a bit of effort</td>
<td>101</td>
<td>2.84</td>
<td>1.55</td>
</tr>
<tr>
<td>4.1 Do not worry; it will settle down; there is medication prescribed for you. The sister keeps the keys</td>
<td>101</td>
<td>2.34</td>
<td>1.52</td>
</tr>
<tr>
<td>5.1 It is good to have someone else to look after her; at least you do not have to worry about her</td>
<td>101</td>
<td>3.23</td>
<td>1.51</td>
</tr>
<tr>
<td></td>
<td>101</td>
<td>2.35</td>
<td>1.40</td>
</tr>
<tr>
<td>Superficial response (II)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 I have told you before that I do not know; we have also been waiting for him all day</td>
<td>102</td>
<td>1.64</td>
<td>1.10</td>
</tr>
<tr>
<td>2.2 If you have a problem with us Madala, I will ask the doctor to have a look, he is also a man</td>
<td>102</td>
<td>1.97</td>
<td>1.50</td>
</tr>
<tr>
<td>3.2 Of course you will, as long as you work harder with the physiotherapist and the nurses</td>
<td>102</td>
<td>3.35</td>
<td>1.47</td>
</tr>
<tr>
<td>4.2 People feel like that sometimes after chemotherapy – we see it all the time; they do not always need medication for it</td>
<td>100</td>
<td>2.06</td>
<td>1.34</td>
</tr>
<tr>
<td>5.2 Most people are not so fortunate to have friends who are willing to help them; many patients have that problem</td>
<td>101</td>
<td>2.56</td>
<td>1.41</td>
</tr>
<tr>
<td></td>
<td>101</td>
<td>2.32</td>
<td>1.37</td>
</tr>
<tr>
<td>Average response (III)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 As I explained before, Sir, I do not know, but is there something I can do for you while you wait?</td>
<td>102</td>
<td>3.50</td>
<td>1.41</td>
</tr>
<tr>
<td>2.3 Don't worry Sir; I will make sure that the curtain is drawn when we check it out</td>
<td>103</td>
<td>4.37</td>
<td>1.09</td>
</tr>
<tr>
<td>3.3 It is difficult to say in your situation Mum but you need to stay focused and do not lose hope</td>
<td>101</td>
<td>3.56</td>
<td>1.47</td>
</tr>
<tr>
<td>4.3 Your temperature rose in reaction to the treatment; I will bring your medication and check your temperature again later</td>
<td>100</td>
<td>3.72</td>
<td>1.42</td>
</tr>
<tr>
<td>Response items</td>
<td>Younger than 40 years</td>
<td>40 years and older</td>
<td>p-value</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td>--------------------</td>
<td>---------</td>
</tr>
<tr>
<td>5.3 Your wife seems to rely on you to get around; being in hospital for such</td>
<td>100 2.68 1.50</td>
<td>79 2.80 1.56</td>
<td>.375</td>
</tr>
<tr>
<td>a long time is difficult for her also</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total average responses (Level III)</td>
<td>101 3.57 1.38</td>
<td>79 3.70 1.36</td>
<td></td>
</tr>
<tr>
<td>1.4 You wanted to see the doctor Mr. Tim and the traffic is getting worse</td>
<td>101 3.20 1.52</td>
<td>80 3.34 1.46</td>
<td>.564</td>
</tr>
<tr>
<td>later – shall I phone him?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4 I apologise for being insensitive Sir, what can we do to make you feel</td>
<td>102 3.40 1.64</td>
<td>79 3.80 1.36</td>
<td>.001</td>
</tr>
<tr>
<td>less exposed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.4 It seems impossible at this stage, what do you and your family thinks</td>
<td>101 1.87 1.18</td>
<td>79 2.56 1.44</td>
<td>.005</td>
</tr>
<tr>
<td>about your progress?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.4 You did not react by having a temperature the previous times my dear,</td>
<td>100 2.95 1.64</td>
<td>79 3.30 1.51</td>
<td>.039</td>
</tr>
<tr>
<td>would you like me to phone the doctor rather?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.4 It is frustrating to depend on others to do what you usually do Sir, but</td>
<td>102 2.95 1.52</td>
<td>79 3.49 1.41</td>
<td>.348</td>
</tr>
<tr>
<td>it is also kind of your friend to help her</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total responses that add deeper meaning (Level IV)</td>
<td>101 2.87 1.50</td>
<td>79 3.30 1.44</td>
<td></td>
</tr>
<tr>
<td>1.5 You seem anxious about not knowing when he will discharge you; I will</td>
<td>103 3.10 1.47</td>
<td>80 3.88 1.28</td>
<td>.022</td>
</tr>
<tr>
<td>remind the doctor, Mr. Tim.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5 You sound upset about being treated in a disrespectful way Mr. Dube; you</td>
<td>102 3.59 1.45</td>
<td>79 3.80 1.31</td>
<td>.058</td>
</tr>
<tr>
<td>would feel less exposed if we cover you appropriately</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5 I hear how difficult it is for you to be hopeful Mrs French when you do</td>
<td>101 2.60 1.44</td>
<td>79 3.38 1.48</td>
<td>.741</td>
</tr>
<tr>
<td>not see improvement; it seems to be a slow process</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.5 You sound anxious about this reaction to the treatment and your face</td>
<td>100 2.88 1.43</td>
<td>79 2.92 1.47</td>
<td>.753</td>
</tr>
<tr>
<td>does feel warm. Why is it different for you today Mrs Polly?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.5 You sound relieved about the support from your friend, and also worried</td>
<td>101 2.98 1.44</td>
<td>79 3.59 1.40</td>
<td>.716</td>
</tr>
<tr>
<td>and disappointed that you are not there for her</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total responses reflective of feelings (Level V)</td>
<td>101 3.03 1.45</td>
<td>79 3.51 1.39</td>
<td></td>
</tr>
</tbody>
</table>

*5% (p-value <.05); ** 1% (p-value <.01) statistical significance; n = number; x = mean; SD = standard deviation
4.4.2 Hypothesis testing with regard to years’ experience as a nurse

Two groups of nurse-participants were defined. The one group had less than 10 years’ experience and the other group had 10 years or more experience as a nurse. A p-value of smaller than 0.05 was taken as a significant difference, on the 5% level of significance, between the perceptions of the two groups. A p-value smaller than 0.01 was taken as a significant difference on the 1% level of significance. In accordance with the general hypothesis in paragraph 3.2, the specific hypothesis to be tested with the Student t-test is:

\[ H_0: \text{There is no statistically significant difference between the means tested with a t-test between the perceptions of therapeutic facilitation of nurses with less than 10 years’ experience when compared to the perceptions of nurses with 10 years’ or more experience as a nurse.} \]

\[ H_a: \text{There is a statistically significant difference between the perceptions of therapeutic facilitation of nurses with less than 10 years’ experience when compared to the perceptions of nurses with 10 years’ or more experience as a nurse.} \]

The results of the statistical analysis are presented in Table 4.4. From Table 4.4 it is clear that \( H_0 \) is rejected in favour of \( H_a \) with regard to items 3.1 (1% level), 3.2 (5% level), 3.4 (5% level), 1.5 (1% level), and 3.5 (1% level) at the stated level of significance.

In spite of the statistically significant different items identified between the two groups with 10 years or more or less than 10 years’ experience as a nurse, it seems that these statistical differences are relatively small and not substantial.

From inspecting the size of the means obtained on the response items with statistically significant differences (3.1; 3.2; 3.4; 3.5; 1.5), the lowest is \( \bar{x} = 1.97 \) and the highest is \( \bar{x} = 3.79 \) on a five-point scale and therefore no specific trend could be observed in this regard. It is therefore concluded that the number of years’ experience as a nurse does not play a role in their perception of facilitating a therapeutic relationship.
Table 4.4: Perceptions of nurses with less than 10 years’ experience compared to those with 10 years’ and more experience as a nurse tested with the Student t-test

<table>
<thead>
<tr>
<th>Response items</th>
<th>Less than 10 years experience</th>
<th>10 or more years experience</th>
<th>t</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>SD</td>
<td>n</td>
<td>SD</td>
</tr>
<tr>
<td>Lack of concern (I)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Please do not ask me that again – he will come sometime today, he is a busy man</td>
<td>95</td>
<td>1.66</td>
<td>1.25</td>
<td>87</td>
</tr>
<tr>
<td>2.1 The whole world will not see it; only the staff in ICU and they have seen everything by now</td>
<td>94</td>
<td>2.01</td>
<td>1.40</td>
<td>87</td>
</tr>
<tr>
<td>3.1 Many people like you have walked again; you can also do that with a bit of effort</td>
<td>94</td>
<td>3.10</td>
<td>1.55</td>
<td>86</td>
</tr>
<tr>
<td>4.1 Do not worry; it will settle down; there is medication prescribed for you. The sister keeps the keys</td>
<td>93</td>
<td>2.54</td>
<td>1.56</td>
<td>86</td>
</tr>
<tr>
<td>5.1 It is good to have someone else to look after her; at least you do not have to worry about her</td>
<td>94</td>
<td>3.18</td>
<td>1.47</td>
<td>86</td>
</tr>
<tr>
<td>Total responses for lack of concern (Level I)</td>
<td>94</td>
<td>2.50</td>
<td>1.45</td>
<td>86</td>
</tr>
<tr>
<td>Superficial response (II)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 I have told you before that I do not know; we have also been waiting for him all day</td>
<td>95</td>
<td>1.66</td>
<td>1.11</td>
<td>87</td>
</tr>
<tr>
<td>2.2 If you have a problem with us Madala, I will ask the doctor to have a look, he is also a man</td>
<td>95</td>
<td>2.05</td>
<td>1.53</td>
<td>87</td>
</tr>
<tr>
<td>3.2 Of course you will, as long as you work harder with the physiotherapist and the nurses</td>
<td>95</td>
<td>3.47</td>
<td>1.41</td>
<td>86</td>
</tr>
<tr>
<td>4.2 People feel like that sometimes after chemotherapy – we see it all the time; they do not always need medication for it</td>
<td>93</td>
<td>2.13</td>
<td>2.36</td>
<td>86</td>
</tr>
<tr>
<td>5.2 Most people are not so fortunate to have friends who are willing to help them; many patients have that problem</td>
<td>94</td>
<td>2.68</td>
<td>1.45</td>
<td>86</td>
</tr>
<tr>
<td>Total superficial response (Level II)</td>
<td>94</td>
<td>2.40</td>
<td>1.57</td>
<td>86</td>
</tr>
<tr>
<td>Average response (III)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 You wanted to see the doctor Mr. Tim and the traffic is getting worse later – shall I phone him?</td>
<td>95</td>
<td>3.52</td>
<td>1.45</td>
<td>87</td>
</tr>
<tr>
<td>2.3 I apologise for being insensitive Sir, what can we do to make you feel less exposed</td>
<td>96</td>
<td>4.39</td>
<td>1.08</td>
<td>87</td>
</tr>
<tr>
<td>3.3 It seems impossible at this stage, what do you and your family thinks about your progress?</td>
<td>94</td>
<td>3.54</td>
<td>1.52</td>
<td>86</td>
</tr>
<tr>
<td>Response items</td>
<td>Less than 10 years experience</td>
<td>10 or more years experience</td>
<td>n</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------</td>
<td>----------------------------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>4.3 You did not react by having a temperature the previous times my dear, would you like me to phone the doctor rather?</td>
<td>93 3.73 1.40</td>
<td>86 4.12 1.22</td>
<td>.042</td>
<td>.052</td>
</tr>
<tr>
<td>5.3 It is frustrating to depend on others to do what you usually do Sir, but it is also kind of your friend to help her</td>
<td>93 2.74 1.53</td>
<td>86 2.72 1.52</td>
<td>.745</td>
<td>.927</td>
</tr>
<tr>
<td><strong>Total average responses (Level III)</strong></td>
<td>94 3.58 1.40</td>
<td>86 3.67 1.35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4 You wanted to see the doctor Mr. Tim and the traffic is getting worse later – shall I phone him?</td>
<td>94 3.13 1.55</td>
<td>87 3.40 1.41</td>
<td>.121</td>
<td>.216</td>
</tr>
<tr>
<td>2.4 I apologise for being insensitive Sir, what can we do to make you feel less exposed</td>
<td>95 3.41 1.63</td>
<td>86 3.76 1.41</td>
<td>.006</td>
<td>.130</td>
</tr>
<tr>
<td>3.4 It seems impossible at this stage, what do you and your family thinks about your progress?</td>
<td>94 1.97 1.31</td>
<td>86 2.40 1.35</td>
<td>.464</td>
<td>.032</td>
</tr>
<tr>
<td>4.4 You did not react by having a temperature the previous times my dear, would you like me to phone the doctor rather?</td>
<td>93 2.92 1.66</td>
<td>86 3.30 1.5</td>
<td>.033</td>
<td>.112</td>
</tr>
<tr>
<td>5.4 It is frustrating to depend on others to do what you usually do Sir, but it is also kind of your friend to help her</td>
<td>95 3.06 1.54</td>
<td>86 3.33 1.43</td>
<td>.398</td>
<td>.239</td>
</tr>
<tr>
<td><strong>Total responses that add deeper meaning (Level IV)</strong></td>
<td>94 2.90 1.54</td>
<td>86 3.24 1.42</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5 You seem anxious about not knowing when he will discharge you; I will remind the doctor, Mr. Tim.</td>
<td>96 3.11 1.49</td>
<td>87 3.79 1.30</td>
<td>.028</td>
<td>.001 **</td>
</tr>
<tr>
<td>2.5 You sound upset about being treated in a disrespectful way Mr. Dube; you would feel less exposed if we cover you appropriately</td>
<td>95 3.53 1.47</td>
<td>86 3.85 1.30</td>
<td>.028</td>
<td>.120</td>
</tr>
<tr>
<td>3.5 I hear how difficult it is for you to be hopeful Mrs. French when you do not see improvement; it seems to be a slow process</td>
<td>94 2.62 1.46</td>
<td>86 3.30 1.47</td>
<td>.890</td>
<td>.002 **</td>
</tr>
<tr>
<td>4.5 You sound anxious about this reaction to the treatment and your face does feel warm. Why is it different for you today Mrs. Polly?</td>
<td>93 2.84 1.42</td>
<td>86 2.97 1.47</td>
<td>.519</td>
<td>.559</td>
</tr>
<tr>
<td>5.5 You sound relieved about the support from your friend, and also worried and disappointed that you are not there for her</td>
<td>94 3.09 1.45</td>
<td>86 3.43 1.44</td>
<td>.940</td>
<td>.112</td>
</tr>
<tr>
<td><strong>Total responses reflective of feelings (Level V)</strong></td>
<td>94 3.04 1.46</td>
<td>86 3.47 1.40</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*5% (p-value<.05); ** 1% (p-value<.01) level of significance; n = Number;  = mean; SD = standard deviation;
4.4.3 Hypothesis testing with regard to professional qualifications

The nurses were divided into two groups: one group consisted of professional nurses with or without a psychiatric qualification and the other group consisted of sub-professional nurses (enrolled nurses, auxiliary nurses and care workers).

The hypothesis was tested with the Mann-Whitney U test of ranks. A p-value of smaller than 0.05 was taken as a significant difference, on the 5% level of significance, between the perceptions of the two groups. A p-value smaller than 0.01 was taken as a significant difference on the 1% level of significance. In accordance with the general hypothesis in paragraph 3.2, the specific hypothesis to be tested with the Mann-Whitney U-test of ranks is:

Ho3: There is no statistically significant difference between the rank orders, tested with the Mann-Whitney U-test, in the perceptions of therapeutic facilitation of professional nurses when compared to the perceptions of sub-professional nurses.

Ha3: There is a statistically significant difference in the perceptions of therapeutic facilitation of professional nurses when compared to the perceptions of sub-professional nurses.

The results of the statistical analysis are presented in Table 4.5. From Table 4.5 it is clear that Ho3 was rejected in favour of Ha3 with regard to items 2.1 (5% level), 3.1 (5% level), 4.1 (1% level), 5.1 (5% level), 1.2 (5% level), 3.2 (5% level), 3.3 (5% level), 1.5 (1% level), and 3.5 (1% level) at the stated level of significance. Despite being statistically significant, those differences are not substantial. This conclusion is based on the relative small differences between the averages as described in paragraph 4.4.1 and paragraph 4.4.2. Further, it seems as if the number differences between the compared groups are far less than the indication of “no difference” between the compared groups on the responses on the 25 items in the questionnaire.
<table>
<thead>
<tr>
<th>Level of facilitation with respect to the dimensions of a therapeutic relationship</th>
<th>Professional Group</th>
<th>Sub-professional Group</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of concern (I)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Please do not ask me that again – he will come sometime today, he is a busy man</td>
<td>82 1.32 0.78 86.27</td>
<td>101 1.70 1.32 96.65</td>
<td>.017</td>
</tr>
<tr>
<td>2.1 The whole world will not see it; only the staff in ICU and they have seen everything by now</td>
<td>82 1.56 1.06 83.34</td>
<td>100 2.08 1.45 98.20</td>
<td>.027 *</td>
</tr>
<tr>
<td>3.1 Many people like you have walked again; you can also do that with a bit of effort</td>
<td>81 2.44 1.44 82.69</td>
<td>100 2.91 1.56 97.74</td>
<td>.048 *</td>
</tr>
<tr>
<td>4.1 Do not worry; it will settle down; there is medication prescribed for you. The sister keeps the keys</td>
<td>81 1.96 1.36 77.59</td>
<td>99 2.68 1.62 101.06</td>
<td>.001 **</td>
</tr>
<tr>
<td>5.1 It is good to have someone else to look after her; at least you do not have to worry about her</td>
<td>81 3.64 1.42 100.67</td>
<td>100 3.11 1.56 83.17</td>
<td>.021 *</td>
</tr>
<tr>
<td>Total responses for lack of concern (Level I)</td>
<td>82 2.18 1.21 86.11</td>
<td>100 2.50 1.50 95.36</td>
<td></td>
</tr>
<tr>
<td>Superficial response (II)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 I have told you before that I do not know; we have also been waiting for him all day</td>
<td>82 1.48 0.85 83.16</td>
<td>101 1.96 1.36 99.17</td>
<td>.019 *</td>
</tr>
<tr>
<td>2.2 If you have a problem with us Madala, I will ask the doctor to have a look, he is also a man</td>
<td>82 1.96 1.38 91.40</td>
<td>101 2.06 1.53 92.49</td>
<td>.875</td>
</tr>
<tr>
<td>3.2 Of course you will, as long as you work harder with the physiotherapist and the nurses</td>
<td>81 2.96 1.54 82.10</td>
<td>101 3.47 1.45 99.03</td>
<td>.027 *</td>
</tr>
<tr>
<td>4.2 People feel like that sometimes after chemotherapy – we see it all the time; they do not always need medication for it</td>
<td>81 2.15 1.22 91.33</td>
<td>99 2.21 1.44 89.82</td>
<td>.838</td>
</tr>
<tr>
<td>5.2 Most people are not so fortunate to have friends who are willing to help them; many patients have that problem</td>
<td>81 2.83 1.52 93.31</td>
<td>100 2.71 1.46 89.13</td>
<td>.583</td>
</tr>
<tr>
<td>Total superficial response (Level II)</td>
<td>81 2.28 1.30 88.26</td>
<td>100 2.48 1.45 93.92</td>
<td></td>
</tr>
<tr>
<td>Average response (III)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 You wanted to see the doctor Mr. Tim and the traffic is getting worse later – shall I phone him?</td>
<td>82 3.74 1.40 97.55</td>
<td>101 3.47 1.43 87.50</td>
<td>.183</td>
</tr>
<tr>
<td>2.3 I apologise for being insensitive Sir, what can we do to make you feel less exposed</td>
<td>82 4.17 1.22 87.96</td>
<td>102 4.33 1.13 96.15</td>
<td>.229</td>
</tr>
<tr>
<td>Level of facilitation with respect to the dimensions of a therapeutic relationship</td>
<td>Professional Group</td>
<td>Sub-professional Group</td>
<td>U</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>n</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It seems impossible at this stage, what do you and your family thinks about your progress?</td>
<td>81</td>
<td>3.96</td>
<td>1.19</td>
</tr>
<tr>
<td>You did not react by having a temperature the previous times my dear, would you like me to phone the doctor rather?</td>
<td>81</td>
<td>4.17</td>
<td>1.09</td>
</tr>
<tr>
<td>It is frustrating to depend on others to do what you usually do Sir, but it is also kind of your friend to help her</td>
<td>81</td>
<td>2.69</td>
<td>1.45</td>
</tr>
<tr>
<td>Total average responses (Level III)</td>
<td>81</td>
<td>3.75</td>
<td>3.28</td>
</tr>
<tr>
<td>You wanted to see the doctor Mr. Tim and the traffic is getting worse later – shall I phone him?</td>
<td>82</td>
<td>3.37</td>
<td>1.37</td>
</tr>
<tr>
<td>I apologise for being insensitive Sir, what can we do to make you feel less exposed</td>
<td>81</td>
<td>3.65</td>
<td>1.49</td>
</tr>
<tr>
<td>It seems impossible at this stage, what do you and your family thinks about your progress?</td>
<td>81</td>
<td>2.30</td>
<td>1.36</td>
</tr>
<tr>
<td>You did not react by having a temperature the previous times my dear, would you like me to phone the doctor rather?</td>
<td>81</td>
<td>3.36</td>
<td>1.47</td>
</tr>
<tr>
<td>It is frustrating to depend on others to do what you usually do Sir, but it is also kind of your friend to help her</td>
<td>81</td>
<td>3.37</td>
<td>1.41</td>
</tr>
<tr>
<td>Total responses that add deeper meaning (Level IV)</td>
<td>81</td>
<td>3.20</td>
<td>1.41</td>
</tr>
<tr>
<td>You seem anxious about not knowing when he will discharge you; I will remind the doctor, Mr. Tim.</td>
<td>82</td>
<td>3.79</td>
<td>1.29</td>
</tr>
<tr>
<td>You sound upset about being treated in a disrespectful way Mr. Dube; you would feel less exposed if we cover you appropriately</td>
<td>81</td>
<td>3.90</td>
<td>1.33</td>
</tr>
<tr>
<td>I hear how difficult it is for you to be hopeful Mrs. French when you do not see improvement; it seems to be a slow process</td>
<td>81</td>
<td>3.30</td>
<td>1.46</td>
</tr>
<tr>
<td>You sound anxious about this reaction to the treatment and your face does feel warm. Why is it different for you today Mrs. Polly?</td>
<td>81</td>
<td>2.93</td>
<td>1.42</td>
</tr>
<tr>
<td>You sound relieved about the support from your friend, and also worried and disappointed that you are not there for her</td>
<td>81</td>
<td>3.32</td>
<td>1.38</td>
</tr>
<tr>
<td>Level of facilitation with respect to the dimensions of a therapeutic relationship</td>
<td>Professional Group</td>
<td>Sub-professional Group</td>
<td>U</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>---------------------</td>
<td>-----------------------</td>
<td>----</td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>SD</td>
<td>Rank</td>
</tr>
<tr>
<td>Total responses reflective of feelings (Level V)</td>
<td>81</td>
<td>3.45</td>
<td>1.38</td>
</tr>
</tbody>
</table>

*5%;** 1% statistical significance; U=observed value; n=number; $\bar{x}$=mean; SD=standard deviation

### 4.4.4 Hypothesis testing with regard to interpersonal skills training

In accordance with the general hypothesis in paragraph 3.2, the specific hypothesis, Ho4: there is no significant difference between the perceptions of three nurse groups that attended either advanced, basic or no interpersonal skills training courses with respect to the level of facilitation of a therapeutic relationship was tested with the Kruskal-Wallis one-way analysis test.

**Ho4**: there is no statistically significant difference in nurses' perceptions when the three groups were compared.

**Ha4**: there is a statistically significant difference in nurses' perceptions when the three groups were compared.

The results of the statistical analysis are presented in Table 4.6. From Table 4.6 statistically significant differences were identified on response items 5.1 (5% level) and 2.4 (5% level) at the stated level of significance. The differences were small and further tests between pairs had to be done. The hypothesis (Ho4) could therefore not be rejected.

Once statistically significant differences between the three compared groups were identified, the Mann-Whitney U-test was applied. The Mann-Whitney U test was used to assess the significance of a difference in the pair-wise comparison of the three groups, for example between group 1 and 2, or group 1 and 3, and/or group 2 and 3.
Table 4.6: Perceptions of the three groups who attended basic, advanced or no interpersonal skills training courses tested with the Kruskal-Wallis test

<table>
<thead>
<tr>
<th>Response items</th>
<th>$\chi^2$</th>
<th>df</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lack of concern (I)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Please do not ask me that again – he will come sometime today, he is a busy man</td>
<td>.019</td>
<td>2</td>
<td>.990</td>
</tr>
<tr>
<td>2.1 The whole world will not see it; only the staff in ICU and they have seen everything by now</td>
<td>1.236</td>
<td>2</td>
<td>.539</td>
</tr>
<tr>
<td>3.1 Many people like you have walked again; you can also do that with a bit of effort</td>
<td>1.295</td>
<td>2</td>
<td>.523</td>
</tr>
<tr>
<td>4.1 Do not worry; it will settle down; there is medication prescribed for you. The sister keeps the keys</td>
<td>1.865</td>
<td>2</td>
<td>.394</td>
</tr>
<tr>
<td>5.1 It is good to have someone else to look after her; at least you do not have to worry about her</td>
<td>8.193</td>
<td>2</td>
<td>.017*</td>
</tr>
<tr>
<td><strong>Superficial response (II)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 I have told you before that I do not know; we have also been waiting for him all day</td>
<td>1.291</td>
<td>2</td>
<td>.524</td>
</tr>
<tr>
<td>2.2 If you have a problem with us Madala, I will ask the doctor to have a look, he is also a man</td>
<td>1.893</td>
<td>2</td>
<td>.338</td>
</tr>
<tr>
<td>3.2 Of course you will, as long as you work harder with the physiotherapist and the nurses</td>
<td>1.500</td>
<td>2</td>
<td>.472</td>
</tr>
<tr>
<td>4.2 People feel like that sometimes after chemotherapy - we see it all the time; they do not always need medication for it</td>
<td>2.070</td>
<td>2</td>
<td>.355</td>
</tr>
<tr>
<td>5.2 Most people are not so fortunate to have friends who are willing to help them; many patients have that problem</td>
<td>.762</td>
<td>2</td>
<td>.683</td>
</tr>
<tr>
<td><strong>Average responses (III)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 You wanted to see the doctor Mr. Tim and the traffic is getting worse later – shall I phone him?</td>
<td>2.016</td>
<td>2</td>
<td>.365</td>
</tr>
<tr>
<td>2.3 I apologise for being insensitive Sir, what can we do to make you feel less exposed</td>
<td>2.714</td>
<td>2</td>
<td>.257</td>
</tr>
<tr>
<td>3.3 It seems impossible at this stage, what do you and your family thinks about your progress?</td>
<td>.784</td>
<td>2</td>
<td>.676</td>
</tr>
<tr>
<td>4.3 You did not react by having a temperature the previous times my dear, would you like me to phone the doctor rather?</td>
<td>.728</td>
<td>2</td>
<td>.695</td>
</tr>
<tr>
<td>5.3 It is frustrating to depend on others to do what you usually do Sir, but it is also kind of your friend to help her</td>
<td>4.151</td>
<td>2</td>
<td>.125</td>
</tr>
<tr>
<td><strong>Adds deeper meaning (IV)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4 You wanted to see the doctor Mr. Tim and the traffic is getting worse later – shall I phone him?</td>
<td>.313</td>
<td>2</td>
<td>.855</td>
</tr>
<tr>
<td>2.4 I apologise for being insensitive Sir, what can we do to make you feel less exposed</td>
<td>7.179</td>
<td>2</td>
<td>.028*</td>
</tr>
<tr>
<td>Reflective of feelings (V)</td>
<td>Response items</td>
<td>( \chi^2 )</td>
<td>df</td>
</tr>
<tr>
<td>----------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>----</td>
</tr>
<tr>
<td>3.4</td>
<td>It seems impossible at this stage, what do you and your family thinks about your progress?</td>
<td>2.751</td>
<td>2</td>
</tr>
<tr>
<td>4.4</td>
<td>You did not react by having a temperature the previous times my dear, would you like me to phone the doctor rather?</td>
<td>.645</td>
<td>2</td>
</tr>
<tr>
<td>5.4</td>
<td>It is frustrating to depend on others to do what you usually do Sir, but it is also kind of your friend to help her</td>
<td>.587</td>
<td>2</td>
</tr>
<tr>
<td>1.5</td>
<td>You seem anxious about not knowing when he will discharge you; I will remind the doctor, Mr. Tim.</td>
<td>.658</td>
<td>2</td>
</tr>
<tr>
<td>2.5</td>
<td>You sound upset about being treated in a disrespectful way Mr. Dube; you would feel less exposed if we cover you appropriately</td>
<td>.871</td>
<td>2</td>
</tr>
<tr>
<td>3.5</td>
<td>I hear how difficult it is for you to be hopeful Mrs. French when you do not see improvement; it seems to be a slow process</td>
<td>5.219</td>
<td>2</td>
</tr>
<tr>
<td>4.5</td>
<td>You sound anxious about this reaction to the treatment and your face does feel warm. Why is it different for you today Mrs. Polly?</td>
<td>.998</td>
<td>2</td>
</tr>
<tr>
<td>5.5</td>
<td>You sound relieved about the support from your friend, and also worried and disappointed that you are not there for her</td>
<td>3.578</td>
<td>2</td>
</tr>
</tbody>
</table>

\* 1% level of significance; \( \chi^2 \)=chi square; df=degrees of freedom

**Ho5:** There is no statistical difference in perception of facilitation of a therapeutic relationship between the ranks of two groups tested with the Mann-Whitney U-test of ranks.

**Ha5:** There is a statistical difference in perception of facilitation of a therapeutic relationship between the ranks of two groups tested with Mann-Whitney U-test of ranks.

On inspection of the size of the differences between the mean of the two compared groups only two cases of significant differences in the ranks were observed. Despite statistically significant differences between the groups who attended basic training courses compared to those who attended advanced training courses on response items 5.1 (0.025) lack of concern and item 2.4 (0.010) that adds deeper meaning, the differences were not substantial (see Table 4.7). The researcher deduced that the interpersonal skills courses that nurses attended had no significant substantial influence on their perceptions of
facilitation of a therapeutic relationship and therefore there was no reason to reject the hypothesis (Ho5).

Table 4.7: Perceptions of two pairs of nurses who attended basic compared to those who attended advanced interpersonal skills training courses tested with the Mann-Whitney U-test

<table>
<thead>
<tr>
<th></th>
<th>Basic training course</th>
<th>Advanced training course</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lack of concern (I)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is good to have someone else to look after her; at least you do not have to worry about her</td>
<td>n</td>
<td>91</td>
<td>3.08</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Add deeper meaning (IV)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I apologise for being insensitive Sir, what can we do to make you feel less exposed</td>
<td>n</td>
<td>92</td>
<td>3.86</td>
</tr>
</tbody>
</table>

*** Tested against 0.0167 (0.05/3) level of significance (Bonferonni adjustment)

4.5 SUMMARY OF FINDINGS

The objectives of the study were to describe nurses’ perceptions of facilitating a therapeutic relationship and to make recommendations regarding facilitation of such a relationship when nursing patients with physical and mental health challenges.

A descriptive overview of the biographical analysis showed that the sample consisted of larger percentages of nurses from the following categories: female (92.4%), younger than 40 years (56.3%), less than 10 years experience as a nurse (52%), basic interpersonal skills training courses attended (51.1%), and of a sub-professional mix of nurses (55.4%).

Nurses’ perceptions were assessed on all levels of facilitation during interactions with patients. Each response was rated on a scale from “not at all” (1) to “to a large extent” (5).
Ideally, nurses in the caring profession should rate those responses to such an extent that patients feel empathetically understood and respected. The findings of the mean scores obtained by nurses in the current study were not in line with the expectation of the researcher and are summarised in Figure 4.2.

![Figure 4.2: A Summary of nurses’ self-assessed perceptions rated on a scale from “not at all” (1) to “to a large extent” (5)](chart)

<table>
<thead>
<tr>
<th>Levels I &amp; II</th>
<th>Responses on the lower levels either lacked concern for the patient’s feelings or were superficial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level III</td>
<td>Average responses were vague and neither hindered nor facilitated a therapeutic relationship and indicated a nursing task</td>
</tr>
<tr>
<td>Levels IV &amp; V</td>
<td>Responses on the higher levels added deeper meaning to what the patient could express, and were reflective of the patient’s deepest feelings.</td>
</tr>
</tbody>
</table>
Furthermore, the size differences between the mean scores or rank orders between perceptions of nurse groups are presented in Table 4.2 to Table 4.7. Even though statistically significant differences were identified for specific items, these were not substantial and no reason, therefore, was found to reject the hypothesis of the study. Finally, it was clear that in comparing nurse-groups, the independent variables age, experience, qualifications and previous interpersonal skills training did not play a role in how nurses perceived a therapeutic relationship (dependant variables).

4.6 SUMMARY

Having presented the research findings in this chapter, a discussion in light of the findings summarised in Figure 4.2 will ensue. In the next chapter, the researcher will conclude with the limitations of the study and suggestions regarding further research. In conclusion, recommendations for facilitation of a therapeutic relationship for nurses working in private general hospitals will be proposed.
5.1 INTRODUCTION

Interaction and understanding at a deeper level enhance facilitation of a therapeutic nurse-patient relationship. As a result, the patient’s expectations are met and nurses become aware of themselves in promoting the mental health and emotional well-being of patients. The research question: “How do nurses in a private general hospital perceive the facilitation of a therapeutic relationship”, was used to formulate the objectives for the study.

In chapter three, the study design, research methods and data collection instrument were discussed. In chapter four the results of descriptive and statistical analysis of the data obtained from the completed questionnaires were presented.

In this chapter, the implications of the results of the statistical analysis will be discussed and conclusions drawn from the main findings which were presented in chapter four (Figure 4.2). The findings will be discussed in relation to the biographical data and nurses’ perceptions of facilitation of a therapeutic relationship. Limitations of the study will be identified and recommendations for practice and training will be proposed. Finally, suggestions for further research and the final conclusions will be presented.

5.2 DISCUSSION

5.2.1 Biographical data: independent variables

Nurses working in three private general hospitals participated in the study. The results indicated that a larger percentage of nurses and care workers who participated in the study were female, younger than 40 years, had less than 10 years experience as nurses, and were from a sub-professional mix.
Many nurses in South Africa leave the nursing profession after the age of 40 years (Govender and Appel 2006:6), and are inevitably replaced with younger nurses; a trend also seen in the age distribution of the private general hospitals of the current study. Hunter (2008:318) on the other hand suggests that personal experiences, values and beliefs develop over time. An assumption was made that the larger percentage of younger nurses in this study were still in the process of developing ethical nursing values, for example, respect, professionalism and honesty. This could have attributed to the lower scores on all levels of facilitation and the way nurses in the study perceived a therapeutic relationship.

Of the participants in the sample, 69% had attended a basic or advanced interpersonal skills training course at some stage. Although some training had taken place the researcher agreed with the findings of Scanlon (2006:319), that there was no clear indication that the taught interpersonal skills of nurses were retained over time.

Private general hospitals in South Africa employ professional as well as sub-professional nurses. Professional nurses are registered with the South African Nursing Council and may also have other qualifications, for example psychiatric nursing. For the purpose of the study, registered nurses with or without psychiatric training were identified.

When considering the changing environment, mental health profile and co-morbidities of patients in a private general hospital, it was of concern that only a small number of nurses in this study had a psychiatric qualification (10.6%). The assumption was that nurses with psychiatric nursing skills should have been more likely to facilitate a therapeutic relationship at a higher level and to transfer those skills to less experienced and sub-professional nurses in practice. Despite psychiatric nursing skills being the basis of a nurse-patient relationship, Mavundla (2000:1570) also mentions that most nurses in South African general hospitals are not psychiatric trained.

The findings indicated a larger percentage of younger, inexperienced or sub-professional nurses. In private general hospitals, sub-professional nurses are employed to fulfil elementary nursing functions. Opportunities exist, however, to develop as auxiliary or enrolled nurses through further training at private nursing colleges. Enrolled nurses have the opportunity to become registered nurses after years of training and clinical experience. The shortage of nurses requires that care workers are employed to fulfil basic duties
previously done by nurses. Care workers were included in the sub-professional group for statistical analysis. Their lack of training and experience are therefore seen by the researcher as a risk when caring for patients with mental health challenges.

The nurse-patient relationship is complex and requires knowledge, skills and a caring, empathetic attitude. The results obtained from the biographical data of the current study have training, quality and financial implications for the private hospitals. Critical skills shortages impact negatively on costs: particularly when considering operational costs of training a younger, less experienced group of nurses (HASA newsletter, 2008).

5.2.2 Nurses’ perceptions of the level of facilitation of therapeutic relationship

The subjective feature of a relationship is the most important characteristic of relationship quality. When individuals thus evaluate their relationships, they compare their actual relationship with stored knowledge of a previous relationship (Hassebrauck & Fehr 2002:253). Nurse participants in the current study were asked to assess their perceptions of a nurse-patient therapeutic relationship.

The most important finding was that with regard to their perceptions, nurses obtained unacceptable scores on all levels of facilitation of a therapeutic relationship. In the nurse-patient relationship, attitudes are expressed at an unconscious level of verbal and non-verbal communication. Nurses’ perceptions are influenced by personal experiences and the way they see the world (Burns & Grove, 2005:12), therefore the researcher deduced that the attitude nurse-participants in the study hold of themselves and towards patients could have been reflected in the lower mean scores and how they perceived themselves in a relationship with the patient.

In the paradigm of the study, the importance of nurses’ attitudes towards patients and the promotion of emotional well-being by nurses were highlighted. The researcher identified incidents of misunderstanding in the nurse-patient relationship, which caused distress to patients and nurses. The findings of the study are that the scores are low on the deeper levels of facilitation and can therefore be seen as a reason for the misunderstanding and the lack of self-awareness and exploration of each other. Hence, the patients’ emotional needs would not be met, and the nurses could be perceived by patients as not being
empathetic and caring. A study by Van Zyl (2011:94) has shown that some nurses portrayed in the media have poor relations with their patients over whom they exert power, and their negative attitudes are impacting on service delivery. In the context of private general hospitals, such a negative impact could also be costly.

The consequences of a lack of respect and communication skills are that patients feel disregarded and misunderstood. This was illustrated by nurses’ higher ratings of responses which were superficial or lacked concern for the patient’s feelings. The findings of this study are not surprising considering the complaints from patients mentioned in chapter one, paragraph 1.3 and reports of nurses who treat patients badly (Bateman, 2010:83). Feedback on the superficial level did not enhance the goals of a therapeutic relationship and concerns raised by the patients.

The results were of further concern because the expectation was that nurses in the caring profession should have the necessary training and guidance that would make them more aware of the patient’s emotional needs. Nurses and care workers interacted on a level that they know best, perhaps limited by their knowledge to interact on a better level.

On an average level (Level III), nurses’ ratings of a relationship showed a willingness and tendency towards responses that relate to a known nursing task. The responses on this level of the interactions did not allow the patients to talk about their feelings. The mean scores obtained were generally higher on the average response level, which meant that the focus was on the medical model and clinical tasks. The findings were not surprising and indicated that nurses, to a larger extent, were more aware of the patients' physical need for reassurance, and privacy. Nurses perceived themselves drawing the curtain for privacy, or attempting to relieve physical discomfort rather than getting involved at a deeper emotional level with the patient.

Nurses who were resorting to more familiar, task orientated responses in the current study can, therefore, be seen as applying a defence mechanism against anxiety by doing instead of being with the patient. Lack of self-awareness, not knowing what to say, or pressure from ethical and professional commitment were identified (Aiken & Aiken 1973; Mavundla, 2000; Reed & Fitzgerald, 2005; McEnhill, 2008). This could result to the use of defence mechanisms such as denial of feelings, or becoming dishonest. Respect and
positive regard are reflected by both physical care and verbal or non-verbal responses to patients’ expressions of feelings. By doing things rather than spending a bit more time reflecting with the patient, non-verbal messages could be interpreted that nurses are unaware of and insensitive to the patients’ emotional needs.

5.2.3 Differences in perception between sub groups of nurses

All categories of nurses were involved when incidents were reported by patients as discussed in chapter one. The researcher therefore expected that personal attributes of the nurses did not make a difference in how they perceived facilitation of a nurse-patient therapeutic relationship.

Possible statistically significant differences in nurses’ perceptions of facilitating a therapeutic relationship between the identified groups were examined. The following independent variables; age, experience, qualifications, and interpersonal skills training courses previously attended, were used to form sub groups in order to statistically test specific hypotheses (Table 4.4 to Table 4.7).

The results indicated that there were no statistically significant and/or substantial differences in nurses’ perceptions of a therapeutic relationship when sub groups were compared. There were small statistically significant differences on a number of response items. The differences were sufficiently insignificant so as to preclude the independent variables (age, qualifications, experience and the previous interpersonal skills training) from playing a role in how nurses perceived facilitation of a therapeutic relationship. No specific trend in the size of differences between the means of these groups was identified and the specific hypotheses could therefore not be rejected in favour of the alternative hypotheses.

The findings were an indication that nurses themselves perceived, irrespective of their gender, age, experience or qualifications that they were not equipped to deal with patients’ emotional and mental health challenges to the extent of enhancing a therapeutic nurse-patient relationship.
5.3 LIMITATIONS OF THE STUDY

A purposive sample of nurses from only three private general hospitals participated in the study, which will restrict direct transferability of the findings to other private and provincial hospitals. A further limitation could be that the few (25) items on the questionnaire resulted in the lack of differentiation between the perceptions of various groups of nurses, but this could be motivated by the limited scope of the study.

Because participants’ culture was not included in the biographical section, this aspect was not explored as a variable which might have had an effect on nurses’ perceptions of a therapeutic relationship.

5.4 RECOMMENDATIONS

The researcher would like to make the following recommendations for practice, training and further research in private general hospitals:

- At a primary level, create awareness of a nurse-patient relationship with the expectation of decreasing incidents of distress and misunderstanding.

- At a secondary level the focus should be on nurses who might be at risk by proposing a higher level of facilitation of a therapeutic nurse-patient relationship for all nurses.

5.4.1 Recommendations for practice

None of the hospitals investigated in the study had a dedicated psychiatric ward. The changing profile of patients and other cost-containment measures therefore contribute to the non-therapeutic environment for nurse-patient therapeutic relationship in general wards. The researcher proposes that an investigation should be conducted in order to develop a therapeutic environment where physical and mental health challenges of patients in these settings could be met: an environment where nurses are able to facilitate a therapeutic relationship with all patients.
5.4.2 Recommendations for training

Effective communication and development of staff lead to enhanced patient satisfaction and mental health outcomes (Hanrahan & Aiken 2008:217). Training should therefore be aimed at bridging the gap between a level of facilitation that lacks concern for the patient’s emotional needs and a level of reflective and empathetic understanding in a therapeutic nurse-patient relationship.

The most important training task is to develop communication skills under the supervision of experienced professionals. Experiential and interactive training courses are recommended to increase self-awareness and reflection of feelings, followed by regular assessments of competence. Collaboration with available capacities should be ensured.

5.4.3 Suggestions for further research

The emotional effects on nurses in private general hospitals caused by the changing patient profile and mental health challenges of patients could be explored. The researcher suggests the development of self-awareness and interpersonal skills training programmes that are aimed at all nurses working in private general hospitals, but especially to the younger, sub-professional groups of nurses.

Due to the cultural diversity of nurses and patients in health care facilities in South Africa, further research of cultural influences on the facilitation of a therapeutic relationship is also recommended.

This study has clearly indicated that nurses’ own perceptions of a therapeutic relationship are not in line with the expectations of the researcher. Further research to explore private general hospital patients’ perceptions with regard to the nurse-patient therapeutic relationship is recommended.
5.5 FINAL CONCLUSIONS

Nurses need to be prepared and trained to engage on a deeper reflective level of respect and empathetic understanding that is required and expected of them. In contrast, the findings showed that nurses’ perceptions of facilitation of a therapeutic relationship were generally at the lower, superficial and average levels. Although the mean scores obtained indicated some awareness of physical needs, their own perceptions seemingly lacked deeper understanding of patients’ emotional and mental health challenges.

Patients need to feel accepted and respected within a safe, empathetic and understanding nurse-patient relationship. The results supported the hypothesis of the study and concurred with other authors who reported that health professionals generally lacked empathy (Wheeler & Barrett, 1994:232; Mavundla, 2000:1570; Reynolds & Scott, 2000:1; Hojat et al., 2002:523).

Of concern is that nurse-participants’ own perceptions of a nurse-patient therapeutic relationship emphasised a general lack of concern and awareness for patients’ emotional needs, irrespective of their training or experience. Nurses are the backbone of the healthcare system and undertake essential life-giving tasks; however, they need to be emotionally and skilfully equipped to give wholistic care. It is clear that awareness of and sensitivity to all patients’ physical and mental health challenges in a changing healthcare environment is well overdue.
REFERENCES


South African Nursing Council: Regulations relating to the Scope of Practice of Persons who are Registered or Enrolled under the Nursing Act, 1978 (No. R.2598 of 30 November 1984).


APPENDICES

APPENDIX 1: QUESTIONNAIRE

UNIVERSITY OF JOHANNESBURG
AUCKLAND PARK

Dear Prospective Participant,

My name is Annalie van den Heever, and I invite you to participate in a research project as part of a Masters Degree in Psychiatry and Mental Health Nursing at the University of Johannesburg under the supervision of Prof. Marie Poggenpoel and Prof. Chris Myburgh.

With your help, I will determine nurses’ perceptions of therapeutic relationships with patients with mental health disorders in a private general hospital with the objectives to identify dimensions in the therapeutic relationship that need to be facilitated in caring for patients with mental health disorders in private general hospitals.

By completing the questionnaire, you will provide information that might add to the knowledge of nursing as well as the quality of care for patients in your hospital. There are no risks involved for you in this study. Your participation is voluntary, confidential and anonymous and only coded numbers will be used on questionnaires and you have the right to withdraw from the study at any time.

The questionnaire which I request you to complete consists of two (2) sections: A and B. Please complete both sections. It will take approximately 15 – 30 minutes of your time and on completion of the questionnaire, I request you to place the folded paper into the sealed box provided.

I appreciate your willingness to participate and thank you for your time.

Yours sincerely

©Me Annalie van den Heever: Researcher
Professor Marie Poggenpoel: Supervisor
Professor Chris Myburgh: Co-Supervisor
QUESTIONNAIRE: THERAPEUTIC RELATIONSHIP©

SECTION A: BACKGROUND INFORMATION

We assure you that your response will remain anonymous. Your cooperation is appreciated.
Please answer the following questions of Section A by crossing “X” in the relevant block or writing down your answer in the space provided.

For example:
If you are a female mark “2” with a “X”

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<th>Male</th>
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<tr>
<td>Female</td>
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If you are 19 years old write in the space provided

| 1 | 9 |

1. Gender

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<tr>
<td>Female</td>
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2. Age (in complete years)

3. How long have you been working as a nurse?(years)

4. Professional qualification

<table>
<thead>
<tr>
<th>Registered Nurse (RN)</th>
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<tr>
<td>Registered Nurse with Psychiatric Qualification</td>
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<td>Enrolled Nurse (EN)</td>
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<td>Enrolled Auxiliary Nurse (ENA)</td>
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<td>Care Worker</td>
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5. Have you attended interpersonal skills training courses?

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<tr>
<td>Advanced training course</td>
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<td>No training</td>
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SECTION B: THERAPEUTIC RELATIONSHIP
This section explores your perceptions of a therapeutic relationship.
Please rate each response by circling a figure on the scale between 1 and 5
For example:
If you never say that, mark “not at all” (1) with “X”
If you say that most of the time mark “to a large extent” (5) with “X”
If you say that sometimes mark 2, 3 or 4 with “X” according to your opinion
There are 5 statements or questions. Each statement has 5 different responses

1. MR. TIM REPEATS THE SAME QUESTION MANY TIMES: “WHEN DOES THE DOCTOR COME TO SEE ME? I NEED TO GO HOME BEFORE 5 PM.”

To what extend do you respond? (Mark your perceptions on this situation 1.1 to 1.5)

1.1 Please do not ask me that again – he will come sometime today, he is a busy man
not at all to a large extent

1.2 I have told you before that I do not know; we have also been waiting for him all day
not at all to a large extent

1.3 As I explained before, Sir, I do not know, but is there something I can do for you while you wait?
not at all to a large extent

1.4 You wanted to see the doctor Mr Tim and the traffic is getting worse later – shall I phone him?
not at all to a large extent

1.5 You seem anxious about not knowing when he will discharge you; I will remind the doctor, Mr Tim.
not at all to a large extent
2. MR. DUBE, A PATIENT IN A BUSY 6 BED WARD HAS A URINARY CATHETER AS WELL AS ECG LEADS CONNECTED TO HIS BARE CHEST. HE SAYS: ‘IT HURTS ‘DOWN THERE’ BUT I DO NOT WANT THE ‘WHOLE WORLD’ TO LOOK AT ME AGAIN.

To what extent do you respond? (Mark your perceptions on this situation 2.1 to 2.5)

2.1 The whole world will not see it; only the staff in ICU and they have seen everything by now

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2.2 If you have a problem with us Madala, I will ask the doctor to have a look, he is also a man

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2.3 Don’t worry Sir; I will make sure that the curtain is drawn when we check it out

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2.4 I apologise for being insensitive Sir, what can we do to make you feel less exposed

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2.5 You sound upset about being treated in a disrespectful way Mr Dube; you would feel less exposed if we cover you appropriately

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### 3. MRS. FRENCH, A BEDRIDDEN PATIENT ASKS OF YOU: “WILL I EVER GO HOME AND WALK AGAIN?”

To what extend do you respond? (Mark your perceptions on this situation 3.1 to 3.5)

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**3.1**  Many people like you have walked again; you can also do that with a bit of effort

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**3.2**  Of course you will, as long as you work harder with the physiotherapist and the nurses

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**3.3**  It is difficult to say in your situation Mum but you need to stay focused and do not lose hope

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**3.4**  It seems impossible at this stage, what do you and your family think about your progress?

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**3.5**  I hear how difficult it is for you to be hopeful Mrs French when you do not see improvement; it seems to be a slow process

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4. MRS. POLLY ASKS: “WHY AM I FEELING SO SWEATY AND HOT TODAY AFTER THE CHEMOTHERAPY?”

To what extent do you respond? (Mark your perceptions on this situation 4.1 to 4.5)

4.1  Do not worry; it will settle down; there is medication prescribed for you. The sister keeps the keys

not at all  1  2  3  4  5 to a large extent

4.2  People feel like that sometimes after chemotherapy – we see it all the time; they do not always need medication for it

not at all  1  2  3  4  5 to a large extent

4.3  Your temperature rose in reaction to the treatment; I will bring your medication and check your temperature again later

not at all  1  2  3  4  5 to a large extent

4.4  You did not react by having a temperature the previous times my dear, would you like me to phone the doctor rather?

not at all  1  2  3  4  5 to a large extent

4.5  You sound anxious about this reaction to the treatment and your face does feel warm. Why is it different for you today Mrs Polly?

not at all  1  2  3  4  5 to a large extent
5. MY WIFE WILL BE OK WHILE I AM IN HOSPITAL....AFTER ALL, MY BEST FRIEND, IS LOOKING AFTER HER BECAUSE SHE DOES NOT DRIVE, YOU KNOW?

To what extent do you respond? (Mark your perceptions to this situation 5.1 to 5.5)

5.1 It is good to have someone else to look after her; at least you do not have to worry about her

not at all  to a large extent

[1 2 3 4 5]

5.2 Most people are not so fortunate to have friends who are willing to help them; many patients have that problem

not at all  to a large extent

[1 2 3 4 5]

5.3 Your wife seems to rely on you to get around; being in hospital for such a long time is difficult for her also

not at all  to a large extent

[1 2 3 4 5]

5.4 It is frustrating to depend on others to do what you usually do Sir, but it is also kind of your friend to help her

not at all  to a large extent

[1 2 3 4 5]

5.5 You sound relieved about the support from your friend, and also worried and disappointed that you are not there for her

not at all  to a large extent

[1 2 3 4 5]
APPENDIX 2: ANECDOTAL EVIDENCE

THE INCIDENT

I was admitted to hospital on the 7th Nov. I must compliment the staff in casualties they were superb but i wish i could have stayed there. I was transferred to ______ to be attended to there. The one afternoon i went to ask one of the nurses a favour where she shouted at me "CAN YOU NOT SEE I AM BUSY YOU WILL WAIT!" Can you imagine? According to me am i paying my medical aid who is paying the bill here and I MUST wait?? ?? I was totally stunned. Today I bumped by big toe so hard against one of their trolley and it feels like it could be broken. I called the nurse and she just looked at my foot rubbed over the toe and said ay shame ill bring you something for the pain. She returned with a myprodol which i can not even drink if she actually read my chart. I called another nurse and asked her if we could just get a bandage because it is really sore, guess her reply.... No we can because them they going to charge you for it and look your toe isnt even swollen. I will bring you an ice pack. That was just after noon. It is now 13h37 and no ice pack nothing.

Herewith i would just like to thank ______ for their wonder service!!!

Keep it up!!!

Big toe's up to you!!

While hospitalised at ______ I was put into a 2-bed ward. I realised after a while that the other patient was in hospital for depression. She was discharged and another patient admitted. The following issues are of concern:

- The patient was admitted and clerked by a nurse in the ward with only a curtain between my bed and her bed. I heard every single word of her history and current status - the patient's confidentiality was severely breached.
APPENDIX 3: PERMISSION TO USE A PRIVATE HEALTHCARE GROUP OF HOSPITALS FOR RESEARCH

Letter Requesting Permission to Conduct the Research

LETTER OF PERMISSION TO CONDUCT RESEARCH

TO THE GROUP NURSE MANAGER
LIFE HEALTHCARE
Oxford Manor
21 Chaplin Road
Illovo
2196
30TH November 2010

Dear Madam/Sir

PERMISSION TO CONDUCT RESEARCH

I am a M. Cur student at the University of Johannesburg, presently engaged in a study entitled: “Nurses’ own perceptions of their therapeutic relationships in providing care for patients with mental health disorders in a private general hospital in Gauteng”, under supervision of Professor Marie Poggenpoel of the Department of Nursing Science and Professor Chris Myburgh of the Department of Psychology of Education at the University of Johannesburg. I request permission to conduct research with the objectives to: a) investigate nurses’ perceptions of facilitating a therapeutic relationship in a private general hospital and b) to recommend levels of facilitation required in a therapeutic relationship when nursing patients with medical, surgical and mental health needs.

With your consent the researcher will identify registered, enrolled, auxiliary nurses and care workers (excluding those employed in specialized units for example intensive care and theatre) from three accessible hospitals to complete a questionnaire. Participation will be voluntary and anonymity will
be ensured by not using respondents’ or the hospital group’s name in the research report. The results will be made available to you.

The benefits of the study will be the added knowledge of quality care in the nursing profession as well as recommendations for practice, training and further research in private general hospitals.

Attached, please find an abstract of the proposal for your perusal as well as the UJ Higher Degrees & Ethics Committee’s approval letter.

I appreciate your time in considering this request.

Yours sincerely

_________________________
ANNALIE VAN DEN HEEVER
THE RESEARCHER

Cell number: 083 258 9953
Correspondence to:
Annalie.vandenheever@wits.ac.za
P.O. Box 1654
Pinegowrie
2123

PROF. MARIE POGGENPOEL & PROF. CHRIS MYBURGH
SUPERVISOR CO-SUPERVISOR
Letter Granting Permission to Conduct the Research

Attention: Annalia van den Heever

APPROVAL FOR RESEARCH STUDY

Our previous correspondence refers.

The Research Committee of the Life Healthcare College of Learning has granted permission for your study entitled:

"Nurses' own perceptions of their therapeutic relationship in providing care to patients with mental health disorders."

We look forward to seeing the results of your research once it is completed.

Yours sincerely,

Anne Retoot
Nursing Education Specialist

UNIVERSITY OF JOHANNESBURG
APPENDIX 4: PERMISSION FROM UNIVERSITY TO CONDUCT THE RESEARCH

FACULTY OF HEALTH SCIENCES
HIGHER DEGREES COMMITTEE

HDC26/01-2011
26 May 2011

TITLE OF RESEARCH PROPOSAL: Nurses’ own perceptions of their therapeutic relationship in providing care to patients with mental health disorders

DEPARTMENT OR PROGRAMME: M.CUR: Nursing

RESEARCHER: VAN DEN HEEVER, AE STUDENT NO. 200837787

SUPERVISOR: Prof M Poggenpoel
CO-SUPERVISOR: Prof CPH Myburgh

The Faculty Higher Degree Committee has scrutinised your research proposal and confirm that it complies with the approved research standards of University of Johannesburg.

The HDC would like to extend their good wishes to you in your endeavour of your research project.

Yours sincerely,

Prof. Heidi Abrahamse
Chair: Faculty of Health Sciences HDC
FACULTY OF HEALTH SCIENCES

ACADEMIC ETHICS COMMITTEE

AEC24/01-2011
26 May 2011

TITLE OF RESEARCH PROPOSAL: Nurse's own perceptions of their therapeutic relationship in providing care to patients with mental health disorders

DEPARTMENT OR PROGRAMME: M.CUR: Nursing

RESEARCHER: VAN DEN HEEVER, AE STUDENT NO. 200937787
SUPERVISOR: Prof M Poggenpoel
CO-SUPERVISOR: Prof CPH Myburgh

The Faculty Academic Ethics Committee has scrutinised your research proposal and confirm that it complies with the approved ethical standards of the University of Johannesburg.

The AEC would like to extend their good wishes to you in your endeavour of your research project.

Yours sincerely,

[Signature]

Prof. M Poggenpoel
Chair: Faculty of Health Sciences
Academic Ethics Committee