CHAPTER ONE: INTRODUCTION AND OVERVIEW

1.1 INTRODUCTION

Community health nursing is the synthesis of nursing practice and public health practice. The major goal of community health nursing is the preservation of the health of the community and populations, through a focus on health promotion and health maintenance of individuals, families, and groups within the community. Thus, community health nursing is oriented toward health and the identification of populations at risk rather than toward an episodic response to patient demand (Swanson and Albrecht, 1993:4). The primary concern of nurses who take on the various roles of the community health nurse is to improve the health of the community. Community health nurses use all of the principles and skills of nursing practice, as well as those of public health practice, to aid the community (Swanson and Albrecht, 1993:82). According to Fitzsimmons and White (1997:97) community health nurses could also be described as "circumstance oriented", responding by circumstances and their potential for causing future health risks.

Hingsley, 1984 (in McGrath et al, 2003:555-565) states that nursing is by its very nature a stressful job. In addition, low wages, inadequacy of equipment and materials, too long working hours and excessive number of patients to care for, have a negative effect on working conditions and the physical/psychological health of nurses (Demir, 2003:807-827). If anxiety is a reflection of stressful work, then some of the work carried out in the late 1950s and early 1960s is relevant to this discussion (McGrath et al, 2003:555-565). Marti Loring (1994:1) holds the opinion that although emotional abuse is a widespread form of violence, it is rarely recognised as such by its victims. Many are convinced that they are at fault and thus do not perceive themselves as abused. If psychological abuse and emotional abuse are seen to be equivalent terms, it gives rise to the question - what is a community nurse's experience of psychological abuse in interaction with others in his/her workplace?

1.2 RATIONALE

Loring (1994:15) cites Martin (1976) and Walker (1984) in the explanation of the term emotional abuse and characterises it to include aspects of non-physical abuse, indirect abuse, emotional abuse, *psychological abuse*, psychological aggression, psychological maltreatment and mental or psychological torture. Regardless of the terminology, this type of violence – fraught with

degradation, fear and humiliation – has been described by Fortune (in Loring, 1994:15) as the most painful, and by Ferraro (in Loring, 1994:15) as the most detrimental to self-esteem. It dismembers the victim's self by systematically attacking personality, style of communication, accomplishments, values and dreams. Verbal, as well as physical, abuse of nurses has for years been the elephant on the dining room table. Everyone knows it is there, but no one wants to talk about it (Bruder, 2001:2).

Lack of positive or other constructive feedback from senior staff has been cited as a problem in a number of studies (Nichols et al, 1981, Pyne, 1981, Revans, 1976, Ashworth, 1985 as cited in McGrath et al, 2003:555-565) and there is much anecdotal evidence in the nursing press on feedback, which is either negative or absent. This leads to the question: to what extent do the above-mentioned issues contribute to psychological abuse?

Another possible factor, or element, to consider is that of the relationship between nurses themselves and, specifically, the extent to which mental abuse occurs within the group. An editorial written by a non-nurse in contact with many nurses through her job as editor of a national nursing journal, is worth considering. "Of the many things which puzzled me when I first explored nursing and nurses, two remain a mystery. One is how horrible nurses are to one another – in the form of seniors victimizing juniors, or of a mutual refusal to acknowledge stress, or an intolerance of colleagues who crack physically or mentally" (Dunn, 1979:1333).

A British study by Hingsley, 1984 (in McGrath et al, 2003:555-565) of nurses and senior nurses in one health authority, identified a number of factors causing stress, and for the purpose of this study linkages will be established in terms of psychological abuse (if they do indeed exist):

- Workload (both in terms of quantity and inability to provide the quality desired), relationships with senior staff, role conflict and ambiguity.
- How nurses deal with death and dying, and the conflict which might be experienced between the demands of work and of home.
- The influence of lack of job satisfaction related to low professional status, as well as the impact of limited promotion prospects.
- Interpersonal relationships with patients, relatives, colleagues and subordinates and the contributing role of inadequate physical resources.

- Having to cope with change in technology and in professional developments might also be a contributing factor, or element (McGrath et al, 2003:555-565).

Initial discussions have indicated that there might be a causal relationship between the various factors listed above and psychological abuse as experienced by nurses in the community setting. A further focus point will be to indicate that a relationship might exist between mental abuse as this might lead to increased levels of stress. A few recent studies have examined causes of stress in different clinical contexts, and the methods of alleviating or coping with stress that promotes health. The relationship between professional depression; "burnout" and personality in long-term nursing have been examined by Firth and Britton (in McGrath et al, 2003:555-565). They found that a number of distinct "burnout" responses were evident amongst staff, including not only "professional depression" and depersonalisation but also the avoidance of problem solving and decision-making.

Maslach and Jackson (1981, in Demir et al, 2002:807-827)) divided the concept of burnout into three categories, namely; emotional exhaustion, depersonalisation and lack of personal accomplishment. Depersonalisation is defined as behaving towards the care-needers without any emotion, as though they are not unique and individual.

Articles published since 1990 in English language professional journals, reveal that research studies related to role stress in nurses fall within five major categories: work environment factors, influencing and predicting factors, model testing, physiological and attitudinal factors, and instrumentation (Lambert and Lambert, 2001:161-172).

Research findings related to the work environment have suggested that a number of factors contribute to the occurrence of role stress for nurses. Some of the more frequently cited circumstances include: low job control, high job demands, and low supportive work relationships. (Chapman, 1993; Fong, 1993; Webster and Hackett, 1999; Cheng et al, 2000; Lally and Pearce, 1996; Melchior et al, 1997; Baba et al, 1999; Van Wijk, 1997 in Lambert et al, 2004:85-97).

The second largest number of studies conducted on role stress in nurses relates to influencing and/or predicting factors. Prior research findings have suggested that the following variables play a major role in influencing and / or predicting the presence of stress and, possibly, to the occurrence of psychological abuse: commitment to career and dealing with others at work

(Stechmiller and Yarandi, 1993:534-541); job-induced tension and the intent to quit one's job (Daily, 1990:33-42); social support (Bourbonnais et al, 1999:95-107); interdomain conflict between work stressors and family stressors (Fox and Dwyer, 1999:164-174); and poor communication (Omadahl and O'Donnell, 1999:1351-1359).

One has to wonder what impact poor communication, negative attitudes amongst colleagues, low salaries, high workload, dissatisfied patients, poor backup / support from management and un-involvement from professional bodies has on the psychological health of nurses. According to Chiu and Kosinski (1997:71-84) a person's job satisfaction can have an impact on his/her emotions, behaviour and work performance and if mental abuse is prevalent, it follows that the latter might be impacted adversely.

While some causes of stress are related to the clinical work of the nurse, some is as a result of the role and organizational pattern within which she or he works. In Thailand, a lack of organizational support was the greatest source of stress amongst public sector nurses, particularly due to lack of involvement in planning and decision making (Pongruengphant and Tyson, 2004:247-254). Dissatisfaction with extrinsic factors such as management decisions and monetary compensation was found to be strongly related to nurses' organizational stress.

Swanson and Albrecht (1993:192-193) are of the opinion that nurses have an advocacy role to fulfil, due to the fact that they are seen to be professionals whose knowledge, skill and concern are used to promote society's well-being through a disciplined change process. Because of their unique status in the lives of patients, because they are interpreters of the health care system to the public, and because their most basic professional activities are profoundly influenced by government-funded programs, public health nurses must know how to participate in the political process. To do this effectively, they need a sound knowledge of community, state, and national government organization and function and a clear understanding of how these factors interact as a system.

Nurses must know how to influence the creation of health care legislation and how to contribute to the election and appointment of key officials. In addition, because policy is fundamental to governance, they need to know about the formulation of public policy and the acts of government and its agencies.

In a study undertaken by Bryant and Cox (2003:567-583) it was found that acts of violence at work embody a variety of organizational experiences including horizontal violence between colleagues, vertical violence between manager and employee (which can be directed from management or staff) and workplace bullying. All of these types of violence have been known to range from shouting to psychological harassment. Psychological violence is more difficult to define than physical abuse, as it rarely involves a visible act.

While organisational change has not been directly linked to workplace violence, effects of organisational change, such as job insecurity and perceived injustice in the workplace, are thought to be linked to personal changes in employees. Bryant and Cox (2003:567-583) further suggests that the impersonal nature of organizations and of organizational change "not only facilitates supervisors who strive for dominance and superiority over employees but also prevents employees from expressing their feelings of injustice, frustration and anger", thus causing disequilibria in employment relations and a "hostile work atmosphere". It would seem that existing grievance procedures are not geared to deal (effectively and efficiently) with mental abuse as experienced within the nursing profession. The extent to which these procedures are utilised and / or operational within the community setting is yet to be determined.

Complaint procedures are meant to offer an "essential safeguard for users of services", and can also be an important source of feedback on which to base quality improvements. However, it is unwise to assume that complaint procedures work well. Managers of services need to be aware of the constraints which operate to prevent complaint procedures from being effective, both as safeguards and as tools for improving quality (Bryant and Cox, 2003:567-583).

The most salient identifying characteristic of emotional abuse is its patterned aspect. It is the clear and consistent pattern of these remarks, such as, the ongoing effort to demean and control that constitutes emotional abuse. The pattern of emotional abuse occurs on two levels – overt and covert – and utilizes several mechanisms of abuse. Overt abuse is openly demeaning. The second level of violence, covert emotional abuse, is more subtle but no less devastating to victims. Because they are often unaware of its essential violence, victims commonly react to covert abuse with feelings of despair and confusion. This kind of abuse consists of an insidious, sometimes complex pattern, of negative feedback (Loring, 1994:1-3).

The following are examples of overt and covert mechanisms of abuse as indicated by Loring (1994:4-5): belittling, yelling, name-calling, criticising, ordering around, sulking, withholding

affection, ignoring, isolation from family and friends, monitoring time, attempting to restrict resources (finances, telephone), interfering with opportunities (job, medical care, education), accusing the victim of engaging in repeated, purposively hurtful behaviours, throwing objects, not (necessarily at the victim), slamming of objects or doors, ridiculing the victim, expressing disgust towards the victim, threatening to abandon (physically or emotionally), expressing excessive jealousy, and coercing the victim into illegal activity.

Loring (1994:4-5) sites the following examples of possible covert mechanisms of abuse: discounting, negation, projection/accusation, denial (of abuse by the abuser) and negative labelling. Subtle threats of physical and/or emotional abandonment, or actual physical and / or emotional abandonment are additional examples of covert mechanisms of abuse.

Over time these covert mechanisms of labelling, discounting, and negation lead to a diminution and destruction of the self. Victims describe a feeling that the constituent parts of the self, the individual characteristics, abilities and skills, preferences and wishes, dreams and aspirations, no longer cohere (Loring, 1994:5).

1.3 PROBLEM STATEMENT AND RESEARCH QUESTION

Abuse in the workplace is nothing new. It has probably been going on since one human started working for another. Progress has been made as to what will be tolerated as acceptable behaviour. Abuse in the workplace should be no more tolerable or legitimate than any other form of abuse in society. In organisations, legislation ensures that physical abuse and sexual harassment are seen as unacceptable, and perpetrators of this type of abuse face legal action. Yet, mental abuse in the workplace continues unrecognised, or at least justified as inevitable (Mann, 2000:1).

The level of mental abuse is difficult to gauge in the nursing profession. Mental abuse undermines the self-esteem and eventually changes the way people view themselves in relation to their surroundings. Nurses lose a sense of what is just and reasonable in the working environment, as they increasingly doubt their ability to carry out tasks, the value of their opinions and ideas, and their general worth in the institution, and come to feel they have no right to any respect or standing in the institution (Mann, 2000:1).

Mental abuse can be seen as being subtlety insidious in nature - individuals perpetrating the abuse are masters at disguising their actions, and the effect on the victim is difficult to detect or to isolate. Furthermore, those inflicting the damage do not see their behaviour as wrong or unjust, because they can justify their actions. Abusers work their way into situations where they will have influence over the vulnerable, especially new appointees and those in highly stressful working situations where deadlines and client satisfaction are crucial (Mann, 2000:3).

Hingsley, 1984 (in McGrath et al, 2003:555-565) is of the opinion that nursing is, by its very nature, an occupation subject to a high degree of stress. Every day the nurse confronts stark suffering, grief, and death as few other people do. McGrath et al, (2003:555-565) proposes that there is a growing body of research about stress in nursing and there are some general indications of the stressful nature of the job.

According to McGrath et al (2003:555-565) there is evidence to support the belief that nursing is stressful and that some causes of stress are found in all specialities. If anxiety is a reflection of stressful work, then some of the work carried out in the late 1950s and early 1960s is relevant to this discussion. Redfern, 1981 (in McGrath et al, 2003:555-565) describes hospitals as being "characterized by anxiety" and referred to the "cycle of anxiety, uncertainty and communication blockage…" and it will be of importance to determine the level to which this cycle repeats itself amongst nurses employed at community health centres.

Loring (1994:1-2) holds the opinion that emotional abuse is an ongoing process in which one individual systematically diminishes and destroys the inner self of another. The essential ideas, feelings, perceptions, and personality characteristics of the victim are constantly belittled. Eventually the victim begins to experience these aspects of the self as seriously eroded, or absent.

International trends, dating as far back as 1980, expressed concern at the unacceptable pressures put upon nurses, some of whom were trying to bridge the gap between the desirable and what is physically possible. Research undertaken by Whittington and Shuttleworth (in Healy et al, 2002(8): 85) indicated that nurses are at higher risk of being mentally abused than any other professional grouping in the health environment.

As far back as 1980 a gap was identified, and it became abundantly clear in the literature survey undertaken for this study that very little, or no, research was conducted which focused specifically on psychological abuse of nurses in the community setting. Thus, clearly indicating the relevance, significance and importance of this study.

Mental and emotional abuse are powerful life events, and researchers Pitzner and Drummond (1997:125-126) recognise that abuse can have a significant impact on the psychological functioning of an individual and that a history of abuse can be linked to a range of negative long-term results. High depression and low self-esteem scores are common long-term consequences experienced by individuals exposed to mental abuse. Flowing from the introduction and rationale, it is apparent that a gap exists in research with regard to psychological abuse as experienced by community health nurses.

In order to have a better understanding of psychological abuse, the researcher developed the following questions:

> **What is a community nurse's experience of psychological abuse in interaction with others in her workplace?**

To make a contribution to the field of community health nursing, the following question was formulated:

> **What strategies can be developed as a result of this research, to assist community nurses to deal with psychological abuse?**

1.4 RESEARCH OBJECTIVE

The objective for this research is twofold:

- To explore and describe community nurse's experience of psychological abuse in interaction with others in the workplace
- To develop strategies, which will assist community health nurses to deal with psychological abuse.

1.5 PARADIGMATIC PERSPECTIVES

The paradigmatic perspectives of the School of Nursing of the University of Johannesburg (2006:2-16) will be used in this research.

1.5.1 Metatheoretical Assumptions

As a metatheoretical departure point for this research, the mission and vision statement of the Department of Nursing at the University of Johannesburg, as well as the assumptions underlying the Theory for Health Promotion in Nursing, will be used. Based on the Constitution of South Africa (Act 108 of 1996) and the mission statement of the University of Johannesburg (University of Johannesburg, 2006:2-7), a Christian approach, which strives towards excellence and promotes the following values will form the basis of the study:

- Unconditional acceptance of people and respect for human rights.
- Sensitivity towards cultures through empathy and caring.
- Realising and facilitating virtues such as honesty, commitment, trustworthiness, acceptance of responsibility and accountability, courage and perseverance.
- Promoting of co-operation and empowerment by being consumer friendly and helpful through availability and accessibility.

The Theory of Health Promotion (University of Johannesburg, 2006:2-7) views individuals as holistic entities, who are in constant interaction with their environments in an integrated manner. The purpose of the theory is aimed at the promotion of health of the individual, family, group and community.

- *Person*

A person within the context of this research refers to a community nurse who experiences psychological abuse in interaction with others in his/her workplace. Cognisance should be taken of the fact that the whole person (community nurse) embodies all the dimensions of body, mind and spirit and that people function in an integrated, interactive manner with the environment in which they find themselves.

- *Nursing*

Community nursing is an interactive process where the nurse, as a sensitive therapeutic professional, facilitates the promotion of heath through the mobilisation of resources.

- *Environment*

The environment includes the internal and external environment of the community nurse. The internal environment consists of the dimensions of body, mind and spirit and the external environment incorporates aspects such as the physical, social and spiritual dimensions of the community nurse in his or her daily life.

1.5.2 Theoretical Assumptions

The theoretical departure point of this research is based on the Theory for Health promotion of nursing as nursing theory, the theoretical assumptions underlying this theory, and the definition of key concepts (University of Johannesburg, 2006:2-7).

1.5.2.1 Definition of key concepts

- *Community Nurse*

Vlok (1996:8) categorises a community nurse as someone whose sphere of work is mainly in the community, i.e. outside of the hospital, and emphasis is placed on preventative health and health promotions measures. A community nurse needs to bring health care as close as possible to the community, be it in the home, the place of work, the school or the clinic situated within easy reach of the target population. A community nurse can therefore be viewed as any nurse who dispenses health care outside the hospital and comes into direct contact with the "patient-in-his-environment".

- *Professional nurse*

Viljoen and Uys (1987:1) views a professional nurse as an individual who is registered with the South African Nursing Council based on the assumption that he/she met the minimum requirements laid down by this statutory body. Furthermore, it is assumed that this individual possesses a disciplined intellectual approach to problem solving, which is in turn based on a broad knowledge base.

- *Community health*

Charlotte Searle (1992:1) is of the opinion that Hanlon (1974) has most appropriately defined community health by stating that "health is a state of total effective physiological and psychological functioning: it has both a relative and an absolute meaning, varying through time and space both in the individual and in the group; it is the result of the combination of many forces, intrinsic and extrinsic, inherited and contrived, individual and collective, private and public, medical, environmental and social; and it is conditioned by culture, economy, law and governments."

- *Psychological abuse*

Loring (1994:15) cites Martin (1976) and Walker (1984) in the explanation of the term emotional abuse and characterizes it to include aspects of non-physical abuse, indirect abuse, emotional abuse, *psychological abuse*, psychological aggression, psychological maltreatment and mental or psychological torture. Regardless of the terminology, this type of violence – fraught with degradation, fear and humiliation – has been described by Fortune (in Loring, 1994:15) as the most painful, and by Ferraro (in Loring, 1994:15) as the most detrimental to self-esteem. It dismembers the victim's self by systematically attacking personality, style of communication, accomplishments, values and dreams.

- *Strategies*

Hanks (1979:650) define strategies as a set of principles put forward to determine standards or to chart a course of action.

1.5.3 Methodological Assumptions

According to Blaxter et al (2003:59), methodological assumptions relate to the approach or paradigm that underpins the research, and will serve as guidelines for the research. The methodological assumptions for this research are based on the research model of Botes (in University of Johannesburg, 2006:9-14), which presents the activities on nursing on three levels, or orders. Level one represents nursing practice, level two incorporates the theory of nursing and research methodology and level three represents the paradigmatic perspective of nursing. The

purpose of nursing research is functional by nature, which implies that a current issue (in this instance to explore and describe the community nurse's experience of psychological abuse in interaction with others in the workplace) needs to be addressed, and solutions must be provided. Measures to ensure trustworthiness will be applied to the research process to ensure rigour. The two principles of post-modern research will be adhered to, namely logic and justification.

1.6 RESEARCH DESIGN

A research design is a blueprint for conducting a study that maximizes control over the factors that could interfere with the validity of the findings. The research design guides the researcher in planning and implementing the study in the way which is most likely to achieve the intended goal (Burns and Grove, 2001:223).

A qualitative, exploratory, descriptive and contextual research design will be utilised. This research will make use of a phenomenological inquiry approach, as it strives to bring to verbalize perceptions of human experiences with all types of phenomena. Since community nursing practice is enmeshed in the life experience of people, the phenomenological research method is well suited to the investigation of the phenomena of psychological abuse amongst community nurses (Streubert and Carpenter, 1995:29).

1.7 RESEARCH METHOD

This research will be conducted in two phases. Phase one incorporates the exploration and description of the community nurses' experience of psychological abuse in interaction with others in the workplace. Population and sampling, data collection, data analysis and literature control, as well as the establishment of validity and reliability, will form part of this phase.

Phase two is based on the processed information gathered in phase one. During phase two strategies will be developed to assist community health nurses who are psychologically abused. The research method is comprehensively discussed in chapter two.

1.7.1 Ethical Considerations

This study will call for not only expertise and diligence, but also for honesty and integrity as well. Ethical research is essential to generate sound knowledge for practice. According to Winter (2000:12) truth do not merely concern the factual events or statements recorded during the data gathering, but the research process as a whole. The following human rights, which will require protection in this study, are:

- *Self-determination*

The right to self-determination is based on the ethical principle of respect for persons. This principle holds that because humans are capable of self-determination or controlling their own destiny, they should be treated as autonomous agents, who have the freedom to conduct their lives as they choose without external controls (Burns and Grove, 2001:196).

Nurses in the field of community nursing will be treated as autonomous agents, by informing them about the proposed study and allowing them to voluntarily choose to participate or not. In addition, the nurses will be informed that they have the right to withdraw from the research at any time without penalty.

- *Privacy*

Privacy is the right an individual has to determine the time, extent and general circumstances under which personal information will be shared with, or withheld from, others (Burns and Grove, 2001:200). The right to privacy of community health nurses in this study will be protected by ensuring that they consent to participate in the study, and reassuring them that the sharing of information will be purely voluntary. Furthermore, participants will be informed that all audio-recordings will be destroyed once data collection is complete.

- *Anonymity and confidentiality*

On the basis of the right to privacy, the research subject has the right to anonymity and the right to assume that the data collected will be kept confidential. (Burns and Grove, 2001:201). The researcher will know the identity of the participants, but their identities will be kept anonymous. In-depth semi-structured interviews will be conducted and naïve sketches will be collected from participants. All data gathered will be treated with confidentiality.

- *Fair treatment*

The right to fair treatment is based on the principle of justice and holds that each person should be treated fairly and should receive what he or she is due or owed. In research the selection of participants and their treatment during the course of the study should be fair (Burns and Grove, 2001:202). To meet the ethical requirements of fair treatment, the researcher will undertake to be on time for each appointment and will terminate the data collection process at the agreed-upon date. Copies of the study findings will be provided to the participants, if so desired.

- *Protection from discomfort and harm*

The right to protection from discomfort and harm is based on the ethical principle of beneficence, which holds that one should do good and, above all, do no harm. According to this principle members of society should take an active role in preventing discomfort and harm, and promoting good in the world around them (Burns and Grove, 2001:203). It is likely that participants will be asked questions that might reopen old emotional wounds, or involve reliving traumatic events and to this extent support will be provided as necessary.

1.7.2 Measures to ensure trustworthiness

Lincoln and Guba's (in Krefting, 1991:214) model of trustworthiness will be used in this research. This model is based on the identification of four aspects of trustworthiness that are relevant to qualitative research, namely:

- credibility
- transferability
- dependability
- confirmability

Measures with regard to validity and trustworthiness are discussed in detail in chapter two.

1.7.3 Phase one: The enquiry and description of the community nurse's experience of psychological abuse in interaction with others in the workplace.

What forms part of phase one is the exploration and description of the community nurse's experience of psychological abuse in interaction with others in the workplace. The following will form part of this phase.

1.7.3.1 Data Collection

During phase one, participants in the research will be selected and an in-depth, semi-structured phenomenological interview will be conducted with each participant. These interviews will be audio recorded and transcribed verbatim. The researchers' comments will be made directly after each interview and the data analysed will be verified. Some participants will be asked to write naïve sketches (Giorgi, 1985:5-8) of their experiences of psychological abuse. A detailed discussion of data collection will be made in chapter two.

1.7.3.2 Population and Sampling

Purposeful sampling is used most commonly in phenomenological inquiry. This method of sampling selects individuals for participation in the study on the basis of their particular knowledge of a phenomenon, for the purpose of sharing that knowledge (Streubert and Carpenter, 1995:43).

Patton (in Streubert and Carpenter, 1995:43) explains that the logic and power of purposeful sampling lies in selecting information-rich cases for study in depth. Information-rich cases are

those from which one can learn a great deal about issues of central importance to the purpose of the research, thus purposeful sampling.

Sample selection provides the participants for the investigation. Participants, once they have agreed to participate, should be contacted before the interview to prepare them for the actual meeting and to answer any preliminary questions they might have. At the time of the first interview, informed consent and permission to tape record, - if this data-gathering instrument is used, - can be obtained. Piloting interview skills and having a more experienced phenomenological researcher listen to the tape of an interview, can assist in the development of interviewing skills (Streubert and Carpenter, 1995:43).

Streubert and Carpenter (1995:24) are of the opinion that the concept of saturation is closely related to the topic of sampling and it refers to the repetition of discovered information and the confirmation of previously collected data. This implies that, rather than sampling a specific number of individuals to gain significance based on some statistical manipulation, interviews will be conducted until repetition of salient points or themes is achieved. The size of the sample will therefore be directly influenced by the extent to which data saturation occurs.

In this research the sample will be registered community nurses that has been working in a community setting for at least three years, and will be drawn from the Lowveld region in Mpumalanga. Sampling criteria and sampling techniques are discussed in detail in chapter two.

1.7.3.3 Data Analysis

Streubert and Carpenter (1995:45-46) hold the opinion that data analysis requires the researcher to dwell with, or become immersed in, the data. This begins with listening to the participants' verbal descriptions, followed by reading and re-reading the verbatim transcriptions or written responses. As the researcher becomes immersed in the data, significant statements are identified and extracted.

In the data analysis phase of this research, word-for-word transcriptions of the audiotapes containing the community health nurses' verbal descriptions of their experiences of psychological abuse will be made. Data analysis is discussed in detail in chapter two.

1.7.3.4 Literature Control

The review of literature should follow data analysis. According to Streubert and Carpenter (1995:46) the rationale for postponing the literature review is related to the goal of achieving a pure description of the phenomenon under investigation. The fewer ideas or preconceived notions the researcher has about the phenomenon under investigation, the less likely the researcher will be influenced by this bias. Once data analysis is complete, the researcher reviews the literature in order to place the findings within context of what is already known about the topic (Streubert and Carpenter, 1995:46).

1.7.4 Phase two: Description of strategies to assist nurses who are psychologically abused

Data collected and analysed during phase one will be used in phase two to develop strategies for utilization by community health nurses who have experienced psychological abuse.

1.8 DIVISION OF CHAPTERS

Chapter one	–	Introduction and overview
Chapter two	–	Research design and method
Chapter three	–	Research results: Experiences of community nurses' psychological abuse
Chapter four	-	Strategies to assist nurses who are psychologically abused
Chapter five	–	Conclusion, evaluation and recommendations

1.9 CONCLUSION

As a point of departure an introduction and rationale was established for the research problem. A gap was identified in existing research in relation to psychological abuse experienced by community nurses, thus necessitating this study. A research question and subsequent research objectives were established in order to study the phenomenon of psychological abuse amongst community health nurses and to develop ensuing strategies. Paradigmatic perspectives were established, key concepts were defined and the research design and method were briefly outlined.

CHAPTER TWO: RESEARCH DESIGN AND METHOD

2.1 INTRODUCTION

In chapter one the rationale of the research, the assumptions and the objectives of the research were discussed in detail and an overview of the research design and research method was given. The latter are discussed in detail in this chapter.

2.2 RESEARCH DESIGN

Burns and Grove (2001:223-225) argues that a research design is a blueprint for conducting a study that maximises control over factors that could interfere with the validity of the findings. It guides the planning and implementation of the study in a way, which is most likely to achieve the intended goal. The control provided by the design increases the probability that the study results will be accurate reflections of reality. Skill in selecting and implementing a research design, being able to identify the study designs and to evaluate the threats to validity of findings due to design flaws, are an important part of critiquing studies. This is important for improving the quality of the study and, thus the usefulness of the findings.

The term research design is used in two ways. Some consider research design to be the entire strategy for the study, from identification of the problem to final plans for data collection. Others limit design to clearly defined structures within which the study is implemented. The design used in this research is qualitative, phenomenological, exploratory, descriptive and contextual in nature (Burns and Grove, 2001:223-225).

The design of a study is the end result of a series of decisions made by the researcher concerning how the study will be implemented. The design is closely associated with the framework of the study and it guides the planning and implementation of the study. As a blueprint, the design is not specific to a particular study. Rather, it is a broad pattern or guide that can be applied to many studies.

Using the problem statement, framework, research questions and clearly defined variables, the researcher can map out the design to achieve a detailed research plan for data collection and analysis.

2.2.1 Qualitative

Qualitative research has a long, distinguished, and sometimes anguished history in the human disciplines. In sociology, the work of the Chicago school in the 1920s and the 1930s established the importance of qualitative inquiry for the study of the human group of life. In anthropology, during the same time period, the discipline-defending studies of Boas, Mead, Benedict, Bateson, Evans-Prichard, Radcliff-Brown and Malinoski charted the outlines of the fieldwork method.

The agenda was clear-cut: the observer went into a foreign setting to study the customs and habits of another society and culture. Soon qualitative research would be employed in other social and behavioural science disciplines, including education, history, political science, business, medicine, nursing, social work and communications (Denzin and Lincoln, 2003:1).

Qualitative research, as a set of interpretative activities, favours no single methodological practice over another. As a site of discussion, or discourse, qualitative research is difficult to define clearly. It has no theory or paradigm that is distinctly its own. Multiple theoretical paradigms claim use of qualitative research methods and strategies, from constructivist to cultural studies, feminism, Marxism, and ethnic models of study. Qualitative research is used in many separate disciplines and it does not belong to a single discipline. Nor does qualitative research have a distinct set of methods or practices that are entirely its own. Qualitative researchers use semiotics, narrative, content, discourse, archival and phonemic analysis, even statistics, tables, graphs and numbers. They also draw upon, and utilize, the approaches, methods, and techniques of ethnomethodology, phenomenology, hermeneutics, feminism, rhizomatics, deconstructualsim, ethnography, interviews, psychoanalysis, cultural studies, survey research and participant research. All of these research practices can provide important insights and knowledge and no specific method or practice can have favour over any other (Denzin and Lincoln, 2003:10).

Qualitative research is an interdisciplinary, trans-disciplinary, and sometimes counter-disciplinary field. It crosscuts the humanities and the social and physical sciences. Qualitative research is many things at the same time. It is multiparadigmatic in focus. Its practitioners are sensitive to the value of the multi-method approach. They are committed to the naturalistic perspective and to the interpretive understanding of the human experience. At the same time, the field is inherently political and shaped by multiple ethical and political positions (Nelson, 1992:4).

Qualitative research embraces two tensions at the same time. On the one hand, it is drawn to a broad, interpretative, post-experimental, post-modern, feminist, and critical sensibility. On the other hand, it is drawn to the more narrowly defined positivist, post-positive, humanistic experience and its analysis. Further, these tensions can be combined in the same project, bringing both post-modern and naturalistic or both critical and humanistic perspective to bear (Nelson, 1992:4).

This rather complex statement means that qualitative research, as a set of practices, embraces within its own multiple disciplinary histories constant tensions and contradictions over the project itself, including its methods and the forms which its findings and interpretations take. The field sprawls between, and crosscuts, all of the human disciplines, even including, in some cases, the physical sciences. Its practitioners are variously committed to modern, post-modern, and post-experimental sensibilities and the approaches to social research that these sensibilities imply.

Qualitative research rests on six significant pillars, namely: a belief in multiple realities; a commitment to identifying an approach to understanding that will support the phenomenon studied; commitment to the participant's point of view; conduct of an inquiry that does not disturb the natural context of the phenomena of interest; acknowledged participation of the researcher in the research; and, conveyance of the understanding of the phenomena by reporting in literary style which is rich with participant's commentary (Streubert and Carpenter, 1995:10).

Qualitative research is best suited for this study, as the researcher wants to explore, give meaning to and describe the community nurse's experience of psychological abuse in interaction with others in the workplace, and to develop strategies which will assist community health nurses to deal with psychological abuse. In-depth semi-structured phenomenological interviews were conducted and naïve sketches were collected from participants during this research. This approach affords the researcher the unique opportunity to observe, document, interpret and analyse the experiences of each participant in the study.

2.2.2 Phenomenological

Phenomenology is a science the purpose of which is to describe particular phenomena, or the appearance of things, as lived experience. It is a system of interpretation that helps us to perceive and conceive ourselves, our contacts and interchanges with others, and everything else in the realm of our experiences, in a variety of ways, including to describe a method as well as a philosophy or a way of thinking. The approach is both inductive and descriptive in its design and is viewed by Streubert & Carpenter (1995:30-31) as a method "… the trick of making things whose meanings seem clear, meaningless, and then, discovering what they mean."

Lived experience of the world of everyday life is the central focus of phenomenological inquiry; and it describes the world of everyday life as the total sphere of experiences of an individual, which world is circumscribed by the objects, persons and events encountered in the pursuit of the pragmatic objectives of life. The phenomenologist is committed to understanding social phenomena from the participants' perspective, and would examine how the world is experienced accordingly. The important reality is what people perceive it to be (Patton, 2002:69).

Phenomenology seeks the very nature of a phenomenon; for that which makes something what it is – and without which it could not be what is (Van Manen, 1990:10). The initial clarity of this definition can fade rapidly because the term phenomenology has become so popular, and has been so widely embraced, that its meaning has become confused and diluted. It can refer to a philosophy (Husserl 1967), an inquiry paradigm (Lincoln 1990), an interpretive theory (Denzin and Lincolin, 2000:14) a social science analytical perspective or orientation (Harper, 2000:727), a major qualitative tradition (Creswell 1998), or, a research method's framework.

Varying forms complicate the picture even more: transcendental, existential, and hermeneutic phenomenology offer different nuances of focus – the essential meanings of individual experience, the social construction of group reality, and the language and structure of communication, respectively (Schwandt, 2001:191-194). Phenomenological traditions in sociology and psychology vary in unit of analysis, group or individual (Creswell, 1998:53). Adding further confusion to the mix, the term phenomenography was coined by Ulrich Sonnemann (1954) to emphasize a descriptive recording of immediate subjective experience as reported (Sonnemann, 1954:344).

What these various phenomenological and phenomenographic approaches have in common is a focus on exploring how human beings make sense of experience and transform experience into consciousness, both individually and as shared meaning. This requires methodologically carefully and thoroughly capturing and describing how people experience some phenomenon – how they perceive it, describe it, feel about it, judge it, remember it, make sense of it and talk about it with others. To gather such data, one must undertake in-depth interviews with people who have directly experienced the phenomenon of interest; that is, they have lived experience, as opposed to second hand experience (Patton, 2002:104-105).

Phenomenology aims at gaining a deeper understanding of the nature or meaning of our everyday experiences. Anything that represents itself to consciousness is potentially of interest to phenomenology, whether the object is real or imagined, empirically measurable or subjectively felt. Consciousness is the only access human beings have in the world. Or rather, it is by virtue of being conscious that we are already related to the world. Thus all we can ever know must present itself to consciousness. Whatever falls outside of consciousness therefore falls outside of the bounds of our possible lived experience. A person cannot reflect on lived experience while living though the experience. For example, if one tries to reflect on one's anger while being angry, one finds that the anger has already changed or dissipated. Thus, phenomenological reflection is not introspective but retrospective. Reflection on lived experience is always recollective; it is reflective on experience that has already passed or been lived through (Van Manen, 1990:9-10).

By phenomenology Husserl (1913) meant the study of how people describe things they have experienced them through their senses. His most basic philosophical assumption was that we could only know what we experience by attending to perceptions and meanings that awaken our conscious awareness. Initially, all our understanding comes from sensory experience of phenomena, but that experience must be described, explicated, and interpreted. Yet, descriptions of experience and interpretations are so intertwined that they often become one. Interpretation is essential to an understanding of experience, and the experience includes the interpretation. Thus, phenomenologists focus on how we put together the phenomena we experience in such a way as to make sense of the world and, in so doing, develop a worldview. There is no separate reality for people. There is only what they know their experience is and means. The subjective experience incorporates the objective thing and becomes a person's reality. Hence the focus on meaning making as the essence of human experience (Van Manen, 1990:10).

From a phenomenological point of view, there is less interest in the factual status of particular instances: whether something happened, how often it tends to happen, or how the occurrence of an experience is related to the prevalence of other conditions or events. There are two implications of this perspective that are often confused when discussing qualitative methods. The first implication is that it is important to know what people experience and how they interpret the world. This is the subject matter, the focus, of phenomenological inquiry. The second implication is methodological. The only way for us to really know what another person experiences, is to experience the phenomenon as directly as possible for ourselves. This leads to the importance of participant observation and in-depth interviewing. In either case, when reporting phenomenological findings, the essence or nature of the experience has been adequately described in language if the description reawakens, or shows us, the lived quality and significance of the experience in a fuller and deeper manner (Van Manen, 1990:10).

There is one final dimension that differentiates a phenomenological approach: the assumption that there is an essence or essences to shared experience. These essences are the core meanings mutually understood through a phenomenon commonly experienced. The experiences of different people are bracketed, analysed, and compared to identify the essences of the phenomenon. Phenomenological research is the study of essences (Van Manen, 1990:10).

In the context of this study, it was important to the researcher to describe as accurately as possible the lived experience of psychological abuse as experienced by the community nurse in the workplace. A phenomenological approach gave the researcher the essence to share the experience.

2.2.3 Exploratory

Exploratory research is focused on the exploration of a relatively unknown area, and its aims are to obtain new insights into a phenomenon, conduct a preliminary investigation as a precursor to a more structured study, and determine priorities for further research, to develop new hypotheses about an existing phenomenon (Garber, 1996:287). In this study, the researcher intended to determine a deeper understanding of the community nurse's experience of psychological abuse in interaction with others in the workplace.

2.2.4 Descriptive

The research is furthermore descriptive in nature as it will accurately, and as clearly as possible, try to describe that which already exists (Garber, 1996:287. The experiences of the participants and the observations of the researcher will be described, and thus documenting the phenomenon of interest (Marshall & Rossman, 1989:78).

In this research the experiences of the community nurse and the observations by the researcher will be described, as well as strategies to assist community health nurses to deal with psychological abuse.

2.2.5 Contextual

Within the framework of contextual design, a phenomenon is investigated in its natural environment. Burns and Grove (2001:65) hold the opinion that the person is integral to the environment and the world is shaped by the self, and also shapes the self. As such, the person is situated as a consequence of being shaped by his or her world and thus the person's ability to establish meanings through language, culture, history, purposes, and values. Therefore, the person has only situated freedom, not total freedom. Each participant's circumstance

within the framework of this research is unique, and as such contributes in a unique manner to the outcome of the research, due to the intrinsic and contextual nature of the design.

2.3 RESEARCH METHOD

In order to give effect to the research objectives, the research was conducted in two phases. The methods for each of the phases are expanded upon in the following sections.

2.3.1 Phase one: The exploration and description of the community nurse's experience of psychological abuse in interaction with others in the workplace

During this phase, the community nurse's experience of psychological abuse in interaction with others in the workplace, was explored, and described by means of an in-depth, semi-structured phenomenological interview.

2.3.1.1 Population and Sampling

According to Mouton (1996:132) sampling is a familiar notion. In everyday life we talk of sampling when we refer to the process of selecting things or objects when it is impossible to have knowledge of a larger collection of these items. In social research, sampling refers to (probability) sampling procedures, which involve some form of random selection of elements from a target population.

Perhaps nothing better captures the difference between quantitative and qualitative methods than the different logics that underpin the sampling approaches. Qualitative inquiry typically focuses in depth on relatively small samples, even single cases selected purposefully. Quantitative methods typically depend on larger samples selected randomly. Not only are the techniques for sampling different, but also the very logic of each approach is unique because the purpose of each strategy is different (Patton, 2002:230).

The logic and power of purposeful sampling lie in selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the inquiry, hence the term purposeful sampling.

Studying information-rich cases yields insights and in-depth understanding rather than empirical generalisation. The purpose of an evaluation is to increase the effectiveness of a program in reaching lower socio-economic groups. One may learn a great deal more by studying in depth a small number of carefully selected poor families than by gathering standardised information from a large, statistically representative sample of the whole programme.

Purposeful sampling focuses on selecting information-rich cases the study of which will illuminate the questions under study. Purposeful sampling is sometimes called purposive or judgement sampling. In judgment sampling, you decide the purpose you want informants (or communities) to serve, and you go out to find some (Bernard, 2000:176).

The term population refers to all those individuals who have met the selection criteria as highlighted in chapter one. Participants are purposefully selected by qualitative researchers to ensure the best possible answer for the research question. Streubert and Carpenter (1995:43) are of the opinion that purposeful sampling is used most commonly in phenomenological inquiry.

Individuals will be selected for study participation on the basis of their particular knowledge of a phenomenon, for the purpose of sharing that knowledge. Participants, once they have agreed to participate, will be contacted before the interview to prepare them for the actual meeting and to answer any preliminary questions they might have.

The criteria for inclusion in this study were twofold in nature, namely (1) being a community nurse for a period of more than three years, and (2) having some insight in relation to the study.

2.3.1.2 Data collection

Kvale (1983:174) argues that the qualitative research interview is technically semi-structured and that it is neither a free conversation nor a highly structured questionnaire.

During the interviews one central question was asked, namely: How do you experience psychological abuse in the workplace?

Interviews were taped and transcribed word for word. The data gathered by the researcher through interviews, and the naïve sketches, were analysed by an independent coder. The typed out version, together with the audio tape(s), as well as the naïve sketches, will constitute the material for data collection.

(a) The Interview-situation: Twelve Aspects

The mode of understanding in the qualitative research interview may be briefly outlined in twelve main aspects. It: (1) is centred on the interviewee's life-world; (2) seeks to understand the meaning of phenomena in his/her life-world; it is (3) qualitative, (4) descriptive, (5) specific; (6) presuppositionless; (7) focused on certain themes; open for (8) ambiguities; and (9) changes; it depends upon the (10) sensitivity of the interviewer; it takes place in (11) an interpersonal situation; and it may be (12) a positive experience.

These aspects may more or less explicitly, be found scattered in concrete descriptions of interview projects. As brought together here they represent an attempt at describing the main structure of the interview method. The internal relations between the different aspects remain insufficiently worked out (Kvale, 1983:174).

(1) Life-world

The subject of the qualitative research interview is the life-world of the interviewee and his relation thereto. The purposes are to describe, and understand, the central themes which the interviewee experiences and lives towards. The qualitative research interview is theme oriented and not person oriented. Two people are talking together about a theme, which is interesting, and important, to both persons. The resulting interview may then be analysed primarily with respect to the life-world that is described by the person, or with respect to the person who is describing his life-world (Kvale, 1983:174).

(2) Meaning

The qualitative research interview seeks to describe, and understand, the meaning of central themes in the life-world of the interviewee. The main task in interviewing is to understand the meaning of what is said. The interviewer thus registers and interprets what is said, as well as how it is said; he must be observant of, and able to interpret, vocalization, facial expressions and other bodily gestures (Kvale, 1983:175).

(3) Qualitative

The qualitative research interview aims at obtaining descriptions from the different qualitative aspects of the interviewee's life-world, as far as possible. Neither in the interview phase nor in the later analysis phase, is the purpose primarily to obtain quantifiable responses. Here it contrasts with the usual questionnaire and content analysis approaches. Precision in the description and stringency in meaning interpretation in qualitative interviews, correspond to exactness in quantitative measurements (Kvale, 1983:175).

(4) Descriptive

The qualitative research interview aims at obtaining uninterpreted descriptions. The interviewee describes as precisely as possible what she experiences, and feels, and how she acts. The question of why she experiences and acts as she does, is primarily the task for the interviewer to evaluate (Kvale, 1983:175).

(5) Specificity

The qualitative research interview seeks to describe specific situations and action sequences in the world of the interviewee. It is not the general opinions which are investigated, but the experiences thereof (Kvale, 1983:176).

(6) Presuppositionless

The qualitative research interview attempts to gather descriptions of the relevant themes of the interviewee's life-world, which are as rich and presuppositionless as possible. Rather than the interviewer coming with ready-made categories and schemes of interpretations, the presuppositionlessness advocated here implies an openness to new and unexpected phenomena. The interviewer should be curious, sensitive to what is said – and to what is not said – and critical to his own presuppositions and hypotheses during the interview (Kvale, 1983:176).

(7) Focused

The qualitative research interview is focused on certain themes of the life-world of the interviewee. It is neither strictly structured with standardised questions, nor entirely non-directive, but it focused on certain themes (Kvale, 1983:176).

(8) Ambiguity

The statements of an interviewee may sometimes be ambiguous. Some expressions may be open to several possibilities of interpretation and the interviewee may give apparently contradictory statements during an interview. Here it is the task of the interviewer to seek clarity as far as possible, whether the ambiguities and contradictory statements are due to a failure of communication in the interview situation or whether they reflect real inconsistencies, ambivalences and contradictions by the interviewee. The aim of the qualitative research interview is not to end up with unequivocal and quantifiable meanings on the themes' focuses. What matters, rather is to describe precisely the inherently contradictory meanings expressed by the interviewee. The contradictory statements of the interviewee need not merely be due to faulty communication in the interview situation, or the personality structure of the interviewee, but may be adequate reflections of objective contradictions of the world in which he lives (Kvale, 1983:176).

(9) Change

It may be that an interviewee comes to change his descriptions of the meanings about a theme, during the interview, at which time the interviewee may himself discover new aspects to the themes he is describing, and he may suddenly see relationships of which he was not conscious earlier (Kvale, 1983:177).

(10) Sensitivity

Interviews obtained by different interviewers using the same interview guide may be different due to the varying sensitivity of the interviewer. They may well vary in the sensitivity to the interpersonal interaction in the interview situation as to their sensitivity towards and knowledge of the topic of the interview (Kvale, 1983:177).

(11) Interpersonal situation

The interview is an interaction between two people. Interviewer and interviewee react in relation to each other and reciprocally influence each other. The interview situation may, for both parties, be characterised by positive feelings of common intellectual curiosity and reciprocal respect, or the interview situation may be anxiety provoking and evoke defence mechanism in the interviewee as well as the interviewer. The interviewer should be conscious of the interpersonal dynamics within the interaction and take these into account in the interview situation and in the later analysis of the completed interview. The reciprocal influence of interviewer and interviewed on both the cognitive as well as the emotional level is, however, not primarily a source of error but a strong point of the qualitative research interview. Rather than seeking to reduce the importance of the interpersonal interaction in the situation, the interviewer needs to recognise and apply the knowledge of, this interaction in the interview (Kvale, 1983:178).

(12) Positive experience

A qualitative research interview may be a favourable experience for the interviewee. The interview is a conversation where two people talk about a theme of interest to both parties. A well carried through qualitative interview may be a rare and enriching experience for the interviewee. It is probably not a very common experience from everyday life that another person, for an hour or more, is only interested in, sensitive towards, and seeking to understand as well as possible, one's experiences of a subject matter (Kvale, 1983:178).

(b) Role of the researcher

Creswell (1994:147) states that qualitative research is interpretative research. As such, the biases, values, and judgement of the researcher become stated explicitly in the research report. Such openness is considered to be useful and positive. Gaining entry to the research site and the ethical issues that might arise, are two elements of this role.

During the interviews one central question was asked, namely: How do you experience psychological abuse in the workplace?

Interviews were taped and transcribed word for word. The data gathered by the researcher through interviews and the naïve sketches was analysed by an independent coder. The typed out version, together with the audio tape(s), as well as the naïve sketches, will constitute the material for data collection.

Poggenpoel (in De Vos, 2000:337) indicates that a researcher can use the tool of bracketing to lay aside, or suspend, what is known about the experience being studied and that this is similar to the idea of achieving an open context. As such in this research project, the researcher posed one primary question to each respondent (community nurse) and allowed the interview to come to its logical conclusion.

Intuiting requires the researcher to become totally immersed in the phenomenon under investigation and is the process whereby the researcher is beginning to know about the phenomenon as described by the participants. To this end the researcher needs to avoid all criticism, evaluation, or opinion and should only pay strict attention to the phenomenon under investigation, as it is being described (Streubert and Carpenter, 1995:36).

(c) Phenomenological interviews

The goal of phenomenological interviews, according to Streubert and Carpenter (1995:31) is to describe the lived experience and to this end the everyday world is viewed as being the total sphere of an individuals experiences, of an individual which is circumscribed by the objects, person and events encountered in the pursuit of living.

During this research the interviews were held in the office at the workplace of the participants. The participant and interviewer were seated together, facing one another. A tape recorder was placed on a table, in between the researcher and the participant. Each participant was assured of privacy and confidentiality.

(d) Pilot interview

A pilot interview serves as a test run for the researcher to experience the complexity and the dynamics within a specific research field. It furthermore provides the researcher with an

opportunity to gain the necessary experience with the chosen research method (Strydom in De Vos, 2000:179-183).

In this research project the researcher undertook a pilot interview to gain experience and exposure to the process of phenomenological interviewing in general and, secondarily, to gain experience for the conducting of subsequent interviews. The participant who took part in the pilot interview was also included in the research.

(e) Observation and field notes

Observation provides depth to a study and makes available contextual information which cannot be provided by means of an interview alone. The purpose of observation and field notes is to obtain accurate and detailed descriptions of the behaviour and reactions of the participants. Field notes are written observations of that which the researcher experiences with his/her senses (Strydom in De Vos, 2000:179-183).

During this research, the model of Schatzman and Strauss (in De Vos, 2000:285-286) was used. The model consists of three elements, namely: observational notes, theoretical notes and methodological notes.

- *Observational notes* give an account of what happened. Little or no interpretation is provided. The account states who said or did what, under given circumstances.
- *Theoretical notes* are self-conscious, systematic attempts by the researcher to derive meaning from some, or all, observational notes.
- *Methodological notes* are mainly reminders, instructions and critical comments to the recorder or researcher.

2.3.1.3 Data Analysis

The following eight steps, determined by Tesch for data analysis as discussed by Poggenpoel (in De Vos, 2000:343-344), were used in this study:

1. The researcher ought to get a sense of the whole by reading through all of the transcriptions carefully, and jot down some ideas as they come to mind.
2. The researcher selects one interview and goes through it asking "What is this about?" and thinking about the underlying meaning in the information, while simultaneously writing down, in the margin, any thoughts which might occur.
3. When the researcher has completed this task for several participants, a list is made of all the topics. Similar topics are clustered together and formed into columns that might be arranged into major topics, unique topics and leftovers.
4. The researcher takes the list and returns to the data. The topics are abbreviated as codes and the codes are written next to the appropriate segments of the text. The researcher tries out this preliminary organizing scheme to see whether new categories and codes emerge.
5. The researcher finds the most descriptive wording for the topics and turns them into categories. This is done in an endeavour to reduce the total list of categories by grouping together topics that relate to each other. Lines are drawn between the categories to show interrelationships.
6. The researcher makes a final decision on the abbreviation for each category and alphabetises the codes.
7. The data material belonging to each category is assembled in one place and the preliminary analyses performed.
8. The researcher recodes existing data if necessary.

The purpose of the qualitative research interview was earlier stated as the description and understanding of the meaning of themes in the life-world of the interviewee. There exists a continuum between description and interpretation, and below six possible phases – which do not necessarily presuppose each other logically or chronologically – are outlined.

(1) A first phase is that the interviewee describes his experiences. He describes spontaneously what he does, feels and thinks about the theme, without any special interpretations of the descriptions from either the interviewer or the interviewee (Kvale, 1983:180).

(2) A second phase would be that the interviewee discovers new relationships; sees new meanings in what he experience and does. The interviewee himself begins to see new connections in life-world on the basis of his/her spontaneous descriptions, and this phase occurs without any direct influence from interpretation by the interviewer.

(3) In a third phase, during the interview the interviewer condenses and interprets the meaning of what the interviewee describes, and may send the interpreted meaning back. The interviewee then has a possibility of replying "I did not mean that" or "that was precisely what I was trying to say" or "No, that was not quite what I felt". The interpretations here may take form of a dialogue within the interview, and this ideally continues until there is only one possible interpretation left, or all the basic contradictions have been worked out.

(4) In a fourth phase, the completed and transcribed interview is interpreted by the interviewer alone or by another person. One may here broadly distinguish between three levels of interpretation: self-understanding, common sense and theory.

(5) A fifth phase of interpretation would be the re-interview. When the interviewer has analysed and interpreted the completed interviews, he/she may give the interpretations back to the interviewee. In the re-interview the interviewee may then comment upon the interviewer's interpretation of his/her statements, and the themes touched upon in the first interview may be explored more fully in the re-interview. This form of re-interviewing implies a continuation of what was above described as a self-corrective interview, and the interviewee gets a further opportunity to correct and elaborate upon the interviewer's interpretation of his statements.

(6) A possible sixth phase would be to extend that the continuum of description and interpretation to include action. This may mean that the interviewee begins to act from new insights he/she might have gained during the interview. In such a case the research interview would come close to a therapeutic interview; and the changes may be brought about by the actions in a broader social context, in the form of an action research, where

the scientists and subjects together act on the basis of experience and insights about social situations, developed through the interviews (Kvale, 1983:182-183).

During this research a clear set of transcripts of the interviews and naïve sketches were provided to an independent coder who is experienced in qualitative data analysis. A consensus discussion took place between the researcher and the independent coder regarding the themes and categories identified.

2.3.1.4 Literature Control

The review of the literature was done continuously throughout all the phases of the research process and essentially this should follow data analysis. The rationale for postponing the literature review was related to the goal of achieving a pure description of the phenomenon under investigation. Once the data had been analysed, the researcher reviewed the literature in order to place the findings within the context of what was already known about the community nurse's experience of psychological abuse in interaction with others in the workplace (Streubert and Carpenter, 1995:46).

2.3.2 Phase two: To develop strategies, which will assist community health nurses to deal with psychological abuse.

In this phase the researcher made use of the collected and analysed data, as well as the literature review, to develop strategies which will assist community health nurses to deal with psychological abuse.

2.4 MEASURES TO ENSURE TRUSTWORTHINESS

Lincoln and Guba (in Holloway and Wheeler, 1996:163) identify four alternatives to develop effective evaluation of qualitative research, namely: credibility, transferability, dependability and confirmability. These alternatives provide the foundations for demonstrating both trustworthiness and the decision trail, in qualitative research.

2.4.1 Credibility

Credibility in a study will be established by ensuring that those participating in the research are identified and described as accurately as possible. The prolonged involvement, persistent observation, triangulation, peer debriefing and member checks can enhance the credibility of the study (Holloway and Wheeler, 1996:163). See Table 2.1 for application of measures to ensure credibility.

2.4.2 Transferability

Transferability relates to how the findings of a study can be generalised or transferred from a representative sample of a population to the whole group. Holloway and Wheeler (1996:166-167) suggest that transferability will be achieved if the researcher has stated the characteristics and settings of those participating in the research. See Table 2.1 in relation to transferability.

2.4.3 Dependability

Dependability is the third alternative for establishing the trustworthiness of qualitative research and is reliant on credibility. According to Robson (in Holloway and Wheeler, 1996:167) a qualitative research study that establishes credibility will also be dependable. One of the ways in which a research study may be shown to be dependable as opposed to consistent, is for its process to be audited, that is, for external checks to be made. Refer to Table 2.1 for an application in this study to ensure dependability.

Table 2.1 MEASURES FOR TRUSTWORTHINESS

MEASURES	CRITERIA	APPLICATION
Credibility	Prolonged and varied field experience	◆ By spending time with the participants, before conducting the interview, the researcher gained their trust, and in this way promoted openness and rapport. ◆ Data was collected until saturation was achieved.
	Establishing authority of researcher	◆ The researcher is a Magister student in the field of community nursing. Supervision was undertaken by two study leaders, with previous research experience, both of whom have doctoral degrees.
	Triangulation	◆ More than one method of data collection: interviews, observation, field notes and naïve sketches.
	Peer examination	◆ Continued support and supervision from study leaders. ◆ Discussions with experts in the field of psychological abuse.
	Reflexivity	◆ The researcher reflected her own observations and thoughts by making observation notes.
Transferability	Dense description	◆ Clearly defined selection criteria. ◆ Description of demographic information of participants. ◆ Complete and richly descriptive data from interviews and results of the research.
Dependability	Dependability audit	◆ Continuous external investigative audits performed by the study leaders during each step of the research process. ◆ Clearly defined research methodology.
	Stepwise replication	◆ Clear description of the steps, which must be followed for the research to become replicative of nature.
	Triangulation	◆ As discussed.
	Peer examination	◆ As discussed.
	Code-recode procedure	◆ Independent data analyses done by researcher and independent coder.
Confirmability	Confirmability audit	◆ Consensus discussion with study leaders and independent coder.
	Triangulation	◆ As discussed.
	Reflexivity	◆ As discussed.

2.4.4 Confirmability

The fourth, and last, alternative for achieving trustworthiness in a qualitative study concerns the notion of confirmability. Lincoln and Guba (in Holloway and Wheeler, 1996:168) point out that confirmability means that the data is linked to their sources for the reader to establish that the conclusions and interpretations arise directly from them. In auditing the study, the following information should be examined: the raw data, the analysed data, the formation of the findings, the process of the study, the early intentions of the study and the development of the measure(s) used. Table 2.1 indicates the extent to which the measure of trustworthiness in terms of confirmability was achieved in this study.

2.5 FINDINGS, LIMITATIONS AND RECOMMENDATIONS

The findings, limitations and recommendations for this study will be made based on the results of the research. Recommendations will be made in terms of nursing practice.

2.6 CONCLUSION

In this chapter the research design and method was discussed. Measures to establish trustworthiness in this study were focused upon. In chapter three, the results, a discussion of the results and the literature review will be given.

CHAPTER THREE: EXPERIENCES OF COMMUNITY NURSES' PSYCHOLOGICAL ABUSE

3.1 INTRODUCTION

In chapter three the results achieved with the five individual in-depth semi-structured phenomenological interviews and the four naïve sketches, undertaken with community nurses, are discussed in detail. The results are described on the basis of main categories and sub-categories which are identified from the data, with the Theory for Health Promotion as an underlying paradigmatic perspective.

3.2 OPERATIONALISATION OF RESEARCH

The researcher experienced difficulty in finding community nurses who were willing to talk and write about their experiences of psychological abuse in the workplace. They were afraid that the information would be made known and then victimization would follow.

Each of the participants who agreed to be part of the research was visited to explain the objective and method of the research as well as the ethical guidelines. This visit was dual in purpose as it was also aimed at establishing a trustworthy relationship and answering any questions about the methology to be followed. An appointment was made for the most appropriate time and place to conduct the interviews and/or to deliver the essay question. All five interviews were conducted in the participants' own offices and the four naïve sketches were written at home.

Data was obtained by means of semi-structured in-depth phenomenological interviews as well as naïve sketches, in order to obtain rich descriptive data (Mouton, 1996:169), which was recorded on audiocassettes and in essay format. Interviews and naïve sketches were used until data saturation was achieved. The length of the interviews varied, based on the needs of the participants to talk.

The audiocassettes of the interviews were given to an experienced person, who transcribed them verbatim. All the interviews transcribed relatively easily and the data was analysed by an independent coder according to Tesch's method (Poggenpoel in De Vos, 1998:343-344) and

discussed until consensus was reached between the researcher and the external coder, who is an experienced psychiatric nursing specialist.

3.3 DESCRIPTION OF THE SAMPLE

A sample of five participants, one of which was part of the pilot study was used for the interview part of the research and four participants were used for the naïve sketches. Participants were selected purposefully, and at the end of the fifth interview and the completion of the fourth essay the researcher found that the data was saturated. The independent coder confirmed this. The sample of the interviews consisted of three white female community nurses and two black female community nurses. The naïve sketches sample constituted three black female community nurses and one black male community nurse. The results, based on the analysed data, will be discussed subsequently.

3.4 DESCRIPTION OF THE RESULTS

The experiences of the community nurses with regard to psychological abuse as experienced in the workplace were divided into main categories and sub-categories. Table 3.1 provides an overview of the results.

Table 3.1: AN OVERVIEW OF THE MAIN CATEGORIES AND SUB-CATEGORIES OF PSYCHOLOGICAL ABUSE AS EXPERIENCED BY COMMUNITY NURSES IN THE WORKPLACE

MAIN CATEGORY	SUB-CATEGORY
1. **Disempowering working conditions** exacerbating nurses experience of psychological abuse in the workplace	1.1 The lack of **human- and physical resources** promoting a sense of disempowerment and exploitation of nurses in the workplace setting. 1.2 Ineffective **communication** in the workplace 1.3 Nurses experience inadequate physical and emotional **safety and protection** in the workplace. 1.4 **Appointment and promotional policies** and the method of implementation thereof, leading nurses to experience their workplace to be unfair. 1.5 Nurse experience a lack of **appreciation and recognition**, demonstrated by the community (patients), employers and the government. 1.6 **Non consultation** of nurses in policy issues of the workplace leading to frustrations at grass roots.
2. **Disrespectful practices** demonstrated by the community (patients) as well as other nurses (co-workers and supervisors) in the workplace setting	2.1 **Verbal abuse** experienced from patients (the community) and rudeness between nurses in the workplace. 2.2 **Abusive practice** demonstrated by supervisors, such as: • Enforcing co-operation by nurses through threats • Indiscretion when addressing nurse-specific issues (mistakes) • Unprofessional treatment *"they treat us as school children"* 2..3 Accusation of acts of **racism** by patients and colleagues, disempowering nurses.
3. Nurses **respond** destructively to psychological abuse in the workplace setting	3.1 Nurses respond **interpersonally** through isolation and less effective verbal expressions. 3.2 Nurses experience a sense of **physical and emotional tiredness** leading to a response of surrendering to their work circumstances. 3.3 The **emotional responses** of nurses when exposed to psychological abuse in the workplace include: • Depression • Anxiety • Frustration • Regret • Hurt

The results are discussed, based on this table, and once main categories and sub-categories have been covered, a literature control takes place.

Both disempowering working conditions, as well as practises of disrespect demonstrated towards them, lead nurses to experience psychological abuse in the workplace setting. Nurses tell stories of psychological abuse from the community (patients), co-workers, supervisors and employers. Various intra- and interpersonal responses to psychological abuse in the workplace are experienced.

3.4.1 Main category: Disempowering working conditions

One of the main themes is a continual reflection of disempowering working conditions, exacerbating the nurse's experience of psychological abuse in the workplace through the following sub-categories: -

3.4.1.1 Sub-category: The lack of human and physical resources

The lack of human- and physical resources promotes a sense of disempowerment and exploitation of nurses in the workplace setting**.** Extracts from the naïve sketches and interviews go a long way to prove this. For instance, regarding staff shortages:

> **"… to little people …"**, **" … pressure and stress of staff shortages … "** and this **" … leads to inability to fulfil role expectation e.g. supervisory roles of clinics … "**.

> **"The few staff attending to many patients end up having burnout due to psychological stresses."**

One nurse went further and explained it in the following manner:

> **"… you see it in the work too little people to do the work and the pressure comes from all and also tantrums that is unrealistic tantrums to everything that needs to be done."**

A British study by Hingsley in 1984 (in McGrath et al, 2003:555-565) identified workload both in terms of quantity and inability to provide the quality desired, as a factor, which contributes to possible psychological abuse taking place. Bakker et al (2006:31) identified excessive workload as being a stressor in the workplace. According to Gwede et al (2005:1123) as well as Shamian et al (2003:81) chronic shortages of staff and the expectation "to do more with less" are of great concern and are seen as job-related stressors. Tyson and Pongruengphant are of the opinion that nurses experience high workloads as a major stressful event (Tyson and Pongruengphant, 2003:248).

The failure of patients to appreciate the over commitment by nursing staff leads to psychological stress and, thus, nurses are psychologically abused.

Many of the community nurses indicated that this negatively affects the quality of care they are able to deliver as they have to deal with:

" … about 50 patients per day per sister …"

while others feel the number to be as high as

" … 80 patients per day …".

Complaints or remarks are as far reaching as

" … we haven't had any tea breaks, nothing to eat or drink …".

Bernardin (2003:327-328) holds the opinion that job demands have been identified as psychological stressors, such as work too hard or too fast, having to much too do (role overload) or having conflicting demands from several sources (role conflict).

Cascio (1998:301) states that adequate resources must be provided in order for staff to perform their tasks and duties and to function as effectively as possible. Without these, implementation of policies will become extremely difficult.

The shortage of nurses:

> **"… causes stress and the amount of patients increase everyday."**

The community nurses furthermore feel that the lack of proper resources and equipment leads to frustration, and if medications are not available, the nurses are to blame. This leads to high levels of frustration and psychological abuse from the patients.

The shortage of staff may be attributed to the lack of mark related compensation and Cascio (1998:385) states levels of pay will always be evaluated by employees before accepting a specific position.

Nurses function and operate in a dynamic organisation and the future is impossible to predict, hence nurses need to take proactive steps to prepare for the future by expanding personal resources. Personal resources would include aspects such as economic stability, higher education and a broader skills base (Marquis and Huston, 2000:178).

Staff have to deal with the ever present problem of shortages as seen in the statement below:

> **"Working under a lot of stress and pressure of staff shortages and things like that we really cannot do anything about I mean I can't do anything about staff shortages – we've try you know you can complain you can toy toy you can do whatever you want but if they don't appoint people there is no point in there is no money they don't appoint people."**

One nurse indicated:

> **"want to do her best but you can't find the proper equipment to do that you end up being frustrated.'**

One naïve sketch participant indicated that:

> **" we feel psychologically abused by being overworked."**

and that they are exposed to workplace violence as the patients:

> **"… while standing in long queues they become inpatient and start passing some vulgar words to the staff."**

Another nurse cited lack of medical supplies:

> **"… they had a poor supply of medication to primary health levels contributes to psychological abuse as the result is that patients are taking the blame to the community health nurse, thus undermining the proficiency and commitment of nurses."**

3.4.1.2 Sub-category: Ineffective communication

A further contributing factor as highlighted by the interviews and naïve sketches is that of ineffective communication in the workplace. Communication is a mere tool to transmit information (Fredriksson and Eriksson, 2003:138). It has been experienced as a case of where:

> **" … communication does not take place at all … "** and there is a general **" … poor response or non-response to issues of urgency … "**.

When an organisation implements effective, successful, internal communication and it is managed effectively, this might result in competent and productive employees (Du Toit et al, 2003:73).

Lines of communication are regarded to be ineffective and:

> **" … information does not spread to all categories of nurses … "**.

According to Mellish (1985:204) an organisation must have structured, official channels of communication and these should be established, written down and made known to all.

Poor communication is a contributing factor to stress (Omadahl and O'Donnell, 1999:1351-1359).

One nurse explained it as follows during an interview:

> **"There is somebody that don't communicate and then on the last minute everybody starts running around and that is when things start going wrong."**

According to Du Toit et al. (2003:67-68) communication is an essential element of management because information cannot be correctly transferred without interactive communication between management and employees. The lack of such communication will leave the organisation with uninformed employees.

A source of stress is role ambiguity, in which nurses simply do not understand what is expected of them on the job, or where what is to be expected is contrary to what they think should be done (Bernardin, 2003:327-328). According to Smith and Preston (1996:35) the lack of role clarity leads to nurses being defensiveness. Nurses felt:

> **" … pressurised to do work that is not part of the job description given to them by their supervisors or the scope of practise differs … "**.

Communication does not seem to take place even within a small group of individuals, as pointed out by the following remark:

> **"I was suppose to attend a workshop and fortunately for I walked to the hospital, ran into somebody who then told me there has been changes, otherwise I would have got into my car, went to the wrong place and everything would have gone wrong – so somewhere along the line communication got a big big role to play into this."**

One nurse clearly expressed her dissatisfaction with her employers' method of communication by saying that:

"… whenever they make this regulation they don't consult any of us at ground level.'

According to Roszak (2005:7) poor communication and lack of collaboration among health professionals is linked to medical errors and staff turnover. A lack of adequate support systems, skills and personal accountability, results in communication gaps that could harm patients.

Another interviewee indicated that:

> **"… where information is not being spread to all categories of nurses, for example, the supervisors have meetings and subordinates are not always informed."**

Cascio (1998:337) is of the opinion that clinics should communicate with their employees as to where the clinic wants to go and what its goals and objective are, so as to erase any possibility of uncertainty.

It seems as if a trust gap exists within the working environment of community nurses, as there are inconsistencies between what management says and what management does – between saying that people are our most important asset, and in the next breath ordering layoffs. The result is one where management thinks it is sending crucial messages, but employees never hear a word (Cascio, 1998:383).

Individuals must be told where they stand in relation to the quality that is expected of them. This is accomplished through appraisal and communication (Ferris and Buckley, 1995:117). The aim of managerial consultation is to listen to what the nurses have to say and to provide an opportunity for the avoidance of mis-communication (Pilbeam and Corbridge, 2002:477).

3.4.1.3 Sub-category: Inadequate physical and emotional safety and protection

Nurses experience inadequate physical and emotional safety and protection in the workplace. Nurses are acutely experiencing the:

> **" … threat of AIDS hanging over our heads as we are working in an unsafe working environment …"** and there is a **"lack in protective needles …"**.

According to Quattrin et al (2006:815) nurses employed in areas such as caring for AIDS patients, are exposed to higher work-related stress.

They furthermore feel that they are being abused due to the fact that there are no:

> **" … policies in place for when they contract HIV in the workplace to compensate them financially or remuneration wise."**

According to Mellish (1985:205-206) policy and procedure manuals are important instruments of good communication in a health-care organisation. The policy manual should deal with the following aspects: the common objective for which the organisation was established, the organisational chart and general personnel policies. The procedure manual will lay down the accepted method of carrying out procedures, medico-legal hazards involved in various procedures, and the how, when, why and what of every procedure.

The nurses experience

> **" a lack of protection in the rural areas."**

The nurses furthermore feel that their supervisors are not defending or protecting them from abusiveness demonstrated by the patients and that there is a constant lack of support via policy issues.

The development of patient aggression and its resulting management cannot continue to be seen in isolation. Organizations need to support their staff in making changes (Duxbury, 2002:335).

Violence appears to be an increasing part of everyday life and is also seen, more than ever, to be impacting on working life. Employers have a duty to look after the safety, health and welfare needs of their employees. In order to meet this obligation, employers have to acknowledge the presence of violence within their workplace and put into place policies and procedures to deal with it. Violence is not just limited to physical attacks but should be defined more widely to

reflect the role that verbal attacks and threats can have on the welfare and health of employees. Work related violence can be defined as any incident in which a person is abused, threatened or assaulted in circumstances related to their work (Pilbeam and Corbridge, 2002:348). Good practice requires employers to undertake risk assessment of the potential violence and to provide their employees with suitable protection (Cheatle, 2001:214).

3.4.1.4 Sub-category: Appointment and promotional policies

Appointment and promotional policies and the method of implementation thereof lead nurses to experience their workplace to be unfair. Nurses feel:

> **" … that there is no acknowledgment for nurses' educational background and years experience in allocation of salary."**

They furthermore feel that there is:

> **" … nepotism in the appointment of nurses … "**

and

> **" … if you go to the platteland they help their friends first … "**.

It has been observed that there is a:

> **"lack of promotion and replacement of white nurses with black nurses and affirmative action policies are viewed as unfair."**

One nurse expressed the opinion that she has:

> **" worked very hard in this profession and I am actually still a junior sister so I never got any promotion basically you see."**

Another nurse experienced a lack of support in terms of policy issues.

3.4.1.5 Sub-category: Lack of appreciation and recognition

Nurses experience a lack of appreciation and recognition from the community (patients), employers and the government.

"I feel, you know that all these years and all the hard work and all the studies … "

For nurses to deliver quality, competent care, they must receive the same high standard of treatment that they have promised to provide to patients. They have the right to courtesy, respect, and dignity. When behaviour standards are not collectively based on these values, those with the loudest voices will create the lowest standards. The culture that allows minor events to pass without immediate corrective action may be challenged by even more serious problems in the future (DelBel, 2003:4).

" … give your everything to people and they just throw it back in your face."

According to Pask (2003:167) the feelings that nurses associate with knowing that they have made a difference to the patient, are a source of sustenance. To have done something that relieved the patient's agony, and which gave the patient her life back, is a source of affirmation to nurses.

The above statement is further supported by a nurse during an interview when she says:

"I feel you know all these years and all the hard work and all the studies is just wasted it is just wasted and if I could have my life over again I would never ever have chosen this profession ever. I sincerely regret the fact that I ever became a nurse, you never get any recognition ever in nursing never."

A naïve sketch participant felt:

"Lack of employer's word of appreciation is indirectly/affecting our performance, dedication and enthusiasm."

Lack of positive or other constructive feedback from senior staff has been cited in a number of studies to be destructive (McGrath et al, 2003:555-565).

During one interview a nurse indicated that she felt despondent because:

> **"the Government is not recognising you at all for what you are doing."**

One participant felt that:

> **"… the lack of the employers word of appreciation is indirectly / affecting or performance, dedication and enthusiasm, which is at the end of the day psychological abuse."**

A naïve sketch participant voiced:

> "**clients do not appreciate service rendered, but complain most of the time and some clients are rude."**

Nurses feel that repeated good performance is not sufficiently rewarded in a manner which they value nor is it done in a timely and fair manner (Cascio, 1998:301).

3.4.1.6 Sub-category: Non consultation of nurses in policy issues

Non-consultation of nurses on policy issues of the workplace leads to frustration at grassroots level. Nurses have a lack of involvement in planning and decision-making and this is a profound source of stress (Pongruengphant and Tyson, 2004:247-254). Nurses at ground level are not consulted when regulations are made, which leads to stress when attempting to implement these regulations:

> **" … that don't work … "**.

Nurses feel that they are not being treated as professionals:

> **" … so with us they say we are professionals but they don't treat us as professionals but they treat us as school children …"**

According to Dunn (1979:1333) nurses are extremely horrible towards one another in the form of senior victimizing juniors or of a mutual refusal to acknowledge stress or an intolerance of colleagues who crack physically or mentally.

Some nurses expressed the feeling that the non-consultation of nurses in policy issues leads to frustrations in the performance of their tasks, duties and functions. The following motivates such beliefs:

> **"I think there is also maybe a big gap we don't know exactly what you are allowed to do you know with all the changes that are taken place in the workplace."**

> **"You are not sure how much authority do you have exactly what you can do."**

It would seem that the non consideration of nurses, especially in the filling of jobs above entry level, can lead to both short and long term losses. It is of utmost importance that the desires, capabilities and potential of the present employees are considered (Cascio, 1998:178). Zammuner and Galli (2005:360) reported burnout to be prevalent amongst nurses with a lower level of job involvement.

Nurses must be actively and willingly engaged in their jobs. They must care about improving their daily work processes and work relationships. Such involvement does not happen just because managers ask for it. Willingness to participate can not be mandated. It has to come from each individual's desire to contribute and make a difference (Ferris and Buckley, 1995:416). Should change take place, it must be implemented after consultation has taken place (Marquis, 2000:72).

3.4.2 Main Category: Disrespectful practises

The research results brought to the forefront disrespectful practices to be experienced in the form of the following sub-categories: -

3.4.2.1 Sub-category: Verbal abuse

Verbal abuse experienced from patients (the community) and rudeness between nurses in the workplace.

According to Simms (2000:68) abusive behaviour is likely to be rooted in the abuser's need to control. Unlike justified discipline, abuse is directed at the person, not the behaviour. Not surprisingly, this need for control intensifies during times of fear, stress and powerlessness.

> "**Patients don't know how to claim their rights and they use vulgar words and we feel as if the community rejects us"**.

Verbal abuse is a form of workplace violence that leaves no visible scars; however, the emotional damage to the inner core of the victim's self can be devastating (Elgin in Sofield et al, 2003:2). Studies have shown that verbal abuse significantly impacts on the workplace by decreasing morale, increasing job dissatisfaction, and creating a hostile work climate (Aiken in Sofield et al, 2003:2).

Nurses experience high levels of rudeness from the community, and this is supported by the following statements:

> **"… they've been terribly rude to you"** and **"One day a person called me so badly and not only about job related things that the person curse me personally infront of a whole lot of people and the patient's in the corridor and not even my supervisor or no one that stood there came up for me they just keep quite and let this man speak to me in that way, and I had to leave actually my job that day I have to go home because I was so broken down I was so hurt inside that I just couldn't go on for the**

rest of the day. It is terrible to give your everything to people and they just throw it back in your face."

and

"… the direct psychological abuse must be from the patients in the way that they talk to us."

Further examples of verbal abuse include the following:

"… manner of approach between colleagues needs a lot of attention, some of us are plainly rude towards each other."

and

"Psychological abuse from colleagues."

Psychological violence is considered the 'underpinning of all forms of abuse'. Yet it is, perhaps, the least understood among all types of interpersonal violence. Psychological violence is often referred to as emotional abuse, psychological maltreatment, verbal abuse, mental abuse, emotional maltreatment, non-physical violence, non-physical aggression. Psychological abuse may work slowly, gradually shattering the victim's confidence and self-worth. A growing body of literature supports the claim that psychological maltreatment is as destructive as physical violence and sexual abuse (Ramiro et al, 2004:131).

Workplace abuse is too often seen as the victim's problem instead of behaviour requiring immediate intervention. When a pattern of hierarchical power overrides collaboration and communication, the potential for verbal abuse rises (Simms, 2000:67).

Verbal abuse primarily involves humiliation, derogatory comments, threats and deprivation, which creates negative perceptions, increases apprehension and stress and diminishes self-confidence and self-esteem (DelBel, 2003:1).

Verbal threats need to be taken seriously, as experts say that individuals who make such statements are likely to act as they have been mentally committed to the act for a long period of time. It may take very little provocation to trigger the violence (Cascio, 1998:589). Violence disrupts productivity and causes untold damage to those exposed to the trauma.

A very serious view is normally taken of violence by or between employees at work. Although it is reasonable to rule that fighting will normally result in summary dismissal, this still needs to be communicated unambiguously. Even in the case of serious or overt violence, it remains necessary to investigate it thoroughly to establish reasons and motivation, but those involved should only be interviewed when they are in a fit state, emotionally and physically (Pilbeam and Corbridge, 2002:449).

Why is it that some victims of verbal abuse do not speak out? Fear of conflict or social embarrassment may silence them, and, in time, they believe that they have caused the abuse themselves (Simms, 2000:68).

According to Bruder (2001:2) verbal abuse between colleagues leads to lower self-esteem, job dissatisfaction, absenteeism and poor work performance.

3.4.2.2 Sub-category: Abusive practises

Abusive practice demonstrated by supervisors include: (a) enforcing co-operation by nurses through threats; (b) indiscretion when addressing nurse-specific issues (mistakes); and (c) unprofessional treatment:

" … they treat us as school children … "

Research in the RSA has shown that a great deal of dissatisfaction, which has led to student, as well as registered staff, resignations, has centred on poor interpersonal relationships. The modern nurse is a modern woman, expecting to be treated as a responsible adult who has ideas of her own, and with self actualisation, recognition and security needs which must be met (Mellish, 1985:285).

“ … if you don’t do this I’m going to transfer you … that’s an open threat and it breaks you down.”

and

“Some of us are being allocated duties that is above our scope of practice.”

According to Mellish (1985:286), it is bad practice to use people for tasks for which they have received no training. The incorrect use of nursing assistants and enrolled nurses is not only a medico-legal hazard, but can also cause a great deal of staff dissatisfaction.

Research has indicated that leadership (through support from supervisors) plays an important role in preventing emotional exhaustion (Laschinger and Leiter, 2006:34).

Nurses are exposed to inhumane treatment because they feel that:

“ …don’t always see you as a human being …making mistakes.”

Supervisors show indiscretion in addressing issues (mistakes) in the workplace in front of other staff … in front of patients

“ … they want to break you down …”.

Leadership style and organisational culture are associated with an increase in productivity and staff satisfaction (Almio-Metcalf and Bass in Clegg, 2000:43). In health care, there is a correlation between the quality of patient care, staff morale and effective nursing leadership (Manley in Clegg, 2000:43). Effective teams are built upon a shared vision, team motivation, trust and mutual respect (Clegg, 2000:43).

Nurses have indicated during the interviews that:

“there is definitely physical abuse if you look at the fact that they put more and more pressure on you. For instance I was in an incidence not very long ago where

my supervisor try to put pressure on me for something that needed to be done that was not actually really my responsibility, but then she tells me if you don't do it, I will punish you."

Disrespectful practices is further more substantiated by statements such as:

"… if somebody comes to you and say to you if you don't do this I am going to transfer you, I mean that is something that cause you to worry because it is a threat that they are given to you."

Some nurses experience the feeling that:

"us nurses we have never actually have rights we don't have any rights."

Another nurse indicated that she would never go back to primary health care due to the:

"psychological abuse and the absolute threats involved I think I could not go forward with that treats because it breaks you down."

Degradation, fear and humiliation have been described by Fortune (in Loring, 1994:15) as most painful. The pattern of emotional abuse occurs on two levels – overt and covert – and utilizes several mechanisms of abuse. Overt abuse is openly demeaning. The second level of violence, - covert emotional abuse, - is more subtle, but no less devastating to victims (Loring, 1994:1-3).

Nurses experience supervisors as acting with indiscretion when addressing issues, and this is substantiated by the following:

"The unfairness. They don't see you always as a human being if you make mistakes yet we are all professionals working but we are still human being you can still make mistakes. When you get your 80th patient a day you are physically tired we haven't had any tea break nothing to eat or drink if you don't drink a glass of water or whatever you drink while you are working you won't get anything if you barely have any time to go to the toilet."

Some experience that their supervisors are trying to:

> "**break them down"** and **"sometimes these kind of things happen infront of other staff it happens infront of patients or they want to break you down."**

3.4.2.3 Sub-category: Racism

Accusation of acts of racism by patients and colleagues is disempowering to nurses. There were statements such as:

> **' … forming a broederbond against her …"**.

Some nurses found it:

> **" … difficult for remediation and to act in the workplace as a supervisor if you are being accused of racism as this is very disempowering … "**.

According to Larsen, discrimination can have severe consequences on staff's wellbeing (2006:6).

Nurses speak about **"we"** and **"them"** and there is a non-acceptance between the different races. Members of the community have made remarks such as:

> **" … they say you are still in the apartheid you know …"**.

Staff get labelled:

> **" … die vark in die verhaal when addressing wrongs in the department."**

and tend to give up in finding solutions to problems which they might experience:

"There is a lot wrong at this stage in my department, but I just don't have the strength to tackle it because at the end you are the loosing person you are the one who pays the price."

Nurses experience problems in terms of racism as highlighted by the following remarks:

"It is a political situation and a lot of race connection can be make out of this because it doesn't matter which way you go racism always get mention and things like that and also that make the work situation very very very difficult it is unfortunately if you are in a supervisor's capacity. There is something that you get your departments flow good and to let everything go well you must apply discipline and the moment you start applying discipline then is not good, then it is not discipline anymore then other things come in and I think I am not the only one that experience this in the work place at this stage in my life, I think all over you will find this."

There seems to be clear friction between the races, and this is supported by the under mentioned statements:

"My direct supervisor is also a white lady and you got me and then the Director is a black lady but she didn't make any comments on that but the person who was charged was a black lady and at the end she says that we was forming a broeder bond against her."

"I don't really think in the workplace we have accepted one another completely and what makes it very very difficult for you as supervisor to take charge to take decisions and do things the right way."

A further example of the perceived racism can be found in the following statement made by an participant:

"White people are not promoted anymore they take you out of your place and put a black person in there and that is very unfair."

It is of importance that a work setting be created where each person can perform his or her duties and reach their full potential and, as such, compete for promotions and other rewards on merit alone (Cascio, 1998:79). One sign of discrimination is disparate treatment – differing treatment of individuals, where the differences are based on the individual's race or colour (Noe, 2004: 82).

3.4.3 Main Category: Nurses respond in destructive ways to psychological abuse

Isolation, less effective verbal expression, physical and emotional tiredness and negative emotional responses form the subcategories of nurses responding destructively to psychological abuse in the workplace setting.

3.4.3.1 Sub-category: Nurses respond interpersonally through isolation and less effective verbal expressions

Nurses respond interpersonally through isolation and less effective verbal expression. Nurses constantly worry about threats, and about taking responsibilities for when:

> **" … the paw-paw strikes the fan …"**

because it will be their responsibility to deal with it. They experience feelings of moodiness, are highly stressed as well as depressed, and they experience interpersonal isolation. They experience feelings of just:

> **" … switching off … let it be … surrendering. You come to a stage where you just let go and you know it is wrong. You hope the problem will solve itself … not good … don't have the strength to start the whole process."**

According to Mellish (1985:285) the area of interpersonal relationships is often the area where the whole nursing service stands or falls. If the nurse-administrator does not set the tone for good interpersonal relationships in the nursing service and does not ensure that this is followed through at all levels, the result is unhappy nursing personnel. This will lead to frustration, resignations, a high staff turnover, loss of team co-operation, inefficiency and poor, if not dangerous, patient

care. Interpersonal conflict has been noted as one of the major sources of stress for nurses (Grout in Rowe and Sherlock, 2005:241).

Nurses respond on an interpersonal level and their family life suffers as a result of this:

> **"I don't think it is very good because the time you go home you are moody you are depressed you are stressed out you know you are just like feel to be left alone you don't want anybody around you if somebody comes near you start shouting and starts shouts or something like that."**

and:

> **"No time for families."**

A community nurse expressed the following to indicate her feelings of loneliness and need for quiet time or isolation:

> **"When I go home I want to be on my own you know I do the things that make me feel okay."**

Stress is about pressure on the individual and may be physical, intellectual, emotional or social. Pressure becomes distressing when the individual perceives it to be either excessive and beyond their coping ability or, alternatively, insufficient to provide stimulation. It is therefore distress which is potentially harmful and distress that ought to be the focus of attention (Pilbeam and Corbridge, 2002:354).

3.4.3.2 Sub-category: Physical and emotional tiredness

Nurses experience a sense of physical and emotional tiredness leading to a response of surrendering to their work circumstances.

> **"… like to be on your own because you are so stressed up physically and mentally you are so tired that you just don't have the strength for anything else…"**

and:

> **"… come to a stage where you say to yourself let it be…"**

During one interview a nurse indicated that:

> **"… you just let go you just let go you know it is wrong and that is what kept you awake at night…"**

It has been suggested that repeated exposure to demanding, aggressive behaviours impacts negatively on job satisfaction and on job performance (Chappell et al. in Ramirez et al, 2006:119). This negative experience, coupled with limited or inadequate training, can render the job exhausting and emotionally taxing (Baillon et al. in Ramirez et al, 2006:119). Turnipseed and Turnipseed (1997:185) are of the opinion that work pressure can be strongly linked to emotional exhaustion. Exposure to stress conditions for a long period of time can lead to emotional exhaustion (Morais et al, 2006:433).

According to Wilkerson and Bellini (2006:440) stress can lead to ineffective delivery of services, exhaustion, physical complaints, anxiety and depression. Forgas and Vargas (in Grandey et al, 2005:894) states that emotion maintenance and regulation are important goals that "probably occupy a disproportionately important role in regulating our everyday behavioural strategies and take up a great deal of our mental resources".

One community nurse explained her physical tiredness:

> **"… there are days that I feel I cannot breath properly because I've worked so hard today…"**

and:

> **"… constantly I was tired when I got home I didn't want to cook there were constant fights because I only want to stay in bed because I became more and more tired…"**

The primary means through which problematic workload, control and verbal abuse affects physical well-being is through their capacity to deplete a person's physical and emotional energy. Physical symptoms are closely associated with the employees' sense of exhaustion at work but they pervade employees' lives outside of the workplace, with one symptom – sleeplessness, - occurring entirely in the personal domain of life (Leiter, 2004:141).

3.4.3.3 Sub-category: Emotional response of nurses when exposed to psychological abuse

The emotional responses of nurses when exposed to psychological abuse in the work place, include frustration, anxiety, depression, regret and hurt. Nurses experience frustration about wanting to change the situation but then finding that this is an almost impossible task. They are irritated by the blatant nepotism seen at the workplace, as well as the theft that occurs.

The issue of nepotism and fraud is expressed by a nurse in the following manner:

> **"And if they see you have got another qualification they don't give you a post you got to have somebody who is a friend who will help you get a job. I can not handle to work with this fraud hanging over our heads."**

Some of them even:

> **" … regret having become a nurse … this was not worth it."**

They are extremely anxious about making mistakes:

> **" … waking up at three o'clock in the morning …"**

Nurses feel that they are:

> **"So stressed up physically and mentally you are tired that you just don' have the strength for anything else."**

Nurses reach a stage where they withdraw, and this is underscored by the following statement:

“ You know so then you come to a stage where you just let go and you just let go, you know it is wrong.

and:

“It is not nice to always be in a conflict situation and you know if you are doing anything about it is going to cause conflict and you are going to be in a conflict situation and then you are going to sit again and start with this whole process all over again, so I for one I’ve learned to switched off if it comes to a point.”

and:

“Often just come to a stage where you said let it be where you hope the problem will solve itself.”

The frustration of nurses who are exposed to psychological abuse in the workplace, is seen in the following statement;

“… the big frustration comes from things that you yourself can’t change it and that builds more and more pressure.”

One nurse continually referred her state of depression during the interview by saying:

“So that is a very depressing thing”

and

“I’m actually a little depressed you know.”

Anxiety is a reflection of stressful work (McGrath et al, 2003:555-565). Maslach and Johnson (in Demir et al, 2002:807-827) identifies three categories of possible burnout amongst nurses, namely: emotional exhaustion, depersonalisation and lack of personal accomplishment.

Nurses experience high levels of anxiety, and one felt:

> **"I was becoming extremely anxious for making mistakes because of the fact that when you make a mistake and everybody is up you are tired and you are worked out that you have two and a half minutes per patient and you become constantly terribly tired."**

and:

> **"I started waking up three o'clock in the morning in a sweat with severe anxiety so bad that I can't cope and it affected my whole life so bad."**

The consequences of psychological abuse against nurses include feelings of shock, disbelief, guilt, anger, depression, fear, selfblame, powerlessness, exploitation, increased stress and anxiety, loss of self-esteem and belief in one's professional competence, avoidance behaviour which may affect the performance of duties, (including absenteeism), negative effects on interpersonal relationships, loss of job satisfaction, low staff morale, and increased staff turnover rate (Distasio in Uzun, 2003:82).

3.5 CONCLUSION

Detailed data was obtained by means of four naïve sketches and five interviews held with community nurses who are exposed to psychological abuse in the workplace setting. The question posed to the participants in separate in-depth, semi structured, phenomenological interviews was **"What is your experience of psychological abuse in interaction with others in your workplace?"** The data was analysed and a main theme and subcategories were identified, after which the experiences of the community nurses, exposed to psychological abuse in the workplace setting, were investigated and described. A schematic presentation of the results obtained from the research can be seen in Figure 3.2.

Kreigh and Perko (1983:8) are of the opinion that some of the emotional responses that were identified during this research can be classified as mental illness, as illustrated in Figure 3.1 on the ensuing page:

Figure 3.1 Tree of mental illness

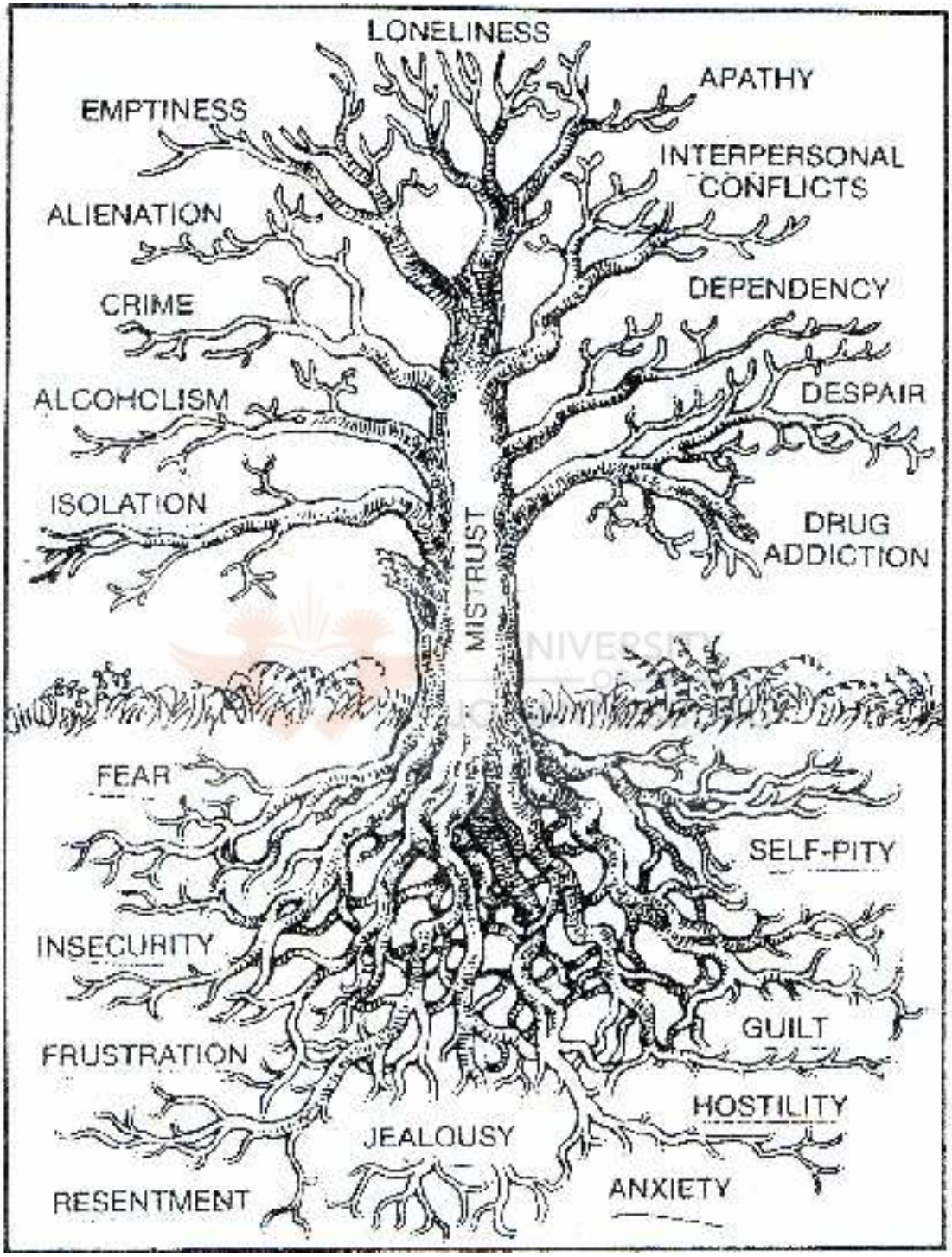

Figure 3.2 Schematic presentation of the results obtained from the research on community nurses' experience of psychological abuse in the workplace

CHAPTER FOUR: STRATEGIES TO ASSIST NURSES WHO ARE PSYCHOLOGICALLY ABUSED

4.1 INTRODUCTION

In chapter three the experiences of community nurses who are exposed to psychological abuse in the workplace setting were investigated, and described by identifying main categories and sub-categories. A literature control was done and brought into relation with the research.

Three main categories came to the fore after the analysis of the raw data was completed, namely: (1) disempowering working conditions exacerbating nurses' experience of psychological abuse in the workplace; (2) disrespectful practices demonstrated by the community (patients) as well as other nurses (co-workers and supervisors) in the workplace setting; and (3) nurse's destructive response to psychological abuse in the workplace setting.

Disempowering working conditions were highlighted by the following aspects: (1) the lack of human and physical resources; (2) ineffective communication; (3) lack of safety and protection in the workplace; (4) problems with appointment and promotional policies; (5) lack of appreciation and recognition; and (6) non-consultation of nurses on policy issues.

Disrespectful practices were manifested in verbal abuse, abusive practices and acts of racism by patients and colleagues.

Nurses responded destructively on an interpersonal level through isolation and ineffective verbal expression when exposed to constant psychological abuse. They furthermore experienced a sense of physical and emotional tiredness, which could in turn, lead to depression, anxiety, frustration, regret and hurt. In chapter four strategies were put forward on how to deal with the psychological abuse that community nurses are exposed to in the workplace setting (Table 4.1).

Table 4.1 STRATEGIES TO ASSIST NURSES WHO ARE PSYCHOLOGICALLY ABUSED

Overall psychological abuse - themes	Psychological support - Strategies
1. Disempowering work conditions	**1. Facilitation of empowering working conditions**
• Lack of human and physical resources • Ineffective communication • Lack of safety and protection in the workplace • Problems with appointment and promotional policies • Lack of appreciation and recognition • Non consultation of nurses on policy issues	Objective: Identify actions that will assist nurses in empowering their working conditions. Actions: - Workload rebalancing, role clarification - Support - Education - Policies to give clarity
2. Disrespectful practices	**2. Facilitation of respectful practices**
• Verbal abuse • Abusive practices • Acts of racism	Objective: Identify actions that will assist nurses in handling abuse and disrespectful practices. Actions: - Do not quietly accept verbal assault - Group support - Develop protocol for reporting and dealing with disrespectful practices
3. Nurses' destructive responses on an interpersonal level	**3. Facilitation of nurses' constructive responses on an interpersonal level**
• Isolation • Ineffective verbal expression • Physical and emotional tiredness – depression, anxiety, frustration, regret and hurt	Objective: Identify actions that will assist nurses in responding constructively on interpersonal level. Actions: - "I am not the cause" - Group support - Counselling - Development of coping techniques

4.2 STRATEGIES

4.2.1 Main category: Disempowering working conditions

The following strategies for disempowering working conditions are proposed.

4.2.1.1 Strategy: Facilitation of empowering working conditions

As seen in the research results a lack of human- and physical resources promoted a sense of disempowerment and exploitation of nurses in the workplace setting. In order to help the community nurse cope with this sense of disempowerment, it is important that adequate resources (human, financial, environmental and informational) are provided, in order to facilitate the performance of tasks, duties and functions as effectively as possible. Coping represents the way that individuals cognitively and behaviourally manage environmental demands in their lives (Lazarus and Folkman in Mearns and Cain, 2003:72).

Hingsley (in McGrath et al, 2003:555-565) stated that workload, role conflict and ambiguity were factors causing stress in the workplace. Articles published since 1990 reveal that the work environment was one of the factors related to stress (Lambert and Lambert, 2001:161-172). Research indicates that work overload is a significant predictor of negative mental health outcomes in nurses (Tyler and Cushaway in Greenglass and Burke, 2002:91).

Personal factors include having unrealistic expectations and low self-esteem, being overcommited, self-critical, authoritarian, lacking a support system and needing to control others (Lavandero and Maslach in Ceslowitz, 1989:534 and Dent & Burtney, 1996:16). Environmental factors encompass work overload, high patient acuity levels, lack of authority to carry out responsibilities, role conflict, inadequacies in salaries and lack of control over hours and working conditions (Jackson and Lavandero in Ceslowitz, 1989:534). The ways individuals deal with stress, and how they cope, may be as important as the actual stressful conditions they experience (Ceslowitz, 1989:534).

Role ambiguity is seen as a source of stress for nurses in the workplace, because they simply do not understand what is expected on the job, or where the expectation is contrary to what

they think should be done (Bernardin, 2003:327-328). A large number of nurses also appeared to be experiencing an increased level of emotional exhaustion, which, in turn, appeared to be associated with low levels of role clarity (Hannigan, Edwards and Burnard, 2004:240). Thus, the importance of role clarification can be seen. Clarity of job roles, or job expectations, encourages empowerment as staff members understand what is expected of them and can identify areas for improvement (Marquis and Huston, 2000:173).

Coping strategies most frequently reported were behavioural and cognitive methods, including talking to other nurses and exercising. The opportunity to participate in a professional support network was of great value to many (Hannigan, Edwards and Burnard, 2004:240). Seeking out social and emotional support by turning to others (other nurses, friends or family) has also been shown to be of benefit (Greenglass in Mearns and Cain, 2003:73 and Penno, 1998:1).

Lazarus and Folkman (in Bowden, 1994:221) defined coping as a person's constantly changing cognitive and behavioural efforts to manage specific environmental and/or internal demands that are appraised as taxing or exceeding the person's resources. Cherniss' (in Bowden, 1994:221) model of the inter-relationship between work stress, coping and change is comprised of two coping outcomes: active problem solving and attitude change. In human service professionals, attitude change over time was often apparent in the following ways:

- Work goals were modified – usually they became more modest.
- Levels of personal involvement were reduced or restricted – the psychological role of work in life was reduced and, increasingly, gratification and fulfilment were sought elsewhere.
- Responsibility for failure was shifted from selves to others.
- General attitudes to people altered – became less idealistic, less trusting and more conservative.
- Increased self-protection and self-enhancement.

Coping with stressful life events can be facilitated by a personality variable such as perceived self-efficacy, a personal resource reflecting the person's optimistic self-beliefs about being able

to deal with critical demands by means of adaptive actions. It reflects the belief of being able to control challenging environmental demands. Social support is a resource, which can alleviate the deleterious effects. Support may be in the form of information, practical assistance and/or emotional support (Bandura in Greenglass and Burke, 2002:93-94). Managers need to see that opportunities be provided for employees to get together, to discuss their experiences in order to support each other (Wood, 1996:35).

Folkman and Lazarus (in Evans et al, 2004:351) suggested two general types of coping. The first is problem-focused coping; the person finds a method for solving stress at its source. The second is emotion-focused coping; the person feels that the source of stress must somehow be tolerated and he/she aims efforts at managing or lessening the emotional discomfort associated with the situation.

A further individual strategy for dealing with stress is the self-management of beliefs and the reframing of perceptions. There are three necessary beliefs:

- Stress is not instinctive, but a 'learned reaction' to stimuli.
- External stimuli do not automatically cause distress, it is the individual who 'chooses' to be stressed.
- It is preferable to 'prevent' unwanted stress rather than suppressing it or expressing it.

The individual preventive response, based on these three beliefs, is to reframe perceptions of pressure by challenging the thoughts themselves. This is done through making the thoughts more reliable, more rational, less exaggerated and less dogmatic, thus preventing 'feelings' of distress (Pilbeam and Corbridge, 2002:358-359).

In the decision-making process regarding where, when, and how to implement recruitment activities, initial consideration should be given to a company's current employees, especially for filling jobs above the entry level. If external recruitment efforts are undertaken without considering the desires, capabilities and potential of present employees, an organization may incur both short- and long-run costs. In the short term, morale may degenerate; in the long run, organizations with a reputation for consistent neglect of in-house talent may find it difficult to attract new employees and to retain experienced ones (Cascio, 1998:178 and Megginson et al,

1999:99). The retention of satisfied nurses is therefore paramount to meet current levels of demand and deliver high quality care (Newman et al, 2002:273).

To the extent that employees, including nurses, are involved in discussions regarding the direction and vision of the future, they are being provided with social support (Greenglass and Burke, 2002:94-95).

According to Du Toit, Schutte and De Wet (2003:75) by using downward communication certain goals can be achieved, namely:

- Specific instructions on how to do the work.
- Information that provides a rational reason for the task to be done.
- Information with regard to organisational policies, procedures and practises.
- Feedback to employees with regard to their performance.
- Philosophical information regarding the mission of the organisation, as well as orientation with regard to the goals of the organisation.

Policy and procedure manuals are important instruments of good communication in a health-care organisation. The policy manual should deal with the following aspects: the common objective for which the organisation was established, organisational chart, general personnel policies, job descriptions/position statements of all categories of workers in the particular unit, interdepartmental means of communication and departmental policies of specific units. The procedure manual should lay down the accepted method of carrying out procedures, ordering supplies and equipment, the medico-legal hazards involved in various procedures, the how, when, why and what of every procedure, who should carry it out, who is responsible, and so on. These manuals must be kept up to date.

A further means of communication often used in health-care organisations is memoranda. These are direct communications, from various heads of department, to all professional nurses in charge of units. Memoranda are brief, factual and contain only essential information. This means that each memorandum deals with one subject only and different subjects are set out in different memoranda. Simple language should also be used. A copy of each memorandum is

filed in the originating department and indexed for easy reference; separate sections for memoranda of the various departments should also be kept (Mellish, 1985:205-206).

Apart from clinic-wide information sessions, a clinic can use the following specific communication techniques to disseminate the quality message to all it employees (Meyer, 1999:376):

- Supervisors must have regular meetings with subordinates to discuss quality related matters.
- Quality improvement teams can be used to discuss quality related matters in the work group.
- Cross-functional teams can be established to ensure that there is more co-operation and synergy between departments on the quality process.
- Seminars can be organised internally or by outside institutions.

According to McGrath et al (2003:555-565) a lack of constructive feedback has been cited as a source for not feeling appreciated or recognized. The following ten positive attitudes (Stern in Marques and Huston, 2000:81) could be adopted in order to overcome the feelings of loss of appreciation and recognition:

- Problems exist to be overcome.
- Success involves the habit of changing habits.
- Action reduces fear.
- The best way to escape a problem is to solve it.
- Life changes occur only when beliefs change.
- Look for opportunity, not guarantees.
- Worry is negative and results from inaction.
- Discovery consists of looking at the same thing as everyone else and thinking something different.
- You cannot operate on yesterday's standards and expect to be successful today.

Managers need to encourage performance, and this requires a co-ordinated approach to performance management. Managers need to provide a sufficient number of rewards that employees really value and to do so in a timely and fair manner. Do not bother offering rewards that nobody cares about – determine the types of rewards employees' value by asking your people what is most important to them (Cascio, 1998:301).

The manager needs to provide subordinates with enough information about organizational and unit goals to enable them to understand how their efforts, and those of their manager, are contributing to goal attainment. If followers (1) perceive that the manager is doing a good job; (2) believe that the organization has their best interests in mind, and (3) do not feel controlled by authority, then the manager will have bridged the authority-power gap (Marquis and Huston, 2000:171).

In order for empowerment to take root and thrive, organizations must encourage these conditions (Dobbs, 1993 in Ferris and Buckley, 1995:416-417):

- Participation
- Innovation
- Access to information
- Accountability

Participation

People must be actively and willingly engaged in their jobs. They must care about improving their daily work processes and work relationships. Willingness to participate can't be mandated; it has to come from each individual's desire to contribute and to make a difference. Organizations that are less hierarchical are encouraging their employees to become more involved. Some even provide empowerment training. Whether the topic is collaboration or total quality, training can encourage people to participate more actively by helping raise their levels of confidence. Sometimes people simply lack enough self-assurance to address problems, and try to solve them.

Innovation

It is almost impossible for empowerment to exist in environments in which innovation is ignored, stifled, or discouraged. Empowerment cannot exist in an organization, which expects employees to do their jobs the way they have always done them.

Access to information

When they are empowered, people at every level make decisions about what kind of information they need for performing their jobs. Information is a source of power.

Accountability

It is important to ensure that employee accountability is egalitarian: In other words, if employees are accountable to managers, then managers also should be accountable to employees.

4.2.2 Main category: Disrespectful practises

The following strategies for countering disrespectful practices are proposed.

4.2.2.1 Strategy: Facilitation of respectful practices

Psychological abuse includes exclusion from decision-making, harassment from managers, colleagues or patients, blocking of career opportunities and isolation (Bryant and Cox, 2004:2). A high level of psychological abuse appears to put its victims at equal risk of developing physical and mental health problems (Ramiro, Hassan and Peedicayil, 2004:132). Psychological abuse is more prevalent than other forms of abuse, and is often more destructive in its impact (Pitzner and Drummond, 1997:126).

Research has amply documented that there are both short- and long term mental and physical health benefits when the relationships in which we participate throughout the life span, are

positive, whereas abusive, restricting and non-nurturing relationships have been found to impair mental and physical health (Cohen and Syme in Vandervoort and Rokach, 2003:676).

According to Simms (2001:68) nurses who have been abused by nursing instructors, managers, other nurses, physicians or patients, learn to be both abuser and victim. Why is it that some victims of abuse do not speak out? Fear of conflict or social embarrassment may silence them, and, in time, they believe that they have brought the abuse upon themselves. Shame and silence fuel the cycle of abuse: a supportive network can provide a strong healing influence. Here are some steps to encourage nurses to break the cycle of verbal abuse:

- Do not quietly accept verbal assault.
- Search for solutions.
- Provide individual and group support.
- Promote collaborative practice.
- Develop a protocol for reporting and dealing with workplace abuse.

Group support is also crucial for anyone dealing with verbal abuse in the workplace. The group should provide a safe environment in which colleagues can share stories and collaborate on Solutions, and set a model for zero tolerance for abusive behaviour. Open and respectful communication among members of the treatment team is critical to preventing abusive behaviour (Simms, 2001:69-71). It is very difficult for nurses to "do" something about abuse if they feel a lack of unity among themselves (Bruder, 2001:4).

Factors that increase the risk of nurses facing violence include heavily charged emotional interactions with patients and their families, work stress, insufficient number of personnel, inadequate security measures and a heavy workload. Those who are exposed to these types of abuse undergo emotional trauma and experience emotions such as anger, anxiety, hopelessness, fear and hurt (Oztunc, 2006:360).

A practical example of group support is the support-system: Code Pink (Earwood in Simms, 2001:70). A nurse would call a Code Pink if she or a colleague were the aim/victims of abuse. All available nurses would respond by gathering at the site of this exhibition and watch the abuser

carry on. By their sticking together and demonstrating their disgust with the behaviour, the abuser was made to realize how inappropriate the behaviour was.

While there is no guarantee that a person will not physically act out, following seven specific principles will help reduce the anxiety and defensiveness that often precede dangerous behaviour. These preventive measures will help to increase the care, welfare, safety and security of everyone in their workplace (DelBel, 2003:4):

- Remain calm. This may be easier said than done, especially when an individual is screaming, making threats, or using abusive language. The verbally escalating individual is beginning to lose control. If the person senses that you are also losing control, the situation will only worsen. Try to keep composed, even when challenged, insulted or threatened.
- Isolate the individual. The presence of an audience fuels the fire and makes it more difficult for the person to back down.
- Watch your body language. As a person becomes increasingly agitated, he or she will pay less attention to your words and more attention to your body language.
- Keep it simple. Be clear and direct in your message.
- Use reflective questioning.
- Embrace silence. Silence on your part allows the individual time to clarify his or her thoughts and restate the message. This can lead to valuable insight.
- Check your paraverbal communication. This refers to the tone, volume, rate and rhythm of your speech.

Managing conflict effectively requires an understanding of its origin. Some of the most common sources of organisational conflict are communication problems. The six most common causes of unit conflict are unclear expectations, poor communication, lack of clear jurisdiction, incompatibilities or disagreements based on differences of temperament or attitudes, individual or group conflicts of interest and operational staffing changes. Diversity in gender, culture and age also has the potential to create conflict; and, as such, needs to be addressed accordingly (Ferris and Buckley, 1995:90).

Prevention strategies for verbal abuse and abusive practices can include the following:

- Consult specialists. Professionals in the area of violence assessment, EAP (Employee Assistance Programmes) counselling, and community support services should be consulted to formulate a plan for identifying, defusing and recovering from violent treatment.
- Create, and explain to all employees, a written policy that sets out the organisation's position on intimidating, threatening or violent behaviour and establishes a procedure for investigating any potentially violent talk or action.
- Establish a crisis management team with the authority to make decisions quickly. This group will evaluate problems, select intervention techniques and co-ordinate follow-up activities such as counselling the victims.
- Offer training and employee orientation – train supervisors and managers in how to recognise aggressive behaviour, identify the warning signs of violence, be effective communicators and resolve conflict (Cascio, 1998:589).

Lazarus and Folkman (in Rowe and Sherlock, 2005:243) state that nurses who experience higher levers of occupational burnout are more likely to vent their frustration by abusing other nurses.

The effects and consequences of abuse can be devastating and long-lasting. Research that has focused on its consequences has found that it is both physiologically and psychologically damaging. Verbal abuse can be conveyed by silence, damaging gossip and other passive-aggressive behaviours, and such behaviours are highly stress-producing. Research has also demonstrated that nursing staff turnover is directly related to interpersonal conflict and verbal abuse. Frequent exposure to angry communication from peers leads to alienation among nurses, which may cause them to resign instead of dealing with their anger and dismay.

Some nurses are better equipped to deal with confrontational and potentially violent situations, but all staff should be trained to recognise potentially difficult situations and to respond accordingly. A survey of interactions between staff and patients/colleagues can indicate triggers for frustration and anger, and causes of violent exchanges. An analysis of these incidents informs managerial action, which may include changes in systems of work and the reduction of waiting time. Nurses who are adequately trained to assess and control violent situations are less

likely to be the victims of attack than those who are unable to manage emotional exchanges (Pilbeam and Corbridge, 2002:349).

4.2.3 Main category: Nurses' responses on an interpersonal level

The following strategies are proposed for nurses' destructive responses on an interpersonal level.

4.2.3.1 Strategy: Facilitation of nurses' constructive responses on an interpersonal level

Isolation, less effective verbal expressions, physical and emotional tiredness and emotional responses, form part of the responses obtained from community nurses exposed to psychological abuse.

Maslach and Jackson (in Demir, Ulusoy and Ulusoy, 2003:2) state that exhaustion results from decrease, or loss, of self-confidence and interest in one's profession, as well as feelings of fatigue and weakness.

According to Maslach (in Beckstead, 2002:2) emotional exhaustion, - having no capacity left to offer psychological support to others, - emerges first. This followed by the professional's attempt to defend him/herself psychologically through isolation from the source of such affect. In this way the professional develops very impersonal relationships with his or her patients in an attempt to avoid stress and emotional fatigue. Nurses may be distancing themselves from their patients as a reaction to their feelings of being emotionally drained by their job (Greenglass, Burke and Fiksenbaum, 2001:214).

Job stress has three types of consequences that are especially relevant: physical, psychological and behavioural. Among the potential physical consequences are coronary disease, etc. Psychological consequences include dis-satisfaction with one's life, low self-esteem, psychological fatigue, boredom, emotional exhaustion, resentment toward the job, and generally poor mental health often manifested in depression (Ferris and Buckley, 1995:453).

A first set of strategies is aimed at the physical symptoms. One of the most important steps is to see a physician about one's current physical health. A thorough physical examination will often

uncover physical symptoms before they become severe. Similarly, seeking help from a counsellor (psychological) is an approach aimed at the psychological symptoms. The mind and body are interrelated, and certain methods by which the mind can control aspects of the physiology are being recognised. It is clear that people can learn to control some of their physiological processes to help them cope. Again psychological support seems to help, whether it comes from people in the workplace, friends or family. Finally, physical activity is important in helping people withstand some of the effects of psychological abuse (Ferris and Buckley, 1995:456).

High depression and low self-esteem scores are common long-term consequences of all abuse types (Pitzner and Drummond, 1996:126).

"I am not the cause" By not assuming the role of victim, one can establish that the abuse is happening to you and not because of you (Simms, 2001:69).

Ketterman (in Rowe and Sherlock, 2003:243) identified different components of abuse. These include: victims feel rejected and devalued; victims feel isolated; victims feel worthless and Hopeless; abuse ignores basic needs such as unconditional acceptance, approval and consistency; the use of vulgar language and crude accusations may corrupt the values and behaviours of the victim; it degrades victims and destroys self-esteem; and, it exploits others for the benefit of the abuser.

The consequences of abuse against nurses include feelings of shock, disbelief, guilt, anger, depression, fear, self-blame, powerlessness, exploitation, increased stress and anxiety, loss of self-esteem and belief in one's professional competence, avoidance behaviour which may affect the performance of duties, (including absenteeism), negative effect on interpersonal relationships, loss of job satisfaction, low staff morale, and increased staff turnover rate (Distasio in Uzun, 2003:82).

Stress is viewed as a relationship between the person and the environment that is appraised by the person as exceeding his or her resources and endangering well-being. Coping refers to the cognitive and behavioural efforts to manage stressful encounters that are appraised as taxing personal resources. Coping may alleviate emotional distress or aid in dealing with the problem

causing the distress. Coping may be viewed as a buffer, which moderates the impact of stress (Ceslowitz, 1989:554).

Previous research indicates that control coping is more effective in reducing stress than escape or more passive coping forms. In a study, those who used control coping strategies were less emotionally exhausted and were more likely to assess their personal accomplishment positively than those who did not use control coping; and, those who used escapist coping experienced more emotional exhaustion (Greenglass and Burke, 2002:93).

It has been found that emotional exhaustion can be lowered through efforts to build staff morale. Building staff morale is consistent with other research showing that social support is associated with lower emotional exhaustion. It was shown that emotional exhaustion was lower with greater self-efficacy. Research has shown that high self-efficacy lowers the experience of stress whereas low self-efficacy puts an individual at risk for increased threat (Greenglass and Burke, 2002:93).

The social influence of managers on their subordinates has long been deemed important in leadership and organizational dynamics. Similarly, the supportive activities of co-workers in general, and work groups, have long been recognized as important aspects of the work environment (Ferris and Buckley, 1995:452).

4.3 CONCLUSION

Three main categories came to the fore after the analysis of data was obtained, namely: (1) disempowering working conditions exacerbating nurses' experience of psychological abuse in the workplace; (2) disrespectful practices demonstrated by the community (patients) as well as other nurses (co-workers and supervisors) in the workplace setting; (3) nurses' destructive responses to psychological abuse in the workplace setting. Strategies, to help nurses and give psychological support, were assigned to each of the main categories. A schematic presentation on the psychological support can be seen in Figure 4.2. In comparison to the destructive, or mental illness, emotional responses according to Kreigh and Perko (1983:9) the mental health illustration is shown in Figure 4.1.

Figure 4.1 Tree of mental health

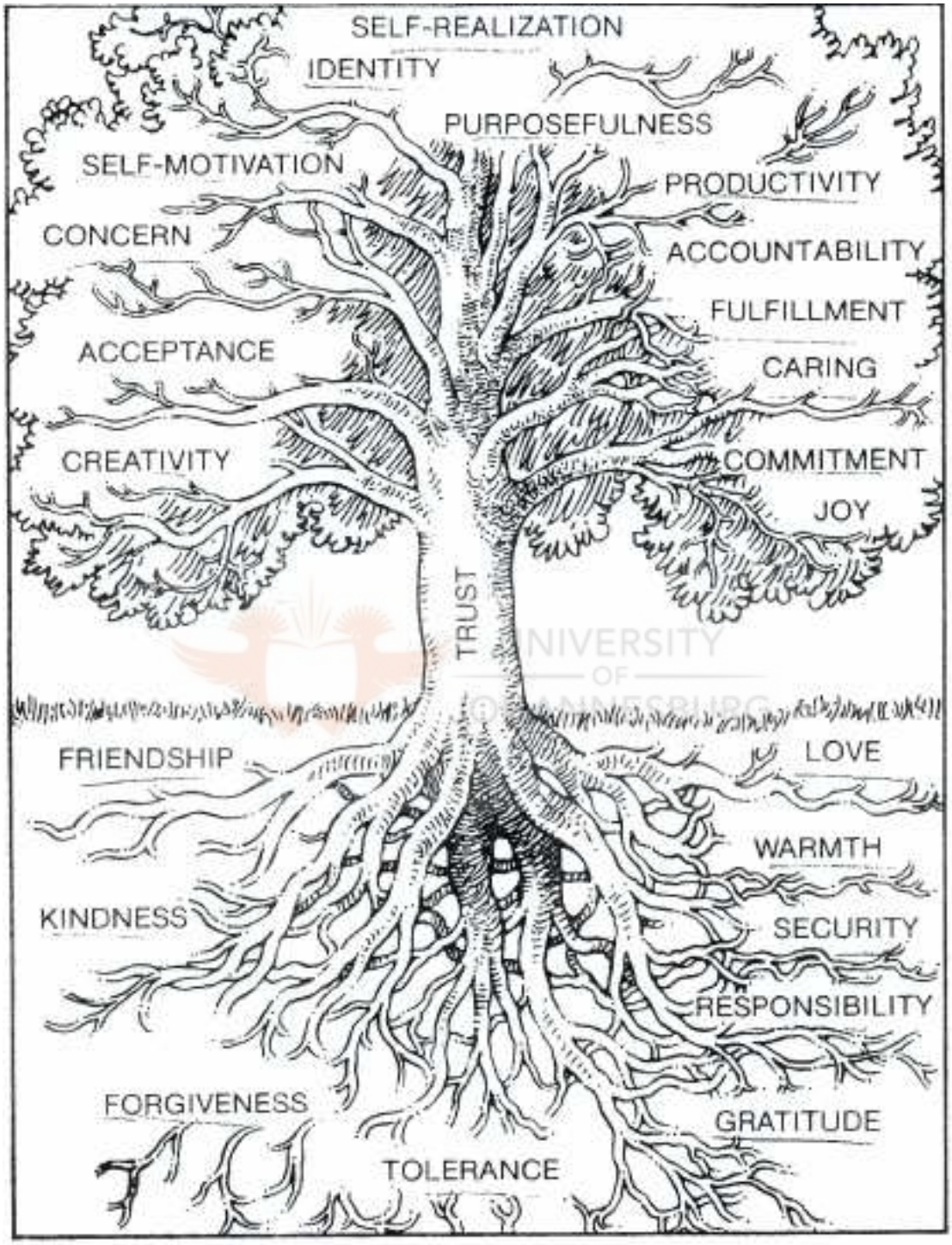

Figure 4.2 Schematic presentation of psychological support for nurses who are psychologically abused in the workplace

CHAPTER 5 CONCLUSION, EVALUATION AND RECOMMENDATIONS

5.1 INTRODUCTION

Chapter 5 is summative in nature, highlighting the conclusion, evaluation and recommendations as relevant to the research.

5.2 OBJECTIVES

The objectives for this research were twofold:

- To explore and describe the community nurse's experience of psychological abuse in interaction with others in the workplace
- To develop strategies to assist community health nurses to deal with psychological abuse

5.3 RESEARCH METHODOLOGY

The research design for this research was qualitative, phenomenological, explorative, descriptive and contextual in nature.

In-depth semi-structured phenomenological interviews were conducted and naïve sketches were collected from participants during this research. The community nurses' experiences of psychological abuse in interaction with others in the workplace, were explored and described by means of in-depth, semi-structured phenomenological interviews.

The criteria for inclusion in this study was twofold in nature, namely (1) being a community nurse for a period of more than three years, and (2) having some insight in relation to the study.

During the interviews one central question was asked, namely: "How do you experience psychological abuse in the workplace?"

Interviews were taped and transcribed word for word. The data gathered by the researcher through interviews and the naïve sketches was analysed by an independent coder. The typed-out version, together with the audio tape(s), as well as the naïve sketches, will constitute the material for data collection. During this research the interviews were held in the office at the workplace of the participants. The participant and interviewer were seated near each other, facing each other.

The tape recorder was placed on a table in between the researcher and the participant. Each participant was assured privacy and confidentiality.

A clear set of transcripts of the interviews and naïve sketches was provided to an independent coder who is experienced in qualitative data analysis. A consensus discussion took place between the researcher and independent coder regarding the themes and categories identified.

5.4 RESEARCH RESULTS AND STRATEGIES

On p 69, Table 4.1 is a summary of the psychological abuse experienced by community nurses and the strategies suggested for psychological support.

5.5 CONCLUSION

Even though not much literature exists with regard to psychological abuse in nursing, this research found it to be a stark reality, which needs to be addressed.

Three main categories came to the fore after the analysis of the data was completed, namely:

- Disempowering working conditions exacerbating nurses' experience of psychological abuse in the workplace
- Disrespectful practises demonstrated by the community (patients) as well as other nurses (co-workers and supervisors) in the workplace setting
- Nurses' destructive responses on an interpersonal level

For each of these categories strategies were proposed, namely

- Facilitation of empowering working conditions
- Facilitation of respectful practises
- Facilitation of nurses' constructive responses on an interpersonal level

5.6 RECOMMENDATIONS

Certain recommendations are made with regards to the research results obtained. Recommendations are being made for community nursing practice, community nursing education and community nursing research.

5.6.1 Community nursing practice

Abuse in the workplace is a widespread problem and has an effect on the professional, as well as the personal, level of the community nurses' life. Nurses need to be taught how to recognize and handle the conflict/abuse that they encounter on a daily basis in the workplace. Policies and procedures need to be put in place in order to protect the nurses from all forms of abuse, especially psychological abuse in the workplace. It is also recommended that an independent governing body be put into place, where nurses can lodge complaints about psychological abuse, but also where they can receive the help they deserve.

5.6.2 Community nursing education

Psychological abuse is very much a reality. Nurses are faced with it every day in the workplace, yet it is never spoken of, either in nursing education programmes or in general. Student nurses need to know the dangers they could be facing in practice. They need to be taught how to recognize and handle psychological abuse.

5.6.3 Community nursing research

Very little literature was available on psychological abuse in nursing. A lot of the literature that was found was in the field of psychology. There is thus ample opportunity for discovering the effects, especially the long-term effects, of psychological abuse in the workplace of the community nurse.

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ANNEXURE A

1. Approval by ethics committee
2. Approval to conduct research
3. Permission to conduct research

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ANNEXURE B

1. Transcription of interview

Key : N: Researcher

D: Participant

N: Do you experience psychological abuse in the work place and how?

Thank you so much for seeing me today I am very privilege that you uhm will spend your time in telling me about your experience of psychological abuse in the work place.
Do you experience it and how what what do you experience?

R:There is definitely physical abuse if you look at the fact that they uhm put more and more pressure on you uhm I for instance was in a incidence not very long ago where my supervisor try to put pressure on me for something that needed to be done that was not actually really my responsibility but then she tells me if you don't do it I will punish you.

N: My goodness.

R: And I mean that is things that really put pressure on to you and it is things that really uhm uhm put you in a situation where you don't know what to do because on the one hand you know it is not really your responsibility but where do you end you want to help and if you go to far it is also not the right thing to do so I think that is quite a difficult difficult situation that they put me in.

N: What do you think uhm are the direct cause of psychological abuse?

R: I think stress and also pressure from all sides because your supervisor is under pressure they put you under pressure and you and all you get is pressure, pressure, pressure and you see it in the work too little people to do the work and the pressure comes from all and also tantrums that

is unrealistic tantrums to everything that needs to be done or somewhere along the communication uhm uhm way there is somebody that don't communicate and then on the last minute everybody starts running around and that is when things starts going wrong that is where everything starts going wrong.

N: So you think communication is a huge part of the problem.

R: Very very huge part of the problem we experience that for instance if you take it we are working for the Municipality but we interact with the Department of Health we interact with with all other the hospitals all other departments and what happens like let me give you an example like yesterday.

Yesterday I was suppose to attend a workshop and I've got a written note on that fortunately for me I walk to the hospital I ran into somebody who then told me whoo there has been changes and things like that otherwise I would have got into my car drove all the way to Nelspruit went to the wrong place and everything would have gone wrong so somewhere along the line communication got a big big role to play into this.

N: What would you say because as I understand you uhm it is about pressure and communication that two that stands out for you as I understand.

How would you say it affects you in the afternoon when you walk out of the door and you are going home.

R: You know uhm I am a person that at night when I have to go and sleep I don't switch off I first go though what happen the whole day you know uhm there are some things I really put aside but something stays with you and and it worries you because if somebody comes to you and say to you if you don't do this I am going to transfer you I mean that is something that that cause you worry because it is a threat it is a open threat that they are given to you and like I said in the beginning uhm how do you go about with this because if you go to far it is not good if you uhm I think uhm uhm to put it another way like I said I think there is also maybe a big uhm uhm gap we don't know exactly uhm what are you aloud to do uhm you know with all the changes that are taken place in the workplace and and things like that we got authority but how far nobody tells

you you are aloud to go thus far you must not cross this line and you must not do that and you must not do that and I think that is also a very big problem because you are not sure uhm how much authority do you have exactly what you can do and then also another thing what I must mention unfortunately it is a political situation and a lot of race uhm connections can be make out of this because uhm it doesn't matter which way you try to go racism always get mention and things like that and and and uhm that also make the work situation very very very difficult it is unfortunately if you are in a supervisor's capacity uhm there is something that you get your departments to flow good and and to let everything go well you must apply discipline and the moment you start applying discipline then it is not good then it is not discipline anymore then other things comes in and I think I am not the only one that experience this in the work place at this stage in my life I think all over will you find this uhm you know for instance I can maybe just mention it I have a disciplinary hearing not long ago with one of my pupils that uhm use one of the municipal vehicles without authority and things like that and as it has to be my direct supervisor is also a White Lady and you got me and then the Director is a Black lady but she didn't make any comments on that but the person who was charged was a Black lady and at the end she says that we was forming a broeder bond against her.

N: Sjuuh

R: You know this is the kind of things that happens that comes in and so I don't really think that in the work place we have accepted one another completely yet there is always this things that happen and what makes it very very difficult for you as supervisor to take charge to take uhm decisions and do things the right way.

I think there is a lot of obstacles if one have to sit and think about it that makes the whole situation very very difficult.

N: If I can come back to a previous question I ask you how do you feel when you go home how do you how do you think uhm what do you think is the impact of all the things that you are

bombarded with if I can put it to you this way what affect does it have on your loved ones around you?

R: Uhm I don't think it is very good because by the time you are go home you are moody you are depressed you are stressed out you know you are just feel like to be left alone you don't want

anybody around you if somebody comes near you you starts shouting or starts shouts or something like that so I don't think it have a good impact on your whole social life and also you know uhm I for instance was a very sociable person but you do find these days that you don't really like company you like to be on your own because you are so stressed up physically and mentally you are so tired that you just don't have the strength for anything else to do so I think it got a very bad impact on your whole uhm your whole family life it's got a bad impact.

N: What do you think you will do for yourself to be able to go on
normally like in present.

R: Well you know you come to a stage where you start switching off and you come to a stage where you say to yourself let it be.

N: Uhm

R: There is a lot of wrong at this stage in my department but I just don't have the strength to tackle it because at the end you are the loosing the loosing person you are the one who pays the price like they say in Afrikaans: you are the "vark van die verhaal".

N: Ja.

R: You know so then you come to a stage where you just let go you just let go you know it is wrong and that is what kept you awake at night because sometimes at night you lay down there and you think for yourself if the paw paw strikes the fan on a certain point at the end you are the responsible person but how do you handle the situation it is not nice to always be in a conflict situation and you know if you are doing anything about it it is going to cause conflict and you are

going to be in a conflict situation and then you are going to sit again and start with this whole process all over again so I for one I've learned to switched off if it comes to a point I switched off in a way what I do is I try to channel my frustration and my things through my sport and things like that and that is the way I carry on that is the way that I carry on.

N: You never completely leave it behind.

R: No you can't you can't because it is like a baggage you know you always have to carry it with you and till it comes to the stage because sometimes there is some problems that your really need to solve uhm especially if there is conflict in the Department itself and at the end it comes to a stage where everything just explode.

N: Uhm.

R: And that is a bad situation but you know uhm like I said you often just come to a stage where you said let it be where you hope the problem will solve itself some do some don't and you have to pay the consequences at the end for that but you do come to a stage where you say to yourself you can't go on anymore just leave it.

N: Ja.

R: And that is not good at all you know it is not good at all it is not good for yourself it is not good for your staff it is not good for your whole department everybody that is involved it is not good but I think it is just the question of you don't have the strength to start the whole process again.

N: Ja.

Is there anything that you would like to add or what you think I've might left out?

R: Uhm No, I don't really think so it is just you know that uhm it would be lovely if you can have a way to tackle your frustrations and you know that you will come to a point that things will change.

N: Ja.

R: You know uhm but I think we will still have to go a long way to go if we are going to got there and I think also a a big scenario and a big thing that contribute to this whole situation maybe also is because you are working under a lot of stress and pressure of staff shortages and things like that things that we really cannot do anything about I mean I can't do anything about staff shortages uhm we've try you know you can complain you can toy toy you can do whatever you want but if they don't appoint people there is no point in there is no money they don't appoint people there is nothing you can do about and there is so many things that you must just accept accept and you just have to carry on but what they don't realise this is all the things that contribute to your frustration why things doesn't go fluently at your department I mean I take myself as a supervisor I am suppose to be a supervisor yesterday I said at the meeting who can I supervise anymore we are responsible for what is happening but we don't have any time to spend at what we are suppose to do.

I mean I've got another clinic that I must visit sometimes I doesn't come to that clinic in three weeks time and not because it is my choice it is just because I have to do other work and leave my work because the service must carry on I can't stop the service I can't close the clinic and said I am going to visit another clinic

N: Uhm

R: I'll open in ten minutes time I'll come back I can't uhm really control my staff for the actions of work I can control it in a way but if somebody comes to me and say: I am sick I'm not coming to work' or just stay away from work at the end if it comes to that I can do something about it you know but if there is nobody to work today there is nobody to work today but the service must run and this is the kind of things you know staff shortage, communication all those kind of things is building up and that is what is cause all this pressure and if it is something that you yourself can manage and can do uhm then it changes but you know most of the time the big frustrations comes from things that you yourself can't change it and and that builds more and more pressure.

N: Thank you so much for talking to me.

END OF INTERVIEW

INTERVIEW 2

N: Do you experience psychological abuse in the workplace and how?

R: No it is what I've experience is what I've lost in pension by moving from one place to another. If you are in the provincial service nê

N: Ja

R: and you move over to the private sector there is no way that they can accommodate your pension or keep it or transfer it over there is no way that they can do something like that.
You've got to start over fresh have a new pension.

N: My goodness.

R: You must work something out you understand because your government pension if you go to a private hospital

N: They pay it out.

R: Ja they pay it out and then you loose a lot of money because they take extra tax on that amount of money so I've been working how long now for 35 years I have about no pension because I didn't work all the time there were about 10 years that I didn't work altogether but uhm moving from one place to another I I was at HV where I get my training then I went to the College where I was a tutor and from there I went to Dundee. From Dundee I went to Ladysmith at the private sector Rivonia and each time that I left a place I lost my pension basically. In total I did not get R20 000 for my pension they did not made provision for us and each time when you go to another place you start as a junior sister on a junior sister

N: salary

R: salary scale and that also irritate the living daylight out of me because I've got everything I've got a S degree I've got a diploma in education in admin I've got a BA degree at Unisa and uhm it didn't help me. That means absolutely nothing I couldn't get a job that was the third thing with all these qualifications I I couldn't get a job because if you go to the Platteland they help their friends first.

N: Uhm

R: And if they see you have got another qualification they don't give you a post you got to have somebody who is a friend who will help you to get a job that also irritated me and then the fourth thing is aids I cannot handle to work with this fraud hanging over our heads that you can get aids through nursing while the Government of Health Services didn't provide for us with safety needles and all that things or give a policy that you know you can be uhm compensated for if you get that disease so that is another thing you can talk for ages about aids at the end the salary salaries is actually not good because I've worked for 35 years now and if you compare my salary with people in private uhm in other works outside nursing there is no comparison I get peanuts really.

Then what else can I say (laugh in voice) the salary uhm (ek kan nie nou eerlik aan iets anders dink nie.

N: Do you feel that in your workplace you've got the experience of psychological abuse here in the workplace.

R: Ja another thing is that White people are not promoted anymore they take you out of your place and put a Black person in there and that is very unfair that is a very unfair policy or system that they have implemented and it should never have been implemented never ever because this is not the place for policy it doesn't work that way and uhm you know that cause a lot of stress in the work environment it cause a lot of unhappiness and uhm people don't want to work together and what we get specifically here at Ridge clinic you cannot dare to say to people but we are closed we are full we cannot take you anymore the minute a White person say that they come and they say oh you are still in the apartheid you know you they think they make it racial commit form that you are a racist while uhm ag you know it is ridiculous I mean and the amount of

people that we see there are months that we see 4 thousand five hundred patients per month and we are 4 sisters it works out about more than 50 patients a day per sister.

N: Oh no..

R: You know it is a lot of work.

N: The pressure.

R: The pressure is just too much to bare you know and so uhm we really feel that impact now it is a little bit better because we are suppose to go over to Government in 2003 and they didn't budget actually for us for nursing this year so uhm we cannot have extra staff or part time staff to help us so we decided that this is the amount of people that we can see and so we cannot exceed that because after all we are just flesh and blood so uhm we can it is a little bit better since we have decided that.

Uhm but before that you know the people think it is our right the government think it is our right that we must go to any clinic that we want to and that we must have excess to any clinic so they kind of fall us at Bushbuckridge that is about 3 and a half hours drive from here they come to this clinic so we were so overloaded but we just could not bare it you know

N: Ja.

R: You know it is the attitude towards us the White people was very difficult to handle and uhm we got this little box where you can put your complains and also your suggestions but you know uhm most of the times there are not only suggestions to make the service better but complaining on the staff which is also very unfair.

N: Ja.

R: I don't like that box really because I feel that is something that they use to break our people down furthermore because we are working and helping them and you know you don't get any recognition.

N: Ja.

R: And the Health Department is just up stairs so if they are not satisfied with what you are doing whether it is justified they quickly run up and say oh you know that sister do this and this wrong usually it is a bunch of lies.

N: Ja.

R: That you do this and that that irritates me it is better now but in the beginning when I started working here yes I couldn't handle that it was too much for me.

N: How do you think all of these things that is happening at the workplace how does it influence you when you go home your family how do you feel and how do think it affects your family.

R: Well I never speak about what is going on here at work with my family because I've got a husband who absolutely hates nursing he cannot handle this profession especially with the increasing number of aids we are not actually allowed to speak about the cases that I see and you know especially when I see a patient with burns or sores or something that grows you know.

N: Uhm

R: That other people are not use to so it does left me a little bit depressed you know especially over weekends when I am alone because I've got only my husband and two boys and they are big already so I'm alone most of the time and that would make me depressed and the fact that there is no uhm there is nothing for me I've worked so very hard in this profession and I am actually still a junior sister that is what I am here because I worked from Pretoria to Dundee and Ladysmith and I come now to Nelspruit so I never got any promotion basically you see.

N: Ja.

R: So that is a very depressing thing.

N: Ja.

R: And you know to accept the fact that other people is place above you it is difficult to handle I think they shouldn't have done that.

N; Ja.

R: So uhm ag I think it is helpful in general they gone through in those days it is so addicting you know you cannot compare the standard of working in a hospital with what I was use to when I was working in the hospital there is no comparison and what irritates me the most is the steeling that is ridiculous..

N: Uhm

R: Now all these things are little frustrations every day you know that make your life difficult and uhm I try not to let them influence my private life but it is difficult I am actually a little bit depressed you know.

N: Ja.

R: I feel you know all these years and all the hard work and all the studies is just wasted it is just wasted and if I could have my life over again I would never ever have chosen this this profession ever I sincerely regret the fact that I ever become a nurse you never get any recognition ever in nursing never.

Here I am you are work your ass off but there is always complains (laugh) so it is difficult and sometimes I can understand that people in their provincial set up think ag you know I am lazy I don't want to do this I don't get a uniform allowance I don't get a lot of money I must work these horrible hours I uhm and all these other things that irritates you the aids and what and what you know you just become or reach the stage in your life where you feel this was not worth it but you don't have something else to do especially at my age I am 53 so what will I do now and even if I

go on pension uhm now say at 60 I won't have a lot I won't have a proper pension so that is really difficult so I think they should have the top people the people who are there to decide over this profession and I am not even belonging to Nivose but they were suppose to look after these matters.

N: Ja.

R: Because you are get so frustrated and that is why so many people are just leaving

N: Ja.

R They are going to other countries where they get money at least for what they are doing because nursing are a difficult job it takes a lot out of you a lot there are days that I feel I cannot brief properly because I've worked so hard today for that salary ag no man that is so ridiculous.

N: Thank you so much for sharing your feelings I appreciate it and I really hope that we can do something somewhere .

R: I don't know how for It is difficult.

N; Ja I know.

R: It is difficult because they have to address racial problems the salary the aids problem and promotion of White people

N: Management

R: Management and they have to think of these things because I will never advise a young person to go for nursing ever.

N: Uhm.

R: There were days that I thought now this is a good profession and I advise people that they must go and they will always get a job but not under these circumstances
You know I have been on AWT once because I've prick myself and I almost died of that stuff.

N: My goodness

R: Yes, I'm almost died it was terrible to use it I have always headaches, nausea stomach pain and you know it took me a month a full month to just get my bowl system back to normal because I was so constipated with all the headache tablets that I took it took a month and you know nobody can tell me I use it for a month and I stopped it now because it was no longer necessary according to me to take it any longer but they said you cannot use ADT and then use it again because it doesn't work anymore if you got that virus in your body it will not work again.

N: You can only use once?

R: You can only use ADT once. That's way these people screamed so well they check who other people they can put on ADT and they must be fault for even one day these tablets must be taken specific times three times a day for one day they cannot be taken for one day otherwise they get resistance so the medicine does not work anymore so nobody can go and use it again because you were suppose to take another medical treatment will it work again then.

N: Ja.

R: So what about us? It seems to me that there is no clarity about ADT the prevention and those kinds of things for us and you know if I prick myself with a needle and the patient is positive do I have to tell my husband to use a condone I mean you know they must think of the implication of that and there must be more safety procedures and methods to use on that level and then they must pay us they must pay us more and give us a policy for the fact that we work with these people.

N; Uhm

R: Because can you really say no I can see you have aids I refuse to take your blood I won't allowed to do this because us nurses we have never actually have rights we don't have the right in fact I am not going to touch you because you are smelly or you have aids or what I I refuse to to put on a drip or draw your blood you those are difficult things that they must think of.

N: Thank you for your time.

R: Okay, I hope it will help you a bit (laugh)

N: It will definitely thank you.

END OF INTERVIEW.

INTERVIEW 3

N: Do you experience psychological abuse in the workplace and how?
Thank you so much for seeing me and I would love for you to share with me your experiences of psychological abuse in the workplace.

R: What shall I say uhm I started of in Primary health care four years ago uhm even though I love the how can you call it the uhm area I've entered primary health care as such I like it because you are very much independent more independent than everywhere else but I never go back because of uhm the psychological abuse and the absolute threats involved uhm I think I could not go forward with that threats because it breaks you down.

Uhm the permanent hearing of the work becomes more and more you have to do this you have to do this but there is no other staff you are the only one to do it so you will do it if you don't do it you jeopardise your own self uhm and if you can't get other people's help and denies things there are a thousand maybe more than a thousand things that is too much uhm I don't know where to start what to say.

N: What make you feel that you were psychological abuse?

R: The unfairness. I'm sure it is not in all uhm workplaces like that but I think in most of them you are treated as with respect and professional always uhm you are just a person who must get the job done and uhm but they don't see you always as a human being if you make mistakes yet we are all professionals working but we are still a human being you can still make mistakes we must still try our best not to you know give the wrong medication and that kind of things but when you get to your 80th patient a day you are physically tired uhm we haven't had any tea break nothing to eat or drink if you don't drink a glass of water or whatever you drink while you are working you won't get anything if you barely have any time to go to the toilet uhm because the patients sits because the load in the waiting room is so high and they get frustrated and then the supervisor get frustrated because the patient's the load is so high and why isn't the work getting done and why why she went through the waiting list now and there is 50 patients and ten minutes later she is back and then there is still 50 patients if not more uhm and you make a mistake because it is so high and if you do make a mistake and every human being would say uhm you know uhm uhm

N: acknowledge

R: Acknowledge that you did make a mistake and try to correct it to the best of your potential uhm and I am not really talking about big mistakes small mistakes then you are the bad sister or haven't you check this or why didn't you do this the moment you should do this and this and this and sometimes these kinds of things happens in front of other staff it happens in front of patients or they want to break you down at this time you all get very tired you know and you made a mistake and for this to become more and more and more. And even some patients I mean it is terrible I mean even for me to stand in a que for 50 minutes if not more we want to be helped as soon as possible and when it comes to sick people or the people with a sick child and they have only 20 minutes that my boss said that I can go to the clinic and now I stand in a que of 80 people or how many and uhm I'm not just being helped now if you see a casualty before the person who is first in line then you are not fair and whatever they may say and they've been terribly terribly rude to you and then you feel bad and then sometimes I just had to swallow and swallow and just turn around and walk away otherwise I would have said stuff that is not good and that is also discourage you because why am I there I am there to help them and they don't see that I want to help them they just think I am nasty and I am rude and I don't want to help them.

One day a person called me so badly and not only about job related things that person curse me personally in front of a whole lot of people and the patient's in the corridor and not even my supervisor or no one that stood there came up for me they just keep quite and let this man speak to me in that way and I had to leave actually my job that day I have to go home because I was so broken down I was so hurt inside that I just couldn't go on for the rest of the day face anyone because I felt so bad even know I might have gone through but it is terrible to give your everything to people and they just throw it back in your face and what it make worse is that my senior didn't say a word to come up for me or took this man out of the corridor into my office to a private place everybody just stood there and then he go on and on and on and I feel she knew that I was given my utmost and she knew that I was the correct one and the patient was in the wrong and took everything out of perspective but still.

N; What affect does it have on your family.

R: Terrible constantly I was tired when I got home I didn't want to cook there were constant fights because I only want to stay in bed because I became more and more tired uhm my child if my child wants a little bit of attention he starts crying for his mummy I was tired and lie in bed and everyone got hurt in this through this whole process and I felt becoming extremely anxious for making mistakes because of the fact that when you make a mistake and everybody is up you you are tired and you worked out that you have two and a half minutes per patient you must do everything you must take the history diagnose the patient you don't even have any other sister who can attend to the patient you must do everything primary health care the basics every every single thing and two and a half minutes it is ridiculous I speak to this patient and it is not professional and I started waking up three o'clock in the morning 4 o'clock in the morning in a sweat with severe anxiety so bad that I can't cope and it affected my whole life so bad if I watch TV and if I heard anything about sick people or diarrhoea or whatever I I became extremely anxious because my mind went back to what did I do today shouldn't I have done this or only I have more time to screen this one it should have been a little bit better or whatever the case may be and so what happen is I was constantly anxious constantly on the tip of my toes and on the tip of my feet and it was a terrible nasty business at work.

N: Anything else that you still want to say?

R: I take my hat of for people who are still doing this really uhm and I just wish someone can stand up and do something and look at the situation and I realise it is difficult to get staff and there is not always enough money but there must be some way to protect us even if there can be a law that said only for instance 40 patients per health profession in Primary Health Care per day or whatever just so that we can protect ourselves and also our patients because they also a right because I will go back anytime because I love it but now there is nothing I can do.

N: Thank you so much for sharing.

ANNEXURE C

NAÏVE SKETCHES

Do you experience psychological abuse in the workplace, and how?

Naïve sketch 1

Overflow of patients from the rural areas to the two urban clinics hoping that those clinics are more advanced than their in rural areas, in that way we feel psychologically abused by being overworked.

Workplace violence – Standing in long queues they become impatient and start passing some vulgar words to the staff.

Staff shortage – The ratio of a community health nurse to patient is not at all acceptable. The few staff attending to many patients end up having a burnout due to psychological stresses. The quality of care is give to patients is not an excellent one.

The failure of patients to appreciate the over commitment by nursing staff leads to psychological stress thus psychological abused.

Lack of employer's word of appreciation is indirectly / affecting our performance, dedication and

enthusiasm, which is at the end of the day is a psychological abuse.

Poor supply of medication to primary health levels is contributing the psychological abuse as the result that patients are taking the blame to community health nurses thus, undermining the proficiency and commitment of nurses.

Naïve sketch 2

Psychological abuse from clients.

Clients do not appreciate service rendered, but complain most of the time.
Clients lie and give incorrect information.
Some clients are rude.
Clients are impatient and start nagging.

Psychological abuse from colleagues.

Disrespect and lack of co-operation.
Poor or lack of communication.

Psychological abuse from senior management.

Poor response or no response at all to raised issues of urgency.
Lack of support with policy issues.
Lines of communication that makes a lot of time to be wasted before an issue can be resolved or approved.
Poor or lack of transparency in financial expenditures or budget management.

Conclusion

There are different levels and different abuses of people at a workplace.
There are also abuses that an individual experienced due to attitude and character.

Naïve sketch 3

Lack of communication.
Lack of mutual respect.
Allocation of duties that are not in your scope of practice.
Exploitation.

Overtime not being considered.
Manner of approach.

Lack of communication.

Where information is not being spread to all categories of nurses, example, the supervisors have meetings, subordinates are not always informed.

Lack of mutual respect between colleagues.

Poor respect, they do not respect each other as expected.

Allocation of duties that are not in your scope of practice.

Some of us are being allocated duties that is above our scope of practice.

Some are also being exploited.

Hours of minutes that are being worked is not considered – we are told by our supervisor that we will get a certificate of recognition.

Manner of approach between colleagues needs a lot of attention, some of us are plainly rude towards each other, but never to the patients/clients.

Naïve sketch 4

It is more stressful to work more hours without incentives. Shortage of nurses causes stress. The amount of patients increases each and everyday, and there's not time for administration but at the end of the day expected to give reports, feedback and statistics with limited time given.

No time for families.

Employers do not take nurses as human beings. Always our services are known as essential

service. No compromise, salaries paid to nurses not everyone or not according to the workload.

A nurse is a nurse from within but our patients is tested each and every day. Media people always after our mistakes or they'll write about the things that are not true.
The community they sometimes reject the nurses, they don't work hand in hand with the nurses.

The time expected is short to give health education to the community because they come with the same diseases we talk about.

Things affecting the nurses is not considered by the government, e.g. salaries, workload and shortages of the nurses or say health workers. In the rural areas no protection.