

**THE RELATIONSHIP BETWEEN WORK STRESS AND YEARS OF EXPERIENCE
AMONGST MALE MENTAL HEALTH CARE NURSING PRACTITIONERS WITHIN
TERTIARY PSYCHIATRIC HOSPITALS IN THE UMGUNGUNDLOVU HEALTH
DISTRICT.**

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DECLARATION

I, Mark Albert Smith declare that the content within this dissertation is my own work. All sources that I have used or quoted have been acknowledged in the text by means of complete references. This study has not been previously submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

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ABSTRACT

Introduction

Psychiatric nursing is a speciality within the nursing profession in which the nurse directs his or her efforts to the early identification of and intervention in emotional problems and work towards the promotion of mental health. In addition, effort is placed on the prevention of mental disturbances, and follow - up care to minimize long - term effects of mental disturbance (Uys and Middleton, 2014:18-20). According to the South African Depression and Anxiety Group (SADAG) (2015), 16.5% of South Africans suffer from common mental disorders like depression and anxiety. Even more concerning is the fact that 17% of children and adolescents suffer from mental disorders.

Mental illness adversely affects the person's brain and at times requires long-term treatment. In this study a total of 158 male mental health care nurse practitioners' were questioned and a quantitative non- experimental cross sectional descriptive survey was conducted to describe male mental health care nurse's practitioners' years of experience in psychiatric nursing and the levels of stress of these nurses was identified. The researcher also determined whether there was any relationship between the stress reported and the years of experience amongst male mental health care nursing practitioners in tertiary psychiatric hospitals in Pietermaritzburg.

Problem Statement

Although there is some evidence of studies related to the challenges faced in psychiatric and mental health nursing, however there is little to no studies in this specifically about male mental health care nursing practitioners at in-patient specialist psychiatric hospitals, hence the need to conduct this study (Robinson, Clements & Land 2003:34; Ngako, Van Rensburg and Mataboge:2012: 1-9; Moylan and Cullinan (2011). In addition, it is not known or understood whether there is a relationship between stress and years of experience in male mental health care nursing

practitioners is working in tertiary psychiatric hospitals in uMgungundlovu Health District.

The researcher thus sees the need for the identification of stress in male nurses in inpatient mental health facilities, investigate years of experience and incorporate measures to mitigate identified stressors for male mental health care nursing practitioners.

Objective

To describe any relationship between work stress and years of experience in a sample of male mental health care nursing practitioners within Tertiary Psychiatric Hospitals in the uMgungundlovu Health District.

Research Questions

- What is the male mental health care nursing practitioners years of experience in psychiatric nursing?
- What level of stress, if any, do male mental health care nursing practitioners in tertiary psychiatric hospitals in uMgungundlovu Health District suffer from?
- Is there is any relationship between stress and years of experience in male mental health care nursing practitioners working in tertiary psychiatric hospitals in uMgungundlovu Health District?

Methodology

A quantitative non-experimental cross-sectional descriptive survey was conducted to describe male mental health care nurse's practitioners' years of experience in psychiatric nursing and the levels of stress of these nurses was identified. This study utilized a survey questionnaire to measure and describe levels of stress in male mental health care nursing practitioners in the clinical field.

Findings

The findings reflected a mature and skilled sample between 30 to 39 years of age who chose to work in tertiary mental care health care. These findings could also reflect that this age group are able to cope with the sources of pressure in these tertiary in-patient psychiatric settings. The experience of participants working at these three psychiatric tertiary hospitals is evident in the findings. It was then concluded that male mental health care nursing practitioners with more years of experience are better able to deal with stress in the workplace.

DEDICATION

“Do nothing from selfish ambition or conceit, but in humility count others more significant than yourselves. ⁴ Let each of you look not only to his own interests, but also to the interests of others”.

Philippians 2:3, 4. (KGV)

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CHAPTER 1

INTRODUCTION

1.1 Background

Psychiatric nursing is a speciality within the nursing profession in which the nurse directs his or her efforts to the early identification of and intervention in emotional problems and work towards the promotion of mental health. In addition, effort is placed on the prevention of mental disturbances, and follow - up care to minimize long - term effects of mental disturbance (Uys and Middleton, 2014: 11-13).

It is concerning that 17% of teenagers and children suffer from mental disorders and according to the South African Depression and Anxiety Group (SADAG) (2015), 16.5% of South Africans suffer from communal mental disorders like anxiety and depression. Mental illness adversely affects the person's brain and at times requires long-term treatment. Most individuals experience ongoing disability and this has been a challenge to rehabilitate vocationally (Uys and Middleton 2014: 43). Mental health is receiving increased attention in South Africa (Lund, Kleintjes, Kakuma, and Flisher, 2010: 394) following the Life Esidimeni incident in Gauteng at the end of September 2017 where it was reported that by end of November 2017, that there was 143 psychiatric mental health care users (MHCU's) who died due to lack of adequate professional psychiatric nursing care (Sowetan Live Times, November 2017). Psychiatric nursing in South Africa is a specialized area of nursing, with unique roles and functions. It involves dealing with the psychological, spiritual, social, cultural and environmental suffering of mentally ill patients on a daily basis (Uys and Middleton, 2014: 18-20).

Internationally and in South Africa, nursing remains a female-dominated profession. Nationally, male nurses comprise only 9.6%, whereas female nurses comprise 90% of nurses in the nursing profession (South African Nursing Council (SANC) Statistics 2017). Provincially, particularly in the KwaZulu–Natal Province, male nurses

comprise only 9.9%, whereas female nurses comprise 90% of the nursing profession (SANC Statistics 2017:1 - 2).

Despite the barriers and challenges in the nursing profession, it has been found that men are willing to enter nursing while they also encourage their male counterparts to choose nursing (Vahid and Zamanzadeh, 2013). This could suggest that there are advantages for men entering nursing and it has further been suggested that men who enter the nursing profession tend to have speedier career development than women and discovered that they are better treated by general practitioner's (Vahid *et al.* 2013). Moreover, it was also felt by men that nursing is a more established occupation and that their career paths are more beneficial with better prospects of progression compared with some other male dominated professions (Vahid *et al.* 2013). Male nurses furthermore found that practicing in defined clinical areas such as mental health, intensive care, anaesthesia, casualty departments, and management could provide better salaries.

Nursing is an important profession and now includes male nurses in line with gender equality and in accordance with the South African Constitution Act 108 of 1996 stated under the section: freedom of trade, occupation and profession;(Section 22, p7). However, these male nurses seem to present with certain stressors in joining the nursing profession leading to symptoms that impact negatively on their mental well – being (Robinson, Clements & Land, 2003:34). These male mental health care nursing practitioners (MHCP's) present with symptoms of aggression, violence, frustration, helplessness, job dissatisfaction and feelings of fear and anger and as a result of these negative experiences, they find it difficult to work efficiently with Mental Health Care Users (MHCUs) with severe psychotic indications. In most mental health establishments, male nurses have to work in extremely stressful settings where they face stressors like a shortage of nurses, severe workload and unpredictable patient behaviour like aggression and violence in the unit. Psychiatric nurses are faced with a variety of stressors in the work environment and nurses in mental health care settings encounter situations in their careers that are uncomfortable or distressing. Each individual will respond in a slightly different

manner to each presented situation in general and the discomfort level of each individual differs in a given situation. Work exposure to stressful situations can lead to depression, violent behaviour and anxiety (Robinson, Clements & Land, 2003).

Many studies have mentioned nursing staff being assaulted by mental health care users (MHCU's) (Ngako *et al.* 2012:1-9; Moylan and Cullinan 2011:526-534; Moloi 2015, Joubert 2014:97-98 and Bimenyimana *et al.* 2009). Duxbury (2002:325) quotes Vanderslott (1998), who reported that male nursing staff were more attacked than female staff, and that it was undoubtedly due to male nursing staff being more involved in the containment of outbursts (Bock, 2011). Female nurses, unlike male nurses are often easier targets for violence, because they are unable to measure up substantially to aggressive male patients.

According to Stevenson, Jack, O'Mara and LeGris (2015:35); Canadian psychiatric nurses perceived that the acquaintance to verbal or physical violence had an effect on both their professional and private lives and nurses shed light on their experiences of violence which affected their abilities to carry out their professional nursing roles. An extensive array of emotions was voiced by nurses experiencing instances of physical violence from patients in an acute care psychiatric inpatient unit in Canada and pronounced physically undesirable consequences or injuries. The wounds defined included musculoskeletal shoulder and knee injuries, scratches, bruises, loss of hair and bites. Other bodily consequences related to patient violence included; headaches, muscle tension, being spat at, having water thrown at them, insomnia and bad dreams. Some participants began to abuse substances and binge on food choices which included alcohol and smoking, due to experiencing patient violence continually (Stevenson *et al.* 2015:35).

With regard to differences in job stress, it was also concurred that there are no legal differences in nursing care and nursing duties for psychiatric nurses centred on gender in Japan and the inclination to participate in certain responsibilities does appear to vary centred on gender (Yada *et al.* 2014:468-476). For example, female nurses in psychiatric departments have a habit of spending more time building relationships with patients and increasing supportive functioning with co-workers

compared to male nurses (Torkelson and Seed 2011) whereas, male nurses in psychiatric departments mainly react to aggressive patients in episodes of severe tension, impatience, and other noticeable psychiatric indicators (Kontio *et al.* 2010; Yada *et al.* 2014:468-476).

In South Africa, psychiatric nursing has been described as a speciality within the nursing profession, which focuses on the early identification and prevention of mental illness, promotion of mental health, treatment of emotional disturbances, with follow-up care aimed at minimizing long-term effects of mental illness in clients and mental health care user's (MHCU's). Mental illness has been further described as a diagnosis of mental health related conditions, as specified by the investigative criteria stated in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (Uys and Middleton 2010: 209).

Male and female mental health care nurse practitioners alike are experts in the assessment, diagnosis and treatment of psychiatric disorders and provide holistic nursing care. Nursing duties include evaluating patients' mental health needs; writing and evaluating psychiatric nursing care plans; running and planning groups including psychotherapy and other psycho - social activities; they also provide personal and supportive care; coordinate care by acting as an advocate for mental health care users (MHCU's) with their families, and other caregivers and administer psychiatric medications as prescribed by the doctor and psychiatrist. Uys and Middleton (2010: 18), state that psychiatric nursing activities also include clerical supervisory duties; serving patients' meals; admissions; transfers and discharging and the restraint of violent patients. All of the above is very stressful; challenging and demanding on the mental health of both male and female mental health care nurse practitioners.

The Mental Health Care Act 17 of 2002 (Government Gazette no 24024) categorizes mental health care users (MHCU's) in different groups ie. involuntary mental health care users, assisted involuntary mental health care users; voluntary mental health care users (MHCU's) and state patients (SPP) committed and awaiting the court's decision respectively. These mental health care users (MHCU's) are admitted into care facilities based on them being a danger to themselves; others and a danger to

property and they are cared for by trained Mental Health Care Practitioners (MHCP's) ie. Psychiatrists; Psychologists; Doctors; Social Workers and Mental Health Care Nursing Practitioners, which includes male and female mental health nurses. However, it seems that male and female mental health care nurse practitioner's experience stressors in the in-patient psychiatric facility differently as mentioned in the following study.

Yada, Abe, Omori, Matsuo, Masaki, Ishida, and Katoh (2014: 468-476) reported that there are differences in job stress accomplished by male and female Japanese psychiatric nurses. Male nurses discovered that the attitude of patients was a distinctive stressor that exaggerated their irritability, but this was not the same for female nurses. It is understood that one of the reasons that male nurses are generally required to deal with hostile psychiatric patients and also physical attacks related to expressive responses, which include anger, violence, and threatening attitudes from patients may possibly result in bad tempers in male nurses (Gates *et al.* 2003; Kontio *et al.* 2010).

Concerning job stressors that affect anxiety, the outlook towards nursing was a distinctive stressor in male nurses, but not with female nurses (Gleeson and Higgins 2009; Keogh and Gleeson 2006; Yada *et al.* 2014: 468-476). It was felt that one of the explanations might be that male nurses practice stronger gender awareness than female nurses. The stronger gender awareness might be due to the great number of female patients that decline to let male nurses physically care for them (Deguchi 2009). Additionally, male nurses also have concern about caring for female patients that result in unwillingness to touch them physically when carrying out their nursing duties (Gleeson and Higgins 2009; Keogh and Gleeson 2006; Yada *et al.* 2014:468-476).

In light of the above; Joubert (2014:67) in South Africa; investigated the roles of male and female registered psychiatric nurses at six in-patient psychiatric hospitals and clinics in the province of Kwazulu-Natal. Findings revealed that the gender sample distribution for females was 65.9% (n=261) and males were 34.1% (n=135). The ratio of female nurses to male nurses was approximately 2:1. This reflects the dominance

of females in the nursing profession. The slightly larger number of males according to Joubert (2014:67) may be due to the fact that psychiatric nursing environments, in comparison to general hospital settings is an environment where staff are potentially at higher risk of physical violence and harm.

1.2 Problem Statement

Experienced and inexperienced male nursing staff both working with intellectually challenged mental health care users (MHCUs) and mentally ill mental health care users (MHCUs) experience stress related factors that can influence their work performance and personal well-being (Tuveson *et al.* 2012: 209). It seems that stress has a negative influence on the psychological well-being and physical health of male nursing staff working in inpatient mental health facilities (Tuveson *et al.* 2012: 209). Results at these inpatient mental health facilities in turn show high absenteeism and personnel turnover, which affects the quality of patient care (Bilgin 2009; Yusi 2015). In light of the above; Joubert (2014:67) also mentioned that nurses working with psychiatric patients may be threatened with psychological anguish, vigorous fluctuations in patients, intense interpersonal interactions and emotional lability and that can be very demanding and perplexing to them.

Studies have shown that there is a link between stress and challenges such as absenteeism; alcohol and drug dependence, professional self - doubt; irritability and inadequate anger management (Bilgin 2009; Yusi 2015). Although there is some evidence of studies related to the challenges faced in psychiatric and mental health nursing, there are no studies related specifically to male mental health care nursing practitioners at in-patient specialist psychiatric hospitals, hence the need to conduct this study (Robinson, Clements and Land 2003:34; Ngako, Van Rensburg, and Mataboge:2012:1-9; Moylan and Cullinan, 2011). In addition, it is not known or understood whether there is a relationship between stress and years of experience in male mental health care nursing practitioners working in tertiary psychiatric hospitals in uMgungundlovu Health District. The researcher thus sees the need for the identification of stress in male nurses in inpatient mental health care facilities and

incorporate measures to mitigate identified stressors for male mental health care nursing practitioners.

1.3 Aim of the Study

The aim of this study was to describe the relationship between work stress and years of experience amongst male mental health care nursing practitioners within tertiary psychiatric hospitals in the uMgungundlovu Health District.

1.4 Objective of the Study

To describe any relationship between work stress and years of experience in a sample of male mental health care nursing practitioners within tertiary psychiatric hospitals in the uMgungundlovu Health District.

1.5 Research Questions

- What is the male mental health care nursing practitioners' years of experience in psychiatric nursing?
- What level of stress, if any, do male mental health care nursing practitioners in tertiary psychiatric hospitals in uMgungundlovu Health District suffer from?
- Is there any relationship between stress and years of experience in male mental healthcare nursing practitioners working in tertiary psychiatric hospitals in uMgungundlovu Health District?

1.6 Significance of the Study

The value of this study may provide hospital and Nurse Managers the necessary information to assist with the identification of stress in male nurses in mental health facilities and put measures in place to mitigate against identified stressors for male mental health care nursing practitioners.

1.6.1 Acronyms and abbreviations

MHCP:	Mental Health Care Practitioner
PNP:	Psychiatric Nurse Practitioner
MHCU:	Mental Health Care User
MDT:	Multidisciplinary team
SANC:	South African Nursing Council
SPP:	State President Patient
MMHCP:	Male mental health care nursing practitioner

1.6.2 Operational definitions

1.6.2.1 Mental health care user (MHCU)

A person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user, State patient, mentally ill prisoner (*Mental HealthCare Act No. 17 of 2002:5*). In this study, a MHCU will refer to a person receiving care, treatment and rehabilitation facilities in the three specific government health institutions in Kwazulu- Natal.

1.6.2.2 Mental health care nursing practitioner (MHCP)

In this study, a MHCP refers to a qualified nurse in the arena of Psychiatric Nursing to provide care, treatment and rehabilitation to MHCUs (*Mental HealthCare Act No. 17 of 2002:10*).

1.6.2.3 Male mental health care nursing practitioner (MMHCP)

In this study, a MMHCP refers to all registered male mental health nurses in South Africa (*Mental HealthCare Act No. 17 of 2002:10*).

1.6.2.4 Mental health

In this study ‘mental health’ will refer to the male nurse who is able to handle and cope with the usual pressures of life, and function effectively at work (Uys and Middleton; 2010:16).

1.6.2.5 Psychiatric Hospital

In this study, a mental hospital is seen as a facility with psychiatric wards, or a custodial clinical environment as is recognised by the National Health Authority, with creative therapeutic wards and clinics for giving care, treatment and rehabilitation to people with psychiatric disorders (*Mental HealthCare Act No. 17 of 2002:10*).

1.6.2.6 Professional nurse

In this study, the term professional nurse refers to a trained registered nurse, who has registered with the South African Nursing Council (SANC) to provide mental health care treatment and rehabilitation treatment to psychiatric patients (South African Mental Health Care Act, 2002:10) and meets the inclusion criteria for the study.

1.6.2.7 Staff nurse

Section 31 of the Nursing Act (Act 33 of 2005) refers to a staff nurse is an individual who implements nursing care within the limits of their qualifications under the supervision of a registered nurse. Staff nurse in the South African context is a nurse who has met the requirements of the South African Nursing Council (SANC) Regulation (R2175) Certificate in Enrolled Nursing, which is a 24 - month programme according to the directives of the South African Nursing Council (SANC 1975). The second year of study includes psychiatric nursing science as part of meeting the requirements of this course (Section (b); (ii); (ee) (section 45 (1) of the Nursing Act, 1978 (Act No. 50 of 1978). In this study, the term staff nurse refers to a qualified enrolled nurse, who has registered with the South African Nursing Council (SANC) to deliver mental health care treatment and rehabilitation services to psychiatric patients (South African Mental Health Care Act, 2002:10) and meets the inclusion criteria for the study.

1.6.2.8 Nurse auxiliary

Section 31(1)(d) of the Nursing Act, 2005 (Act No.33 of 2005), an auxiliary nurse is a person who carries out elementary nursing procedures and take care of patients on a

none specialized level under the supervision of a registered nurse. An auxiliary nurse in the South African context is a nurse who has met the requirements of the South African Nursing Council (SANC) Regulation (R2176) Certificate in Enrolled Nursing, which is a 12 - month programme according to the directives of the South African Nursing Council (SANC 1975). As part of section 6. (1) of the course objectives in training (i) identifies and carries out his obligation in respect of the elevation of the physical and mental health of man and the prevention of physical and mental disorders in man) (section 45 (1) of the Nursing Act, 1978 (Act No. 50 of 1978). In this study, the term nursing auxiliary refers to a qualified nursing auxiliary, who has registered with the South African Nursing Council (SANC) to provide mental health care treatment and rehabilitation services to psychiatric patients (South African Mental Health Care Act, 2002:10) and meets the inclusion criteria for the study.

1.6.2.9 Forensic patient/state patient

Commonly referred to as “SPP” means that the person is kept in a secured forensic unit of a specialist psychiatric hospital for treatment after being found not fit to stand trial for the criminal act he committed by virtue of his mental incapacity or illness and or was unable to understand the court proceedings (Mental Health Act Section 42 of Act no: 17 of 2002).

1.6.2.10. Mental Health Nursing or Psychiatric nursing care

Mental health nursing is as an interpersonal process in which counselling is aimed at supporting and facilitating healthy lifestyle functioning (Uys and Middleton; 2014:17). In this study, psychiatric nursing care will be used interchangeably with mental health nursing care.

1.7 Theoretical Model: Stress Vulnerability Family Coping Skills Model Of Adaptation

A theoretical model helps to guide and organise the study and provides the background in which a problem is examined and data are collected and analysed. A

model is a visual or symbolic illustration of a theory or theoretical framework which often assists to direct intellectual ideas in a succinct and convenient form and is frequently described as a figurative representation of reality which reflects organised ideas (Polit and Beck 2012:128; Brink, van der Walt, and van Rensburg: 2012:26). The researcher shows that the anticipated study is a reasonable addition of current knowledge and It provides a diagrammatic representation of certain interactions among occurrences, and its uses ciphers and illustrations to represent an idea (Brink 2012: 26). A model helps the researcher to edify the way in which he can interpret a state of affairs, occurrence or group of people and in relation to health sciences research, may help to explain and monitor specific research tasks, or provide a prearranged context (Brink 2012:26). With regard to this study, the stress vulnerability family coping skills model of adaption model will be used.

The stress vulnerability family coping skills model of adaption assists as a guide for professionals and families to guarantee that the person with a psychiatric illness has the best possible recovery and outcome (Hazeldene foundation 2008:1; Mueser & Glynn 1990:129). This model can also be used to understand the causes of psychiatric illness and how psychiatric illness and addiction can influence each other. Further to this it is also beneficial in the management of co- morbid psychiatric illnesses.

“Vulnerability” refers to our basic weakness to mental health disorders and this is determined by our inherent personality and our childhood experiences. It is exaggerated by our use of medications, and our probability of using alcohol or drugs (Hazelden foundation 2008:1; Meuser and Glynn 1990:129).

“Stress” refers to the trials and tests we face in our personal lives and this is affected by our survival skills, societal support, and participation in significant activities like sports and pastimes and leisure pursuits. (Hazelden foundation 2008:1; Mueser and Glynn 1990:129).

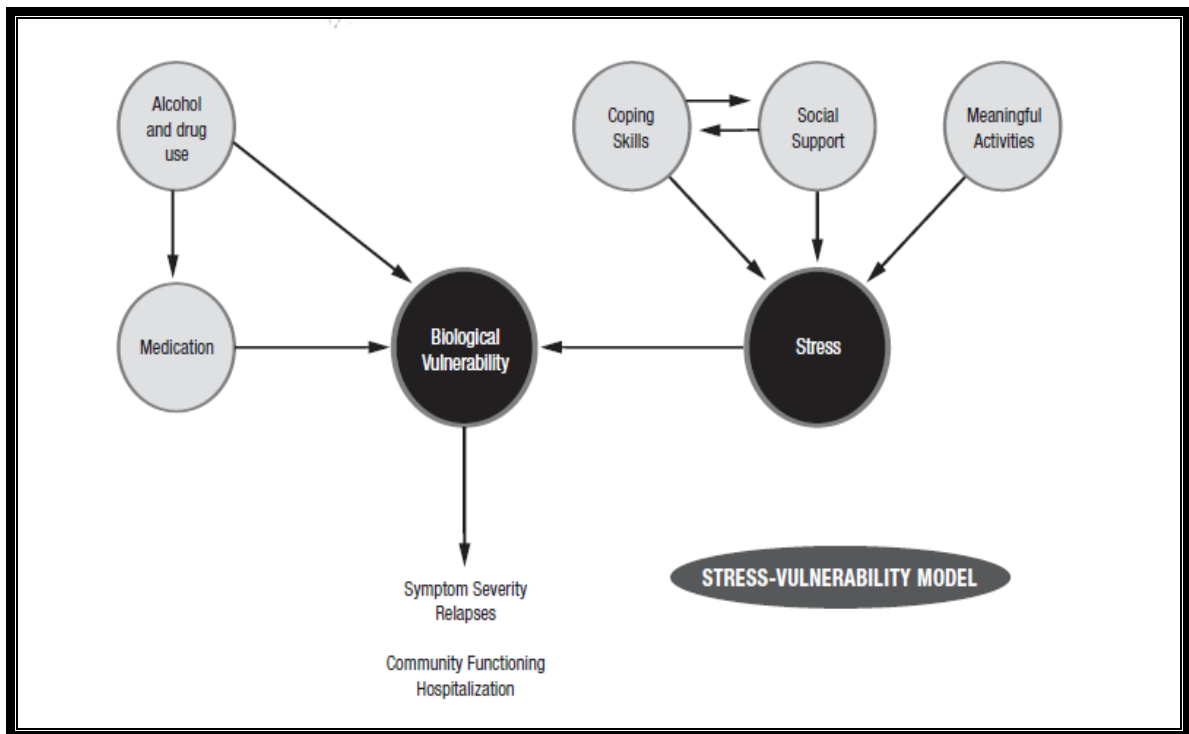


Figure 1: The Stress-Vulnerability Model of co-occurring Disorder

Since this study focuses on the relationship between work stress and years of experience amongst male mental health care nursing practitioners; their social environmental stresses eg. heavy workload; home - work conflict etc. has an impact on their psychobiological vulnerabilities leading to eg. anxiety and major depression. If not managed properly these leads to further impairments, disabilities and handicaps in their lives eg absenteeism in the workplace; alcohol and drug dependence, professional self - doubt, uncertainty about own capabilities, conflicts in the home and work situation and conflicts with other professionals in the work place. It is important for male mental health care nursing practitioners to understand the protective factors that are available to reduce their psychobiological vulnerabilities and stress e.g. assertiveness skills training workshops, workshops on the management of anger and aggression of MHCUs, social support, control of alcohol and drug dependence and create good interpersonal and intrapersonal relations with other professionals (Hazeldene foundation 2008:1; Mueser and Glynn 1990:129).

According to Hazeldene foundation (2008:1) and Mueser and Glynn (1990:129), all psychiatric conditions have a genetic basis, but socio - environmental stressors and influences like handicaps can affect their course over time. The stress vulnerability family coping skills model of adaption points out that an optimistic outcome of a psychiatric illness is more likely if the environmental stress is decreased or managed well for example; if medication is taken as recommended and alcohol and drug use is stopped. Professional work colleagues, the individual (MMHCP) and their families all functioning together can mend the continuing course of mental illnesses. This results in a healthier life for all male mental health care nursing practitioner's (MMHCP) and their family members (Hazeldene foundation 2008:1; Mueser and Glynn 1990:129).

1.8 Summary

Male nurses in mental health facilities face many stressful and challenging situations in the clinical mental health field. It is important for males in psychiatric nursing to understand their own individual work experiences and develop coping strategies in order to function effectively and efficiently in the mental health field. The literature in the next chapter will closely highlight what is presently known with regard to the topic of concern that is to describe the relationship between work stress and years of experience in male psychiatric nurses.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

A literature review involves examining, searching, interpretation, accepting and forming decisions about the available research and concepts as well as presenting it in a well-thought-out manner (Burns and Grove 2005:96). Polit and Beck (2008:757) refer to it as an imperative summary of current knowledge on a topic of interest, often organised in demand for the research problem to be positioned in perspective. The literature is all the written recommended sources significant to the subject of interest and further assists in the choice of the research design, theoretical framework and forms the foundation for the present study. (Brink, van der Walt, and van Rensburg: 2015:54).

The purpose of this review is to express to the reader what is presently known regarding the relationship between work stress and years of experience using a sample of male mental health care practitioner's in Pietermaritzburg tertiary psychiatric Hospitals in KwaZulu- Natal. This extensive literature review is done in the English language literature available on the following databases: Wiley online library; Pubmed and Ebsco host Web: proquest.com.dutlib. from the year 1990 to 2017.

2.2 Historical Development of Men in Nursing

Prior to the 19th Century, virtually each book and article about men entering the nursing profession pronounces the extensive account that men have been caregivers to the sick (Stokowski 2012:1). Increasing gender exclusivity occurred within the nursing profession from the beginning of the historical period of Florence Nightingale, which was associated with a feminist perspective, thus creating possible judgment towards men entering the nursing profession (O'Lynn, 2004). Evans (2004) reported that while this perception decreased towards the end of the 20th century, nursing still

remains a female-dominated profession globally, often linked with continuing gender-specific stereotypes (Kelly *et al.* 2012).

Nursing was one of the only professions exposed to women, whereas men had many other better-paying and more esteemed career choices at that period in time (Stokowski 2012; Keogh and Gleeson, 2006; Torkelson and Seed, 2011). Florence Nightingale is extensively responsible for the "demise of men" in nursing, as she believed that complete nursing care should be removed out of men's hands. Nightingale has been mentioned as saying that men were not suitable for nursing. Her improvements encouraged "gentlewomen" to replace the inexperienced nurses that previously took care of the sick. As a result, "nursing" became equated with "women's work," and this made it challenging for men to choose nursing as a profession of choice and men however, continued to be represented in nursing, but their numbers dropped (Stokowski 2012).

Although a few colleges of nursing for men functioned in North America in the initial 20th century, most hospital departments of nursing (the primary setting for the education and training of nurses) prescribed unreliable policies about the admittance of men in nursing. With the opening of Title IX of the Education Amendments of 1972 (US Legislation), it was no longer possible for educational programs to differentiate against any individual based on their masculinity or femininity and men gradually, rather than hurried into the nursing profession. The quantity of men in the nursing workforce mounted progressively, from 2.7% in 1980 to 6.6% in 2008. In contrast, women in medicine developed from 7% in 1969 to 48% at present (Stokowski 2012; Keogh and Gleeson, 2006; Torkelson and Seed, 2011).

Times gone by has established that male nurses have been a marginal group within the nursing profession and men have continually been involved in nursing, working in places such as military services and correctional services (Dingwall, 1978; Davies, 1980; Mackintosh, 1997). The initial group of trained male nurses arrived in the United Kingdom in 1947 and the quantity of male nurses over the years has gradually improved globally (Squirens, 1995; Armstrong, 2002; Girard, 2003; Inoue and Chapman 2006:560; Mackintosh 1997).

In spite of the worldwide rise for males entering the nursing profession; (Eswi, and El Sayed, 2011), male nurses continue to be the marginal in this profession (Meadus & Towmey, 2011; Leradi, Fitzgerald and Holland, 2010). In the United States of America, male nurses was found to be about 6% of the nursing inhabitants, in Canada 5.8%, and in China less than 1% of the total population of nurses (Landiver, 2013; Rajacich, Kane, Williston and Cameron, 2013; Wang, Li, Hu, Gao, Zhao and Huang, 2010). Just like numerous other countries, in South Africa, nursing remains a female dominated occupation. Nationally and provincially, male nurses comprise only 8.5% whereas female nurses comprise 91.5% of nurses in the nursing profession (South African Nursing Council, 2012).

Abushaikha, Mahadeen, Abdelkader, and Nabolsi; (2014:61) also stated that nursing is traditionally and historically recognised as a female dominated profession. Male nurses have had numerous contributions that have led to the improvement and growth of the nursing profession especially in the fields of mental health; emergency care and nursing in the armed forces (Landivar, 2013; Meadus and Tworney, 2011). Nevertheless, the origins of international scarcity of male nurses can be explored to limitations and restrictions and in allowing male nursing students to enter into the nursing profession internationally and keeping these male students in the nursing profession (Meadus and Tworney, 2011).

However, in a qualitative study by O'Connor (2015) the author illustrated the gendered aspects of career choice, experiences for men choosing nursing and how a masculine identity can be argued within the nursing profession. Conclusions from this study specified contradictions and difficulties for men in recognizing with the nursing profession and little help is given to men to join the nursing profession. Also, for men who have chosen to nurse, there is an effort to detach themselves from the accustomed motivations for choosing nursing such as caring and in fact actually choosing nursing as a career of choice (O'Connor 2015; Latham *et al.* 2013).

Psychiatric nursing is considered to be as one of the most demanding professions in both Japan (Yada *et al.* 2010) and internationally (Leka *et al.* 2012; Melchior *et al.* 1997; Nakakis and Ouzouni 2008; Shen *et al.* 2005; Yang *et al.* 2004). There are around 85 000 psychiatric nurses working in Japan, and the resignation ratio of new graduate nurses in psychiatric departments is succeeding only to that of long - term illness wards (Japanese Nursing Association 2006; Statistics and Information Department Minister's Secretariat Minister of Health & Ministry of Health, Labour and Welfare 2009). As a result, the complications of job stress in psychiatric nursing has lately been receiving attention and deliberation (Tuveson *et al.* 2012; Ward 2011; Yada *et al.* 2011), and many studies have been piloted in this regard (Edwards and Burnard 2003; Edwards *et al.* 2000). The experiences of psychiatric nurses, arrogances of patients, approach towards nursing, and communication are the shared stressors experienced by psychiatric nurses (Yada *et al.* 2011) and therefore, the fear of the psychological needs of psychiatric nurses has turned out to be a vital occupational health subject (Leka *et al.* 2012; Yada *et al.* 2011).

Yada, Abe, Omori, Matsuo, Masaki, Ishida, and Katoh (2014: 468-476); also mentioned that even though the nursing profession has traditionally encompassed a large number of women, the percentage of male nurses has been increasing, both inside and outside of Japan. In 2000, there were 22 189 male registered nurses in employment in Japan, and this quantity improved to 53 748 in 2010 (Health Statistics Office *et al.* 2011). It is also revealed that there were 21 269 male assistant nurses in employment in 2000, rising to 23 196 by 2010. In 2010, there were more than 77 000 male registered nurses and assistant nurses in Japan (Health Statistics Office *et al.* 2011) and there was a high percentage of male nurses in the psychiatric field. For instance, earlier research in Japan has shown that the percentage of male nurses who work at psychiatric hospitals is more than 30% of the total number of nurses (Nakamigawa 2006). Epidemiological studies in the UK, USA, and Canada have also proposed for greater ratios of male psychiatric nurses associated with other units in nursing (Edwards *et al.* 2001; Hanrahan and Aiken 2008; Robinson *et al.* 2003).

Muller, Preston, and Dyjak, (2010) in their study mentioned that psychiatric nursing has traditionally attracted more male nurses, whereas general nursing has always been dominated by females. It was also felt that men have been able to contribute a lot to mental health by bringing some masculine traits that sometimes proved to be useful when dealing with psychotic patients. It was also concluded that there are some barriers for men entering the area of mental health, and in fact, they exist in the nursing profession in general and many male nurses are reconsidering their career options for various reasons, causing the retention rates in the profession to fall. It was considered that even before marketing mental health nursing to men, we need to think about what nursing education can do to attract more male students into nursing colleges and universities in the first place. It was also felt that nurse managers steer their interests towards the area of psychiatric nursing and to address the current shortages. Also nursing educators have to adopt strategies for drawing men's' attention to nursing programmes especially in psychiatric nursing (Muller, Preston, and Dyjak, 2010).

2.3 Stress in Mental Health Nursing

Stress is well-defined theoretically as the bodily, biochemical, and expressive process that yields strain and can cause diverse ailments. Stress can be perceived as either constructive or destructive although stress is generally considered damaging. Many events can be the source of undesirable stress for some persons and constructive stress for others. In further difference of opinion, not all people are stressed by the same circumstances (Menaghan, and Mullen, 1981; Lazarus and Folkman, 1984; Lieberman, Chrousos and Gold, 1992; Pearlin, Weiner, 1992; Lovallo, 1997).

There is minimal research concerning the relationship between work stress and years of experience of psychiatric nurses in South Africa. Globally, there is evidence of studies related to the challenges faced in psychiatric and mental health nursing, and the relationship between their years of experience, work stress and expressive

capability in particular, and the themes that emerged from focus group discussions with male (n=8) and female (n=13) participants. Firstly, nurses felt unsafe in these environments. Secondly, the nursing care rendered was compromised by negative emotions and attitudes. Finally, participants believed that a caring and supportive workplace environment would promote quality nursing care in these wards (Ngako, van Rensburg and Mataboge 2012: 5).

According to Colligan & Higgins, (2010) and Azizollah *et al.* (2014) stress can be caused by any troubled events in an individual's work and social environment. Lazarus and Folkman (1984:19) who defined stress as a specific association between an individual and his or her surroundings that is considered by the individual as being demanding or beyond his or her means and thus threatening his or her wellbeing. Additionally, Cushway *et al.* (1996) found that stress cannot be only, the environment or the person but can also be a product of the both (Cushway *et al.* 1996). The consequences of work stress occur in the work context and the consequences are; absenteeism, leaving the job, and poor job satisfaction, which may influence the quality of mental health, care in a mental health clinical environment (Cushway *et al.* 1996).

Abdairahim;(2013: 30-37) also agreed that stress is a word used by people in diverse educational, societal and unemployment environments. Psychiatric nursing is regarded as a demanding profession that links with resilient human aspects of health and illness (Arafa *et al.*, 2003). The occurrence of work stress among nurses is largely seen as an expensive concern of any health care establishment. This cost results in reduced productivity, absenteeism, nursing turnover, short and long-term ill health, clinical incompetence, direct medical, legal, and indemnity fees, workplace mishaps and emotional difficulties (ILO,2000; Arafa *et al.*, 2003).

Khamisa, Peltzer, Ilic and Oldenburg (2016:256 - 257) pursued to determine whether individual stress is a more substantial predictor of exhaustion, work fulfilment and overall health than job stress. Conclusions exposed that individual stress is a better forecaster of exhaustion and overall health than work gratification, which is better foreseen by work stress. In addition, the outcomes of this study offered possible

answers to reduce the influence of individual and job stress on work satisfaction, exhaustion and overall health. Recommendations in this study included handling approaches and recruitment policies, which need to be appraised within emerging countries like South Africa, to determine their value (Khamisa, Peltzer, Ilic and Oldenburg; 2016:256 - 257).

Yada, Abe, Funakoshi, Omori, Matsuo, Ishida and Katoh (2011) studied the level of job stress in registered psychiatric nurses working in different psychiatric units of a major government psychiatric hospital located in the central region of the Kingdom of Saudi Arabia and discovered that half of the psychiatric nurses included in the study had moderate levels of job stress. Job stress among nurses is one of the central anxieties in the arena of mental health nursing; it was discovered that stress conveyed harmful impacts on both nurses' health and their ability to cope with job demands. Studies have consistently exposed that most psychiatric nurses were experiencing moderate levels of job stress. Researchers have recommended that constant in-service programmes for understanding the unique pressures that have an influence on mental health nurses can assist and escalate the stress demeanour capability among mental health nurses (Yada, Abe, Funakoshi, Omori, Matsuo, Ishida and Katoh; 2011). The following section will distinguish between stress and sources of pressure.

2.3.1 Distinguishing between stress and sources of pressure

A study by Azizollah *et al.* (2014) in Iran explored the relationship between work stress and performance amongst hospital nurses. It was identified by the Health Safety Executive United Kingdom (HSE) that stress helps to improve our performance e.g. we all need a definite amount of stress to perform well just like any actor or actress and athlete, who has to perform well. However, complications arise when the causes of stress become too abundant without any time to recuperate, or when just one source of stress is too excessive for us to cope with (Boswell, 1992, Tsai, 1993; Health Safety Executive United Kingdom; Azizollah *et al.* 2014).

Stress can be expected more widely, as a situation, which happens when an individual recognises the pressures on them, or the requirements of a state of affairs, are more extensive than they can manage with. If these requirements are huge and continue for a lengthy period without any interruption, psychological, bodily or social harm may occur as mentioned by the Health & Safety Executive UK (HSE). Stress has a helpful effect on employees of any institute to a certain degree up to which an employee is able to cope with, commonly it goes beyond the controllable limits and has a damaging result on employees (Boswell, 1992, Tsai, 1993; Health Safety Executive United Kingdom; Azizollah *et al.* 2014).

Job stress happens when individuals identify that they struggle in handling with the difficulties relating to work and that their sense of health is being threatened. (Tyler and Cushway, 1996, Simoni and Paterson, 1997). Many stressors related with nursing have been distinguished for example; too much managerial work, scarcity of staff, nonexistence of support from supervisors and co-workers, work overload, doubt concerning treatment, etc. were some stressors frequently encountered by nurses (Tyler and Cushway, 1996, Simoni and Paterson, 1997). These stressors were established to be undesirably related to nurses' body and emotional health (Health Safety Executive United Kingdom; Azizollah *et al.* 2014).

2.4 Work Experience in Psychiatric Nursing

Bimenyimana *et al.* (2009:4) related the lived experiences of mental health nurses of hostility and ferocity from mental health care user's (MHCU's) in a Gauteng psychiatric hospital. Results exhibited that the level of ferocity and hostility to which mental health nurses were exposed was devastating and the costs were shocking. The causative reasons to this viciousness and hostility were: shortage of staff; the non-existence of support amongst the members of the multidisciplinary team (MDT); the emotional status and the conditions in which mental health care user's (MHCU's) are admitted; and the absence of organised and comprehensive orientation among newly selected staff members. As a result, mental health nurses are emotionally and

substantially affected and they reacted with feelings of desperateness and weakness, anxiety, irritation, defeat, anguish, substance abuse, absenteeism, vengeful behaviour and the development of an “I don’t care” approach (Bimenyimana *et al.* 2009:4). Under work experience in psychiatric nursing the following two subthemes look at psychiatric nurse’s entering an unsafe world and having an unsupportive environment.

2.4.1 Entering an unsafe world

Ngako, van Rensburg and Mataboge (2012:5), observed mental health nurse practitioners (MHNP’s) nursing mental health care users (MHCUs) presenting with severe psychiatric indications in a government mental health establishment in Gauteng Province, South Africa. Male and female mental health nurse practitioner’s (MHNP’s) who had more than one - year experience nursing in a government health care institution in Gauteng were included in the study. Three themes that emerged were entering an unsafe world where care became an affliction; undesirable psychological responses and arrogances towards MHCUs that conceded quality nursing care; and they made an appeal for a fostering environment that would improve superiority nursing care (Ngako, van Rensburg and Mataboge 2012:5).

In a similar study which explored and describe the experiences of nurses caring for mental health care users (MHCUs) in an acute admission unit at Lentegeur Psychiatric Hospital in the Western Cape Province which described both encouraging and undesirable experiences by Sobekwa *et al.* (2012:35 - 61)). Nurses described caring for MHCUs as perplexing and felt insecure when carrying out their responsibilities as some experienced attacks by MHCUs and sensed that they were not sustained by the supervision of the establishment. Nurses also related experiences with absences of staff whilst having to deal with increased amount of admissions of patients. And due to the increased load of work, this remained a challenge that ultimately led to feelings of psychological fatigue and breakdown. In spite of the undesirable experiences, nurses persisted to be enthusiastic about caring for MHCUs, and the strong solidarity that manifested during the conversations

seemed to be their strong points and observing the recovery of MHCUs (Sobekwa *et al.* 2012: 35 - 61).

Also, in agreement, the environment at an acute in-patient public health facility in Gauteng was found to be characterised by MHCUs' disrespectful behaviour, violence and sexual intimidation (Ngako, van Rensburg and Mataboge 2012:5). Three themes arose from male (n=8) and female (n=13) participants. Firstly, nurses felt unsafe in these environments. Negative emotions and attitudes that compromised nursing care was rendered and participants also believed that a caring and supportive workplace environment would promote quality nursing care in these wards (Ngako, van Rensburg and Mataboge 2012:5). The following section further highlights this.

2.4.2 Unsupportive environment

Psychiatric nurses of both genders performed clinical duties in the Forensic, Acute, Chronic, Mental Retardation, Affective Wards and Outpatient departments (Moloi, 2015:78 - 81) in a psychiatric hospital in central South Africa. Three main themes emerged namely, stressful working conditions exist in a psychiatric hospital; the environment is unsupportive towards psychiatric nurses and the patient's needs and lack of psychological support.

Under the sub- theme: safety of self; professional nurse's verbalized their concerns that they are at higher risk than other multi-disciplinary team (MDT) members in health care service as they spend 24hours on day and night duty, facing violent and aggressive behaviour from patients. They commented that the hospital security personnel are not fully supportive of them, because of lack of training in mental ill-health issues as well as being not covered by a danger allowance if any incidence occurs (Moloi; 2015: 78 - 81). Stubbs and Dickens (2008: 351-352) agree that there is a tendency for violent and aggressive behaviour by psychiatric patients towards clinical staff in almost all psychiatric hospitals and this has a harmful effect on their physical, emotional and spiritual well-being (Stubbs and Dickens; 2008:351 - 352).

Stevenson (2015:35); in a similar informative descriptive study explored psychiatric nurses' experiences of violence from MHCUs in an acute inpatient setting in

hospitals or long-term facilities in Canada. Nurse's experienced verbal and emotional abuse; physical assault and sexual abuse by acute psychiatric patients under their care. A total sample of (n = 12) nurses identified 33 occasions of work - related patient ferocity which occurred during the delivery of inpatient mental health care i.e. (n =8) were female nurses and (n = 4) were male nurses with a median 6 years' clinical experience. It was found in the study that nurses use a range of strategies to maintain their personal safety and to prevent, and manage patient violence. The participants also recommended the necessity for better-quality instruction, briefing following an incident and an understanding work environment to prevent mental health care user (MHCU) ferocity (Stevenson; 2015:35).

In the Limpopo province in South Africa; Tema, Poggenpoel and Myburgh (2011), also highlighted the experiences of mental health nurses open to violence from mental health care user's (MHCU's) who had more than 1- year experience in a forensic ward. A total of (n =9) mental health nurses, (n =2) male and (n=7) females and their ages ranged between 26 and 58 years and who had 1–6 years' experience in the forensic ward, were included in the sample. In the forensic, ward under the theme, "shortage of male nurses", and this intensified their frustrations, specifically when difficulties such a hostile conduct was displayed. Male nurses reported being injured and being emotionally drained, began to abuse substances, and used this as a coping method.

Overall findings have indicated that working in the forensic ward is demanding because mental health nurses were exposed to aggressive behaviour from mental health care user's (MHCU's) and this was a test of their psychological health. Recommendations were suggested to nurse supervisors, to provide support in handling with stress, mobilization of resources in the use of security procedures and self-management to preserve individual excellence for forensic psychiatric nurses (Tema; Poggenpoel and Myburgh; 2011). The following section further highlights the levels of work stress in psychiatric nursing.

2.4.3 Levels of work stress in psychiatric nursing

Current explanations of stress all differentiate that it is an individual experience caused by afflictions or pressures on a person, and influences upon the person's capacity to survive and his/her view of that capacity (Ricardo *et al.* 2007). Job-related stress occurs when there is a difference between the difficulties of the job and the resources and abilities of the individual employee to meet those burdens causing place of work mishaps and non-attendance of employees. As quoted in by Ricardo *et al.* (2007), by a recent report by the National Association of Mental Health, which distinguishes between stress and pressure, where pressure can be defined as a personal feeling of tension or arousal that is activated by a possibly demanding state of affairs. However, when pressure surpasses a person's ability to handle, the result is stress (Ricardo *et al.* 2007). The following subsections further highlights this aspect on work related stress with regard to gender differences, job burnout and physically and emotionally demanding work.

2.4.3.1 Gender differences related to job stress

Mental health nursing is considered to be one of the most challenging profession both in Japan (Yada *et al.* 2010) and globally (Leka *et al.* 2012; Melchior *et al.* 1997; Nakakis and Ouzouni 2008; Shen *et al.* 2005; Yang *et al.* 2004; Yada *et al.* 2014). The problem of work stress in mental health nursing has lately been receiving attention recently (Tuveson *et al.* 2012; Ward 2011; Yada *et al.* 2011), and many studies have been directed to mental health nursing (Edwards and Burnard 2003; Edwards *et al.* 2000). Work-related stressors also appear to differ centred on the nurse's sexual category e.g. research has established that female nurses come across more sexual harassment from mental health care user's (MHCU's) and consequently, they decline to actually care for male mental health care user's (MHCU's) (Chen *et al.* 2009; Libbus and Bowman 1994; Nijman *et al.* 2005). Disproportionately, male mental health care nurses come across both physical and vocal attacks from mental health care user's (MHCU's) (Adib *et al.* 2002; Gacki-Smith *et al.* 2009; Gerberich *et al.* 2005; Hamadeh *et al.* 2003; Shogi *et al.* 2008). Male mental health nurses are aware of the label that portrays nursing as a female profession and experience work

stress constantly (Dale *et al.* 2013; Deguchi 2009). Male mental health nurses experience apprehension causing an unwillingness to actually care for female patients (Deguchi 2009; Gleeson and Higgins 2013; Keogh and Gleeson 2006). Bearing in mind gender differences related to work stress, there is a greater need than before for adapted mental health care that considers these differences, as the percentage of male nurses in mental health nursing establishments rises (Yada *et al.* 2014).

This is also evident in a similar study in the United States of America where the findings suggested that male nurses who were not comfortable with the caring role of nursing chose psychiatric nursing as an area of speciality, because psychiatric nursing involved task-orientated or masculine duties, which would justify almost 40% of the sample being male (Torkelson and Seed 2011: 39). The gender differences between male (n=28) and female (n=45) psychiatric nurses at in-patient units focused on job performance and job satisfaction levels (Torkelson and Seed 2011: 34). Observations and a self-rated questionnaire showed that female nurses spent significantly more time creating healing relationships with patients, whilst some nurses spent no time in this role (Torkelson and Seed: 34).

In a similar study by Oywer (2011:5-6), the percentage of male mental health nurses is slightly higher than female mental health nurses in Kenya. The general population of female nurses in this specific country is greater than the male population, since nursing is viewed as a female dominated profession (Cutcliffe 2003:340). The Australian Health Workforce Committee (AHWAC) (report 2003:3) also reported it in this study; that the ratio of male to female nurses working in mental health, has traditionally been higher than other nursing fields. In 2001, when the countrywide ratio of registered male nurses stood at 34%, South Australia had 40.7 % males working in mental health which proposes that possibly more males are enticed to mental health nursing, and they could possibly be concentrating for future recruitment campaigns (Oywer; 2011:5-6).

2.4.3.2 Job burnout

Job and workplace individualities have been recognized as “stressors” by Ashtari *et al.* (2008); in a study to assess the relationship between work performance and job burnout amongst 32% males and 67% female Iranian Mental health professionals from Raazy Psychiatric Center, Tehran, Iran. There was a noteworthy correlation between job burnout and an inability for job performance. It was revealed that finding suitable solutions to diminish burnout in mental health staff was crucial and solutions and strategies suggested were: hiring new and fresh staff to decrease the workload, reasonable salary rates, decision making interventions, leading management training for heads of departments, developing safety policies, developing a suitable reward system, staff to take compulsory leave, development of stress coping teams, goal directed staff meetings, educating and supervising staff, discharging chronically ill comorbid patients to their families and practical resource allocation (Ashtari *et.al.*2008).

Forensic mental health nurses who nurse patients with severe and enduring mental health needs are at risk of suffering from occupational stress, and developing burnout syndrome (Dickinson *et al.*2008). This is due to the fact that forensic mental health nursing is often singled out as a challenging area of nursing because forensic nurses work with patients who are often viewed by the public as “social misfits” (Dickinson *et al.*2008).

Phillips (1983) justified the conflict in the approach when dealing with the mentally ill offender, which may be seen in terms of whether the patient is a mentally ill person who needs to be averted within the healthcare environment for treatment or if he or she is first or foremost a criminal who must redress the sentence before their health problems can be attended to, even though he or she may be found guilty by reason of insanity or being unfit to stand trial. The two systems complicate treatment in the forensic unit, which includes the judicial system, and the health system. The continued perceived threat of violence and actual physical violence contributes to high levels of stress amongst forensic mental health care nurses (Coldwell and Naismith, 1989).

In a quantitative cross - sectional study by En - Chi Shih *et al.* (2016) highlighted personal uniqueness, work stressors, and occupational burnout among mental health nurses' in hospitals and medical centres in the Kaohsiung area of Southern Taiwan. The purpose of this study was to examine the reasons influencing occupational burnout among (n = 217) mental health nurses (n = 6 males) and (n = 211 females). Results showed that a nurse's age, work area, rank, hospital level, psychiatric work, and overtime work were associated with the nurse's level of occupational burnout. There was a positive association between job stress and burnout and showed that overall job stress, total years in nursing, age, maintenance of relationships with patients, personal assessment system, and meeting medical differences are predictive factors for psychiatric nurses' overall occupational burnout and its three dimensions of emotional tiredness, depersonalization, and personal achievements (En – Chi *et al.* 2016).

Dickinson *et al.* (2008:85) in a different light; showed a study in a forensic hospital in the United Kingdom to compare forensic nurses with ordinary mental health nurses in terms of burnout and job satisfaction which showed that mainstream nurses were noted to have high levels of burnout than the forensic nurses on the 22 - item Maslach Burnout Inventory (MBI) in areas of emotional exhaustion and depersonalization. Forensic nurses recorded higher levels of job satisfaction than ordinary nurses and showed increased fulfilment with their present situation at work and involvement in decision making, and more ease with the amount of support they receive (Dickinson *et al.* 2008; Happell *et al.* 2003). Forensic mental health nurses who work with acute patients with severe mental health needs were acknowledged as having occupational stress and developing burnout syndrome (Dickson *et al.* 2008:82). It was established that the main stressors were increased workload, conflict among work colleagues, and lack of involvement in decision-making. Furthermore, staff were encouraged to embark on professional development which included psychosocial interventions training. Recommendations to reduce stress and burnout were nurse managers needed to ensure an open communication with nursing staff and deal with frustrations; staff were encouraged to rotate wards; staff to

have proper clinical supervision; and to increase personal and professional development as well as decrease boredom and apathy (Dickson *et al.* 2008:82).

In a South African study, which scrutinized the effect of individual stress on burnout, job satisfaction and general health of nurses, it was speculated that individual stress envisages burnout, job satisfaction and general health of nurses better than work stress (Kamisa *et al.* 2016:252). Findings showed that individual stress is a better predictor of burnout and general health but not job satisfaction. In line with the findings of this study, individual stress has been found to adversely affect work roles which result in employees facing high burnout (Khamisa *et al.* 2016: 256; Wang *et al.*, 2012; Yavas, Babakus, and Karatepe, 2008). It was recommended that nurses were trained on coping strategies to protect themselves against individual stress. Preventing burnout and work stress can be improved through addressing shortage of staff, which can be achieved through retention and recruitment policies (Buchan and Aikan, 2008; Khamisa *et al.* 2016:257).

2.4.3.3 Physically and emotionally demanding work

In a study by; Bimenyimana *et al.* (2009; Curatonis 32(3):4 -13) which shed some light on the lived experience by psychiatric nurses of hostility and violence from patients in a Gauteng psychiatric institution. The violence that respondents experienced was expressed either emotionally, verbally or physically with causative factors like staff shortages; lack of support from management; the type of patients that were admitted and multidisciplinary team members (MDT) as well the lack of organized and complete orientation among newly appointed staff members. As a result; psychiatric nurses were expressively, emotionally, and physically affected and they replied with despair, hopelessness, fear, anger, frustration, helplessness, absenteeism, reprisal, substance abuse, and the development of an “I don’t care” attitude (Bimenyimana *et al.* 2009; Curatonis 32(3):4 -13).

Also male nurses involved in physically demanding work reported in a study by (Rajacich *et al.* 2013); whereby participants described being called upon for clinical tasks that required physical strength for example they were always called upon to lift

heavy patients and to assist with aggressive patients because they were physically stronger than female nurses and called upon more often when they were short staffed. Other male participants also categorized nursing as having a philosophy of exchange where they themselves received help from female colleagues in return for providing help in more difficult tasks and they were grateful when female colleagues assisted them in nursing tasks that female patients felt uncomfortable with. (Rajacich *et al.* 2013).

Moschovopoulou *et al.* (2011:372) explored the training needs of 70 nursing staff in acute wards in the Psychiatric Hospital of Thessaloniki, Greece. Forty percent (n = 28) were male mental health nurses of different categories. The study showed that staff working in acute units in a psychiatric hospital was required to undertake teaching programs related to every day clinical practice. This was revealed in the majority of the reactions on carefully chosen issues on practical clinical nursing skills from the staff. From their replies, it seemed clear that staff was anxious about attending programs in essential fundamentals of acute nursing mental health care which included management of violence and aggression; risk assessment; the suicidal and psychotic patient; assessment and communication skills in order to become enhanced in daily clinical practice (Moschovopoulou *et al.* 2011:372).

2.5 Studies that depict the relationship between stress and coping strategies in Psychiatric Nursing

It was established that the relationship between emotional competency, work stress and years of experience was stronger for female than male nurses in a quantitative exploratory study amongst a sample of Australian mental health nurses (Humpel *et al.*, 2001). The study examined the connotation between the extent of period in mental health nursing and emotional ability and stress. The participants included 24 female mental health nurses and 18 male mental health nurses working at three mental health inpatient units in regional Australian hospitals with diverse age groups and diverse years of experience. Emotional competency and work stress were

measured using the Multifactor Emotional Intelligence Scale (Mayer *et al.*1999) and the Mental Health Professionals Stress Scale (MHPSS: Cushway *et al.*1996). A noteworthy relationship was found between emotional competency and stress. Nurses with six years and more work experience had higher levels of emotional competency and those with less than two years' experience were found to experience implicitly more personal uncertainty (Humpel *et al.*,2001).

In a similar study by Abdairahim, (2013:30 - 37); the purpose was to gain more evidence about job stress in mental health nursing, coping strategies, and the relationship between job stress and coping strategies through identifying issues contributing to stress in mental health nurses; the effects of pressures on their health and the various coping strategies engaged by them in Jordan in the Middle East. With regard to the causes of stress, most of the study concentrated on substantial workload, poor professional relationships, the risk of violent and aggressive patients, managerial concerns, communication and cooperation, shortage of staff, lack of support, the complex treatment modalities and remedies, and incompetently trained staff. With regards to the ways of coping with stress among male mental health nurses, the most common methods of coping are casual methods such as past times and hobbies outside of work which showed that there is a gap that health care establishments rarely help male mental health nurses to cope with pressures. Management and peer support were recognized as one of the least frequently used coping methods. Generally, male mental health nurses acknowledged family support, as an important component in their management of stress. It was also suggested that health establishments recognize the need to provide appropriate support for male mental health nurses (Abdairahim; 2013: 30 – 37).

In a quantitative quasi - experimental study by Ghandhi *et al.* (2014:42) they evaluated the efficiency of a stress management program on stress decline in 60 mental health nurses employed in a psychiatric hospital in Bangalore, India. Included in the study were male and female nurses working with mentally ill patients for more than one year. It was established that stress could have an emotional influence on the physical and mental health leading to encounters in the work zone and regular

absenteeism due to increased mental illness and great turnover of staff. The stress management methods that were combined influenced nurse's stress levels positively (Ghandi *et al.* 2014:42).

Furthermore, the stress, coping and prospects of nurses working in tertiary and referral hospital in state of Goa, India is due to the fact that the work environment of nurses are changing significantly; resulting in the occurrence of new stressors in the workplace and there was a need to identify emerging stressors and how nurses cope with these stressors by Fernandes *et al.* (2015:49). It was believed that the result of the stress influence depends on the coping skills of the nurse. Results revealed that nurses reported that their work is demanding. Causes that contributed to stress were categorized in groups such as doctors and co- workers; patients and their families; staffing & workload; supplies/equipment; problems among nurses themselves; and managerial issues. 62% reported "staff shortage" as a main stressor and 46% reported that shared understanding among nurses and other members of the multidisciplinary team helps in reducing stress.

The coping strategies used were mental detachment (16%), problem solving/preparation (12%), spiritual coping (12%), problem prevention (62%), and social provision (10%). Respondents felt the need to have regular staff meetings and in - service training programs for nurses. The majority felt that management are not doing anything regarding stressors in the workplace of which was expected from them. It was suggested that there is a need to improve interpersonal relationships with doctors and colleagues, improve nurse patient ratio's, non-interference from management that be related to managerial work and to build cohesiveness amongst nurses (Fernandes *et al.*2015:49).

Mental health nurses use largely problem-focused methods to deal with work stress in a study by; Abdalrahim *et al*; (2013:35). Generally, used problem-focused methods include problem orientation and social support. Problem orientation is focused at solving work-interrelated matters, whereas social support acts as a form of emotional coping for nurses. Largely, mental health nurses identify social support, particularly family support, as an important constituent in their coping with stress. It was

suggested in this study that health establishments identify the need to provide appropriate support to nurses, perhaps in line with western health establishments. The purpose of this study was to gain more knowledge about mental health nursing work stress, handling strategies, and the relationship between work stress and coping strategies through recognising the reasons causing stress in mental health nurses, the effects of stressors on nurses' health and the numerous coping approaches employed by them (Abdalrahim *et al.* 2013:35).

2.6 Psychological Health of Male Nurses

It was determined that the psychological health of the male nurses was found to be not as good as that of their female counterparts in a study of nurses in Nigeria by Akinawo *et al.* (2012). It was revealed that marriage had a considerable positive effect on the psychological health of male nurses and there was major positive job - status difference in the psychological health of these nurses (Akinawo *et al.* 2012). Negative perceptions of male nurses by the society is also capable of precipitating and maintaining a poor psychological health status and this factor had been found to have implication not only for the health of male nurses but also on their interest in pursuing the nursing career. Marriage seemed to serve as a buffer although marriage means additional responsibility (Akinawo *et al.* 2012).

It was also recommended in the study that an advocacy programme focusing on the important roles played by male nurses in our health care delivery system might change the negative public perception of male nurses in our society. Psycho-education intervention programmes such as self - assertive training, cognitive behavioural therapy for male and staff nurses in our hospitals will also serve as motivation programmes. Sex-discrimination in schedule of duties and career programmes should be minimized which may boost the morale of the male nurses and subsequently improve their mental health (Akinawo *et al.* 2012).

Rajacich *et al.* (2013), in a study which reflected the experiences of male nurses also reported under the sub - theme: "Multiple stressors and fear of burnout" that

participants who have thought about leaving voiced their concerns that they would not be able to work as nurses for the rest of their nursing profession as they risked facing burnout and/or other emotional impairment e.g. One participant spoke about his fears that one day he will reach a physical breaking point health wise. He stated that he is burdened with tasks and running all the time and sometimes, he could not keep up especially when there is a shortage of staff. Another participant who took early retirement from acute nursing care, witnessed colleague's burnout and succumb to psychological strains (Rajacich *et al.*2013). The following subsections look at how self esteem, negative stereotyping and discrimination impacts on the mental health of male nurses.

2.6.1 Self Esteem, experiences and impact on male nurse's mental health

In a qualitative investigative study directed to explore the clinical learning experiences of male nursing students at the University of the Western Cape in South Africa; and how these experiences impacted on their self - esteem by Buthelezi *et al.* (2015:3-4). Apprehensions and worries were emphasised by male nursing students to their clinical supervisor about their clinical learning experience in caring for female patients in a female-dominated profession. This incited a need to sincerely understand the lived experiences of student male nurses regarding their clinical learning in nursing clinical practice. Conclusions of this study recognized three major themes: the influence on their self- esteem; and the social support of male students working in a female - dominated profession and experiences that associated to their limitations in the clinical learning environment. It was felt that male nurses should be supported in nurse training; as the rate at which males are now arriving in the nursing profession is now increasing (Buthelezi *et al.*2015:3-4).

Moreover, Buthelezi *et al.* (2015:3 - 4); under the theme: The impact on student's self-esteem; one of the sub-theme's that materialized was: "Decreased sense of self-worth"; it was established that male students experienced nursing as a female - dominated profession which resulted in an absence of sense of belonging. Male nursing students also felt undervalued because of the oral abuse from clinical supervisors e.g. a few male students felt uncomfortable in Midwifery as there were no

distinguished role models. Some male students could not stand verbal abuse from their clinical supervisors, and were not supported by professional nurses in charge of the unit as they were often scolded at in front of patients (Buthelezi *et al.* 2015:3 - 4).

In a similar study by Rajacich *et al.* (2013); under the subtheme: “Feeling underappreciated”; one participant described some unhappiness with the nursing management e.g. It was felt that their concerns were not heard and their contributions were not recognized. Participants also described that they are mostly responsible for the daily operational of units and for patient welfare and they felt that their hard work goes unrecognized and uncorroborated. In some instances, some participants testified of hostile behaviour on the part of management (Rajacich *et al.* 2013).

On a positive note, Rajacich *et al.* (2013); also stated under the subtheme: “The rewards of being a nurse”, the participants stated that in spite of the high levels of stress they experienced in nursing, they felt that they were producing an obvious change in their lives of their patient, and that they are able to be more involved passionately with their work in a way that most jobs do not allow eg. one participant mentioned that helping people through a possibly overwhelming incident if you have enough understanding and enough awareness; one can make an impression on them to possibly have a very negative incident seem not so bad (Rajacich *et al.* 2013).

2.6.2 Negative stereotyping and discrimination

Considerable evidence of discernment against men in the nursing profession is related to their communications with society as related by McMurry, (2011:26). Male nurses are often deliberated as being feminized males and men’s movement into old-fashioned female jobs is often observed by society as a step down in position, while women who enter traditional male professions are thought to have taken a step up in social standing. This specific form of discrimination may be most significant in clarifying why men are not well embodied in the nursing profession. Men who otherwise might indicate an interest in and ability for nursing are disheartened from

entering the nursing profession due to undesirable stereotypes related with men in nursing. These preconceptions can be hurtful to their self-esteem and possibly drive some men out of the nursing profession altogether. These undesirable stereotypes related to men who do “women’s work” can pull men out of specific bedside nursing and direct men into more gender “genuine” practice careers (McMurry, 2011:26).

It was mentioned that when men entered nursing, it was a dreadful experience reported by Sayman; (2014:15). It was found that in nursing school that these participants first struggled to show their masculinity and that they had experienced clinical instructors treating them disrespectfully. Upon progressing from nursing school and entering the clinical area, they unrelenting felt overwhelmed and isolated, and remembered occurrences of labelling and conveyed frustration at gendered work duties, feelings of mistreatment by their peers, dysfunctional working relationships with doctors, and sometimes an unsafe working environment. It was reported that nurse supervisors treated them in a disrespectful, ill-mannered, and unpredictable manner, and that they were given substantial patient accountability while still in clinical orientation.

Findings established that the lived experiences of these men revealed established and work-related power struggles among themselves, physicians, and their female colleagues. It was also found that their experiences might be a manifestation of how they attempt to point themselves as a side-lined population, perhaps for first time in their nursing career. It is anticipated that Information from this study may be beneficial to increase the conversation to stakeholders on more operative means to recruit, support, and keep men in the nursing profession (Sayman; 2014:15).

2.7 Summary

From the reviewed literature in the various mental health clinical area’s; the various researcher’s show different and similar perspectives with regard to: levels of work stress; job burnout; an unsafe working environment and how this has impacted on the psychological wellbeing of male mental health care nursing practitioners both

locally and globally. It was also revealed that the relationship between work stress and years of experience had a positive connotation for female than male mental health care nursing practitioners. The participants in the various literature also recognised the need for better-quality training, counselling following an incident in the clinical area, and a caring work setting to avert patient ferocity. It was further recommended that health establishments identify the prerequisites to deliver proper care to male mental health care nursing practitioners. The research method is a method that is used to organize and assemble a study in a systematic way from the start to the end (Polit and Beck. 2012:556). In the next chapter, the research design and method that will be used to describe male mental health care nursing practitioners' years of experience in psychiatric nursing and their levels of stress. This will be explained in full. Chapter 3 will clarify the plan and the structure of the study by discussing the research methodology in detail to meet the purpose of the research.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This chapter provides an outline of the research approach used to conduct the study. The research design, the population and sample; data collection process; investigation of data and the ethical considerations involved in this study will be discussed.

3.2 Research design

The research design describes how, when and where data are to be collected and examined (Parahoo 2006:183, Burns and Grove, 2009:41). The objectives that have been identified for the study guided the researcher in deciding on the design. A quantitative nonexperimental cross-sectional descriptive survey was conducted to describe male mental health care nurse's practitioner's years of experience in psychiatric nursing and their levels of stress were identified. The researcher further determined whether there was any relationship between the stress reported and the years of experience amongst male mental health care nursing practitioners in tertiary psychiatric hospitals in Pietermaritzburg.

3.3 Quantitative research design

Quantitative research is focused on a small number of narrow and succinct concepts with pre-set ideas about how the concepts are interconnected (Brink *et al.* (2012:11). The researcher is not involved in data collection hence his/her involvement is from a distance (Burns and Grove; 2011; Polit and Beck 2008).

In this study, a non- experimental, cross - sectional descriptive research design was used (Brink *et al.*2012:112). According to Brink *et al* (2012:112); descriptive designs are used in studies where more evidence is required to observe, describe and record traits of something that occurs naturally which may be a basis for theory

development. These studies utilized a survey questionnaire to measure and describe levels of stress in male mental health care practitioners in the clinical field.

3.4 Setting

The research setting is a specific place where data is collected in a study (Polit and Beck 2012:49; Burns and Grove 2012:59).

In this study, the research setting was in the following three tertiary psychiatric hospitals: Townhill Hospital, Fort Napier Hospital and Umgeni Hospital in the Umgungundlovu Health District in KwaZulu–Natal respectively. These hospitals provide tertiary and clinical services to Mental Health Care Users (MHCUs) across the province of KwaZulu–Natal.

The three tertiary psychiatric hospitals provide treatment, care and rehabilitation services to approximately 3 071 006 people (Statistics South Africa, 2012). Umgeni Hospital centres on providing care, treatment and rehabilitation services to people with intellectual disabilities while the other two hospitals offer mental health care services to people with mental illnesses. Fort Napier Hospital offers services to both patients with mental illnesses and patients admitted for 30 days observation as well as State President Patients (SPP) under forensic psychiatric nursing. The KwaZulu - Natal Department of Health provides a comprehensive mental health service from primary health care clinics and community health centres making referrals to district hospitals who then refer to regional hospitals and then finally tertiary psychiatric hospitals when the need arises. (Mkhize *et al.*2004). These district areas are also known as catchment areas and are found in every district (Mkhize *et al.*2004).

3.4.1 Umgeni Hospital

Umgeni Hospital is a tertiary hospital situated in Howick, which provides care for intellectually challenged persons with physical and mental disabilities. These MHCUs are diagnosed with severe to profound intellectual disability and other secondary conditions such as autism, epilepsy and physical disabilities. The severity of mental handicap ranges from severe to profound mental handicap and this

hospital provides for MHCUs of all race groups from 3 years of age and upwards within KwaZulu-Natal Province. Umgeni Hospital has 459 operational beds and provides complete and empathetic care to estimated 362 intellectually challenged individuals with severe to profound mental handicap. Patients are accommodated in 12 wards agreeing to the nursing care and treatment they require. To be able to preserve the quality of patient care, Batho Pele Principles and patients' rights are obeyed in accordance to the Chapter 3 of the Mental Health Care Act 17 of 2002. Single wards lodge between 26 to 52 mental health care users (MHCUs), thereby making a home environment challenging, but all nursing staff and student nurses strive to achieve the objective of creating a therapeutic and homely environment for all mental health care users (MHCUs). This hospital has no security wards and able bodied and wheel chaired Mental Health Care Users (MHCUs) move about inside the establishment under direct and indirect supervision (criteria for admission; 2017).

3.4.2 Townhill Hospital

Townhill Hospital is a high-quality psychiatric tertiary hospital and only mental health illnesses, which are unable to be treated at a district health care level, are referred to this hospital. The services offered at Townhill Hospital are:

- Psychotherapy wards for the voluntary admission of referred MHCUs requiring intensive psychiatric therapy under Chapter 5; Section 25 of the Mental Health Care Act 17 of 2002.
- An outpatient department for assessment by psychologists and/or psychiatrists of MHCUs that are referred from primary and district level of mental health care.
- An outpatient child and adolescent service, (which also became available in 2007/8 as an adolescent in-patient unit).
- Intensive care inpatient wards for MHCUs with severe psychiatric illnesses e.g. schizophrenia, major depression, bipolar affective disorders and other psychiatric illnesses.

- Hospital admissions of around 6 months for MHCU's with repeated relapses on outpatient treatment are admitted in rehabilitation wards.
- Elderly MHCU's, either in residential care or from families that can take them back may be admitted for 6 to 8 weeks for assessment and stabilisation of psychiatric illnesses are accommodated in psycho-geriatric wards.
- Neuro-psychiatric services were established in 2008.

3.4.3 Fort Napier Hospital

Fort Napier Hospital is considered a specialized hospital serving only patients who are admitted under forensic psychiatric nursing as well as intellectually challenged patients (MHCU's). Sixty percent (60%) of patients admitted are State Presidential Patients (SPP) and admitting three types of patients (MHCU's) namely:

- Chronic long-term high functioning patients transferred in from Townhill Hospital and who are admitted under the Mental Health Care Act 17 of 2002 who are patients that are admitted permanently, they stay for about 15 years.
- Forensic Psychiatric Nursing Patients are admitted under the Mental Health Care Act 17 of 2002 (Chapter 6) and sections 77 and 78 of the Criminal Procedures Act 51 of 1977 who are observation cases awaiting trial prisoners admitted for psychiatric assessment by specialized doctors/psychiatrists for not more than 30 days observation and State Presidential Patients (SPP) patients who are admitted for about 10 years and then go for trial at court.

The assigned approved beds at Fort Napier Hospital are 450 in number with 370 beds useable presently.

3.5 Population

A population is the entire group of persons that meets the criteria that the researcher is interested in studying (Brink and Wood 1998; Burns and Grove 2011; De Vos 2005; Polgar and Thomas 2000; Polit & Beck 2008; Rossouw 2003). In order to make a population accessible, it is necessary for a researcher to define a population to a specific geographic boundary e.g. uMgungundlovu Health District in the KwaZulu-Natal province (Brink *et al* 2015:131).

In this study, the population were all male mental health care nursing practitioners employed at the three specialised tertiary hospitals in the uMgungundlovu Health District. The estimated total population of male mental health care nursing practitioners at all three tertiary hospitals was 227 (see Table 3.1). These male nurses consisted of all categories of nurse's: professional nurses, staff nurses and auxiliary nurses. The input from all categories of male nurses gave valuable insight with regard to work stress; as not one male nurse of any category is immune to work stress. They are all registered with the SANC and are accountable for their acts and omissions whilst working in the clinical psychiatric area.

The present study utilized the population of male professional nurses (R425 and R880); male staff nurses (R2175) and male auxiliary nurse's (R2176) at the three psychiatric hospitals in KwaZulu-Natal for data collection. All these nursing programmes include a psychiatric component. In this study the population was the entire population of male mental health care nursing practitioners (n=227). Refer to table 1 in text.

Table 1: Number of Male Mental Health Nursing Practitioners per Hospital

Name of institution	No of male mental health care nursing practitioners
Fort Napier Hospital	85
Townhill Hospital	91
Umgeni Hospital	51
Total	227

3.6 Sample

Brink *et al.* (2012:132) and Polit and Beck (2012:275) define a sample as when the researcher chooses to study a subsection of a research population which makes up a research sample. The sample meets certain eligible criteria that the researcher is interested in and involves the selection of participants who meet the inclusion criteria and have information useful to answering the research question.

3.6.1 Sampling strategy

In order to access as many male mental health care nursing practitioners, a consecutive sampling strategy was adopted in this study. This allowed for input from a large population. This can be described as the entire accessible population being sampled within a stipulated period of time (Polit and Beck 2012:264). Telephonic contact with the nursing service managers and at the research presentations at these facilities revealed that there are 112 male professional nurses; 27 male staff nurses; 88 male auxiliary nurses employed at these facilities. Refer to table 2 in text.

Table 2: Number of Male Mental Health Nursing Practitioners per Category per Hospital

Name of institution	Total no. of Male Professional nurses	Total no. of Male Staff nurses	Total no of Male Auxiliary Nurses	Total no. of male Mental Health Care Nursing Practitioners per hospital
Fort Napier Hospital	48	7	30	85
Townhill Hospital	42	14	35	91
Umgeni Hospital	22	6	23	51
Total	112	27	88	227

3.7 Inclusion and exclusion criteria

Eligibility or inclusion criteria are the required traits of the target population viewed as essential by the researcher for inclusion in the study (Burns and Grove 2009: 345; Polit and Beck 2012: 274). Exclusion criteria are the specific features which removed potential participants from the study (Burns and Grove 2009: 345; Polit and Beck 2012: 274). The researcher utilized the following inclusion and exclusion criteria for this study.

3.7.1 Inclusion criteria

All categories of male mental health care nursing practitioners over the age of 18 registered with the South African Nursing Council (SANC) and all must be employed by all three institutions.

These male mental health care nursing practitioners perform clinical duties on day and night duty in the psychiatric wards (the Forensic, Acute and Chronic wards, Intellectual disability wards, Out Patient Departments; Psycho-Geriatric wards, Psychotherapy Units and the Child & Adolescent Unit.

3.7.2 Exclusion criteria

All female nurses employed at the above - mentioned institutions.

3.8 Data collection

In structured data collection, data is collected from participants in a similar, pre-specified way and it involves the collection of data according to a pre - established plan. The process differs depending on the research design being used and data can be collected by means of questionnaires, interviews, observations or scales. (Polit and Beck 2012:191; Brink *et al.* 2015: 57).

3.8.1 Data collection instrument

The questionnaire, which was modified for this study, was the Mental Health Professionals Stress Scale (MHPSS) by Cushway *et al.* (1996). This questionnaire pertains broadly to mental health professionals and was applied specifically to measure stress in the population of male mental health nurse practitioners sampled and it was adapted for this study.

3.8.1.1 The Mental Health Professionals Stress Scale (MHPSS)

Cushway *et al.* (1996) MHPSS was applied specifically to measure stress in the population of male mental health care nursing practitioners. The instrument has been used before in the study below and adapted for the South African context: "Stress, burnout and the attitudes and experiences of mental health professionals working with clients who meet the criteria for a diagnosis of personality disorder" (Cotes; 2004). Permission to use the scale was obtained from the developer of the instrument Professor D Cushway (See attached annexure 1d).

This is a 41 item self-report measure composed of seven subscales which represent specific causes of stress which are: heavy workload, organizational structure and processes, lack of resources, client/patient related difficulties, relationships and meetings with other professionals, professional self-doubt and home-work conflict. All scales of the MHPSS have been established to show acceptable internal consistency with Cronbach's alphas ranging from 0.60 to 0.87 and good concurrent validity has been established with MHPSS scores showing the foreseen relationships with a range of measures including job satisfaction, psychiatric symptomatology, self-reported stress level and social support (Cushway *et al.* 1996). Participants were asked to rate how much each of the 41 statements applied to them on a scale of 0-3 (0 = does not apply to me, 3= does apply to me). Each person's overall score was made by computing the mean of their total score on the scale, with the means of each of their seven subscale totals also being calculated (Cushway *et al.* 1996).

The adapted questionnaire used in this study consisted of two sections, which were designed around the research aim and objectives. The questionnaire was made up of the following subsections:

Section A: Demographics of participants included questions related to demographic and other personal and professional background information. This section consisted of 8 questions of which seven are closed ended questions and one is open-ended question. Closed-ended questions provided a set of options and that closely matches the suitable answer from which respondents may choose one or more items (Polit and Beck 2012: 721; 297).

Question 1-7 asked about the participants their gender, age of respondents in years, nurse training programme completed, highest nursing qualification, job title in the nursing profession, unit/ward currently working in and the amount of years working in the mental health care clinical environment. The only open ended questions used in this study offered participants the opportunity to write a response in their own words which was question no 8, whereby participants had to indicate whether it was their choice to work in a mental health care environment and to answer either "Yes" or "No" and to specify reasons (de Vos *et al.* 2011:196; Polit and Beck 2012: 297).

Section B: relates to sources of pressure at work in the mental health care environment which is a 41 item self-report measure composed of seven subscales which represent specific sources of stress i.e. workload, organizational structure and processes, home-work conflict, client/patient related difficulties, lack of resources, professional self-doubt and relationships and conflicts with other professionals (Cushway *et al* (1996). All 41 questions in this section indicated Likert Scale type questions. Polit and Beck (2012: 732) describes a Likert Scale as a combined measure of attitudes involving the summary of scores on a set of items that respondents rate for their degree of agreement or disagreement and also which is frequently used to test attitudes and feelings (Polit and Beck 2012: 732; Brink, 2002:160).

3.8.2 Validity and reliability

Reliability and validity with regard to research findings are of great significance in all studies (Brink *et al* 2012:127). Brink *et al.* (2012:171) further states that reliability and validity are closely related and the researcher needs to consider both of these qualities when choosing a research instrument.

3.8.2.1 Validity

Validity is concerned with the accurateness and reliability of scientific findings (Burns and Grove 2011; Brink *et al.* 2012:127). Validity is also described as a quality standard stating the amount to which interpretations made in a study are precise and justifiable; in measurement, the amount to which an instrument measures what it is anticipated to measure (Polit and Beck 2012:745). The research instrument has been used in previous studies and the validity and reliability are presented in Table 3 below:

Table 3: Validity and Reliability of the Questionnaires Reported in the Previous Studies

Author	Title	Validity	Reliability
Cotes; J (2004)	“Stress, burnout and the attitudes and experiences of mental health professionals working with clients who meet the criteria for a diagnosis of personality disorder”;	Inferences made in the study are precise and well -founded. Good concurrent validity has been demonstrated.	Cronbach’s alphas ranging from 0.60 to 0.87.
Humpel, N., Caputi, P., (2001)	‘Exploring the relationship between work stress, years of experience and emotional competency using a sample of Australian mental health nurses’	Inferences made in the study are precise and well -founded. Good concurrent validity has been demonstrated	A reliability coefficient of 0.85 for this measure. Ciarrochi <i>et al.</i> found alpha to be 0.76. For this study, the reliability coefficient was 0.66.

3.8.2.2 Reliability

Brink *et al.* (2012:126) states that reliability is concerned with the consistency, steadiness and repeatability of the informants’ accounts, as well as the researcher’s ability to collect and record information correctly. Polit and Beck (2012:741) concurs that reliability is the amount of uniformity or dependability with which an instrument measures a trait. For this study, the questionnaire was adapted from the Cushway *et al.* (1996) Mental Health Professionals Stress Scale (MHPSS) to measure stress concerning broadly to mental health professionals.

3.9 Pilot study

Brink *et al.* (2012:132) and Polit and Beck (2012:195) both concur that a pilot study which is sometimes referred to as a 'introductory study' is a small-scale study conducted prior to the main study on a narrow number of participants from the population at hand. Its purpose is to investigate the viability of the proposed study and to detect possible errors in the methodology of the proposed study. Pilot studies are not just studies with a small number of participants, nor are they small, exploratory studies. The focus of pilot studies is not practical in that their primary purpose is not to answer research questions. The objective of a pilot study is to prevent an affluent fiasco that is, a costly but flawed largescale study. For this reason, pilot studies are sometimes called feasibility studies.

For the present study, nine questionnaires were given to conduct the pilot study. These included one male nurse from each category from the three Tertiary Psychiatric Hospitals who piloted the questionnaire. These questionnaires were not included in the main study. The respondents did not experience any ambiguity in any question asked, all the instructions on the questionnaire were followed with ease and therefore the instrument was judged to accurately collect the information as required. These male nurses did not participate in the main study.

3.10 Data collection

Data collection is the means of collecting information needed to address the research question. Burns and Grove (2009: 441), state that data collection is an accurate, organized collecting of evidence relevant to the research objective and inquiry in a study. The data collection method is accomplished according to a set of ethical principles (Polit and Beck: 725; Burns and Grove, 2009: 441). Data was obtained from eligible participants using the validated questionnaire.

3.10.1 The data collection process

The data collection process commenced once written ethical approval was granted by the Durban University of Technology Institutional Research Ethics Committee (Appendix 7a) ethical clearance no: 092/17. Following approval, the researcher obtained written permission from the facilities included in the study and the Department of Health, KwaZulu-Natal, Research and Knowledge Management.

The researcher then undertook a sequence of telephonic and e-mail communication with the Nursing Service Managers. This permitted the researcher to brief the Nursing Service Managers on the data collection process, to gain their co-operation and address pertinent concerns. Meetings were arranged with the Nursing Service Managers and hospitals' Chief Executive Officers to discuss the purpose and value of the study. Research presentation dates with Operational Nurse Managers were arranged at these meetings. At the appointed research presentations with Operational Nurse Managers; the procedure for data collection was explained, dates and times for the delivery and collection of the questionnaires was negotiated and the inclusion and exclusion criteria explained. Preparations were made for safe storage of questionnaires and planned times for male mental health care practitioners to complete the questionnaires. This information was circulated to all the Operational Nurse Managers via their Nursing Service Managers at the hospitals acknowledged for the study.

Survey questionnaires (Appendix 1b) and letters of information and consent (Appendix 1a and 2) were personally delivered to each hospital by the researcher pre-arranged with the Nursing Service Managers. An invitation to contact the researcher if needed was arranged. An advertising poster was placed in each ward/unit inviting all categories of male nurse's (Appendix 3) to participate in the study. The researcher then carried two labeled and sealed cardboard post boxes, which were used as a drop box for nurses to place their questionnaires and consent forms in respectively. Together with the drop boxes an advertising poster was placed in each ward to remind male nurses to support the completion of the questionnaires. The questionnaire took between twenty-five (25) to thirty (30) minutes to complete.

Arrangements were made with the Nursing Service Managers and Operational Nurse Managers to store drop boxes in a safe place in the Nurse Managers Office and also where questionnaires could be dropped off. The whole data collection process was overseen by the researcher who then collected the sealed drop boxes a month later, on a date agreed-upon with the Nursing Service Managers and Operational Nurse Managers. The data collection process commenced in February 2018 and completed in the latter part of May 2018. All 158 questionnaires returned were prepared for data capturing and analysis.

3.10.2 Data preparation

Following the data collection process, the researcher collected the sealed boxes with completed questionnaires from the Operational Nursing Service Managers. Each questionnaire and consent form was coded by the researcher as depicted in table 4. According to Burns and Grove (2009: 432) and Polit and Beck (2012:722) coding is a means of systematically capturing and arranging the data into numerical form.

Table 4: Distribution and Numbering of Questionnaires and Consent Forms

Hospital	Category Code Examples	Description	Numbered from:	Totals
Townhill	THHRN 2	Townhill Hospital Professional Nurse 2	1 to 44	44
	THHEN 7	Townhill Hospital Staff Nurse 7	1 to 6	6
	THHENA 10	Townhill Hospital Auxiliary Nurse 10	1 to 18	18
Fort Napier	FNHRN 5	Fort Napier Hospital Professional Nurse 5	1 to 34	34
	FNHEN 3	Fort Napier Hospital Staff Nurse 3	1 to 8	8
	FNHENA 16	Fort Napier Hospital Auxiliary Nurse 16	1 to 19	19
Umgeni	UMRN 11	Umgeni Hospital Professional Nurse 11	1 to 11	11
	UMEN 21	Umgeni Hospital Staff Nurse 21	1 to 8	8
	UMENA 15	Umgeni Hospital Auxiliary Nurse 15	1 to 10	10
Total				158

3.10.3 Data capturing

Raw data is explored and organized before it is analyzed and interpreted. A spreadsheet affords the researchers to sort information, to identify specific data and record data (Brink *et al.* 2012: 177). For this study, all questionnaires were collected, verified, and the data was manually captured on a spreadsheet by the researcher

3.11 Data analysis

According to Polit and Beck (2012:725), data analysis is the methodical arrangement and production of research information and, in quantitative studies, the analysis of theories using that information. Data analysis involves classifying, collection, controlling and summarising the information, and describing them in significant terms (Brink *et al.* 2012:177). Data collected for this study was summarised and analysed, using the statistical software SPSS version 22.0. Descriptive statistics, a binomial test and inferential statistics (one sample t-test) were used to examine the data in this study.

3.11.1 Descriptive statistical analysis

According to Polit and Beck (2012:379), descriptive figures are used to describe and produce statistics. Means and proportions are examples of descriptive statistics. Descriptive statistics are used to describe and summarise information, and thus tell us what the data set looks like. These statistics transform and reduce a collection of data into an organised, visual representation or picture in an assortment of ways so that the data have some meaning for the readers of the research report (Brink *et al.* 2012:179). Descriptive statistics provide immediate information about data, for example, the number of patients who are male or female or the average age of patients (Greasley, 2008). In this study, descriptive statistics included amongst others, means and standard deviations where applicable. Frequency distributions are presented in tables or graphs.

3.11.2 Binomial test analysis

Binomial distribution is a numerical dissemination with known properties describing the number of incidences of an occurrence in a series of observations and forms the basis for examining dichotomous information (Polit and Beck 2012: 720). A binomial distribution is the likelihood distribution of the number of “successes” (e.g., heads) in a sequence of independent yes/no trials (e.g., a coin toss), each of which yields “success” with a specified probability (Polit and Beck 2012: 407). It tests whether a substantial proportion of respondents select one of a possible two responses. This can be prolonged when data with more than two (2) response options is divided into two separate groups.

3.11.3 Inferential statistics

Inferential statistics use sample facts to make a suggestion about the population of the study at hand from a smaller sample. (Brink, van der Walt and van Rensburg 2012:179). In this study, a one sample t-test was used and tested whether a mean score was considerably different from a scalar value (Brink, van der Walt and van Rensburg 2012:179).

3.12 Ethical considerations

Ethics is well defined as a classification of moral values related to the extent to which the research process maintains the legal, professional, and social responsibilities of the study applicants (Polit and Beck 2012: 727). The three essential ethical principles that guide researchers during the research process are beneficence, justice and respect for persons. These principles are based on the human rights that need to be secure in research, specifically the right to autonomy, confidentiality, secrecy and own discretion, fair treatment and to be protected from discomfort and harm. (Brink *et al.* 2012:35).

The proposal was reviewed by the Department of Nursing Research Committee, Faculty Research and Higher Degrees Committee and the Institutional Research and Ethics Committees (IREC) of the Durban University of Technology. Ethical clearance from IREC was approved with ethical clearance no: 092/17. Permission was sought from the Chief Executive Officers and Hospital Managers of the three provincial tertiary specialist psychiatric hospitals i.e. Fort Napier Hospital (Annexure 4b); Townhill Hospital (Annexure 5b) and Umgeni Hospital (Annexure 6b). An official request to conduct the study was sent to the KwaZulu-Natal Provincial Health Research and Knowledge Management Committee and letters of support were received (Annexure 9).

Male professional nurses, male staff nurses and male auxiliary nurse's anonymity was safe guarded as the questionnaires did not necessitate any identifying details. Participation was voluntary and participants could withdraw at any time from the study. A letter of information with specifics of the study was incorporated as part of the questionnaire. Participants were requested to complete a consent form once they had decided to partake in the study. The contact details of the researcher's supervisor, the university's ethics committee and the researcher, was presented on the questionnaire and on the consent form for participants who had queries. Completed questionnaires and consent forms were placed in closed separate boxes so that there was no way of connecting a questionnaire to the participant. All completed questionnaires were sealed in a safe once collected. They were then retrieved for data analysis and re-secured after analysis. All paper copies of the questionnaire and consent forms will be shredded after 5 years by the researcher.

3.13 Summary

A quantitative, non-experimental descriptive survey design was used to address the research objectives of this study. Male Mental Health Care Nurse Practitioners of all categories were sampled and administered the adapted Cushway *et al.* (1996). Mental Health Professionals Stress Scale (MHPSS) was used to measure their stress. Data were analysed using the statistical software SPSS 22.0. Statistical tests that were conducted on the data included descriptive statistics; binomial test and

inferential statistics (one sample t-test). The fundamental ethical principles that guided the researcher during the research process were respect for people, beneficence and justice and fairness which were observed throughout this study. The results of the study are presented in the next chapter.

CHAPTER 4

PRESENTATION OF THE RESULTS

4.1 Introduction

In this chapter the data analysis, interpretation and findings are presented. The aim of the study was to describe the relationship between work stress and years of experience amongst male mental health care nursing practitioners within Tertiary Psychiatric Hospitals in the uMgungundlovu Health District. The research objectives were to:

1. To describe male mental health care nursing practitioners' years of experience in psychiatric nursing.
2. To identify levels of stress in male mental health care nursing practitioners in tertiary psychiatric hospitals in the uMgungundlovu Health District.
3. To determine if there is any relationship between stress and years of experience in male mental health care nursing practitioners in tertiary psychiatric hospitals in the uMgungundlovu Health District.

The data was collected between February and May 2018, by means of a self-administered questionnaire.

4.2 Sample realisation

The population consisted of a possible 227 male mental health care nursing practitioners and a sample of 158 was realised, which reflected a response rate of 70%. This was a good response rate and was possibly due to the researcher allowing respondents 3 months to complete the questionnaire after the initial drop-off date.

Table 5 illustrates the distribution and response rate across the three psychiatric facilities in uMgungundlovu Health District.

Table 5: Distribution and Receipt of Questionnaires and Consent Forms

Hospital	No of male mental health care nursing practitioners per hospital	No of questionnaires distributed	Questionnaires completed	Questionnaires not completed
Townhill	91	91	68 (75%)	23 (25%)
Fort Napier	85	85	61 (72%)	24 (28%)
Umgeni	51	51	29 (57%)	22 (43%)
Total	227	227	158 (70%)	69 (30%)

4.3. Data analysis

The data collected was analysed using SPSS version 22.0. During the analysis of the data, various tests were used as described in Chapter 3. Descriptive statistics including means and standard deviations, where applicable, are presented in the method of cross-tabulations, graphs and other figures. Binomial tests and inferential statistics comprised the use of correlations and chi-square test values, which are interpreted for significance using a p-value of 0.05.

4.3.1 Analysis of demographic data

The analysis of demographic data relates to age, training programme completed, highest nursing qualification, job title in the nursing profession, ward currently placed in, work experience (total no of years working in the Mental Health Care Setting) and the choice of working in a mental health care setting. Gender is not analysed, as all participants are male.

4.3.1.1 Age grouping

A total of 131 participants (83%) indicated their age with 33.5% (n=53) in the age category of 30 to 39 years, 21.5% (n=34) aged 40 to 49; 12% (n=19) were between 18 and 29 years, whilst 12% (n=19) were in the age category 50 to 59 years. Only

3.7% (n= 6) of respondents indicated they were 60 years and above. 27 participants (17%) did not reveal their age. The ages ranged from 19 years to 64 years with a mean age of 40.08 years (SD 10.267). Refer to figure 2 in text.

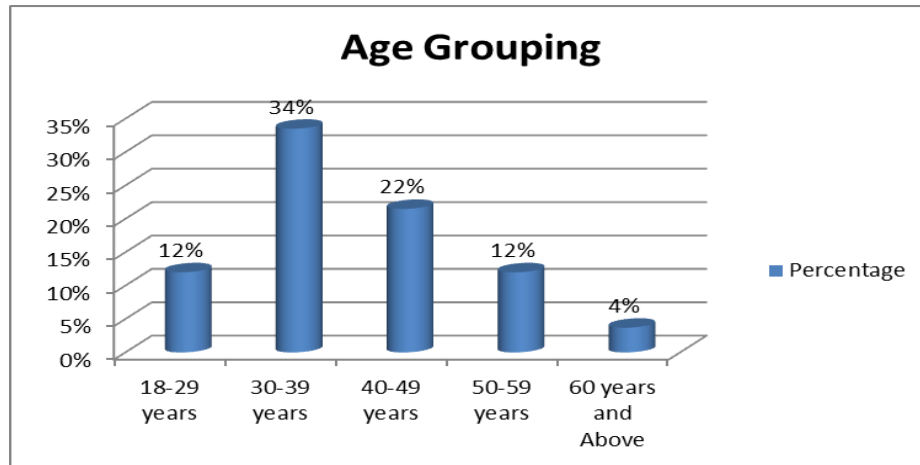


Figure 2: Age Grouping

4.3.1.2 Nurse training programme

A majority of participants (29.7% n=47) were auxiliary nurse's, with just under a quarter of respondents (24.7% n=39) professional nurses with a Diploma in Nursing (General, Community, Psychiatry) and Midwifery and 19.6% (n=31) of those sampled held an Advanced Psychiatric Nursing qualification; Staff nurses (Enrolled nurses) comprised 13.9% (n = 22) and only 12% (n=19) of respondents reported having a Diploma in Psychiatric Nursing.

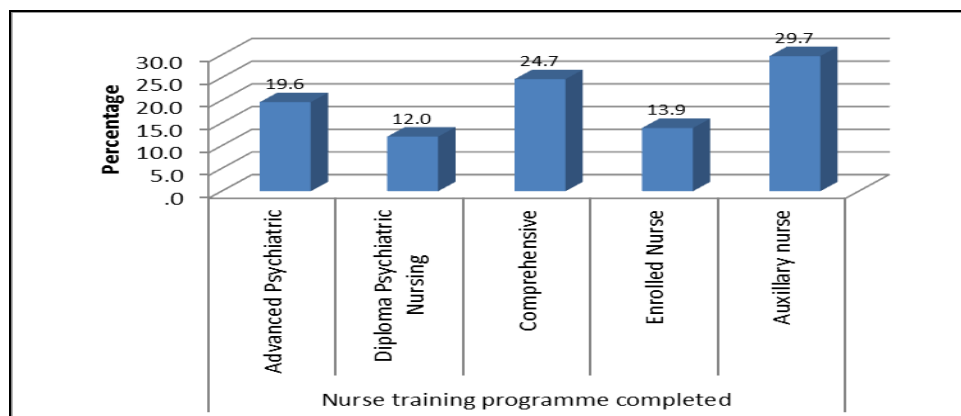


Figure 3: Nurse Training Programme

4.3.1.3 Highest nursing qualification

The largest number of participants (29.7% n=47) reported being Auxiliary nurses, followed by those who reported having a Diploma in Nursing (General, Community, Psychiatry) and Midwifery (23.4%. n = 37). Only 26 participants (16.5%) reported having an Advanced Diploma in Psychiatric Nursing, an additional registration with the South African Nursing Council. 22 participants (13.9%) had an Enrolled nurse qualification and (11.4%.n = 18) had a Diploma in Psychiatric nursing. Five (5) participants (3.2%) had a bachelor's degree and only 1 (0.6%) participant possessed a PhD in Psychiatric Nursing whilst others (1.3%. n=2) were not clearly specified. Figure 4 below illustrates the highest nursing qualifications of the participants.

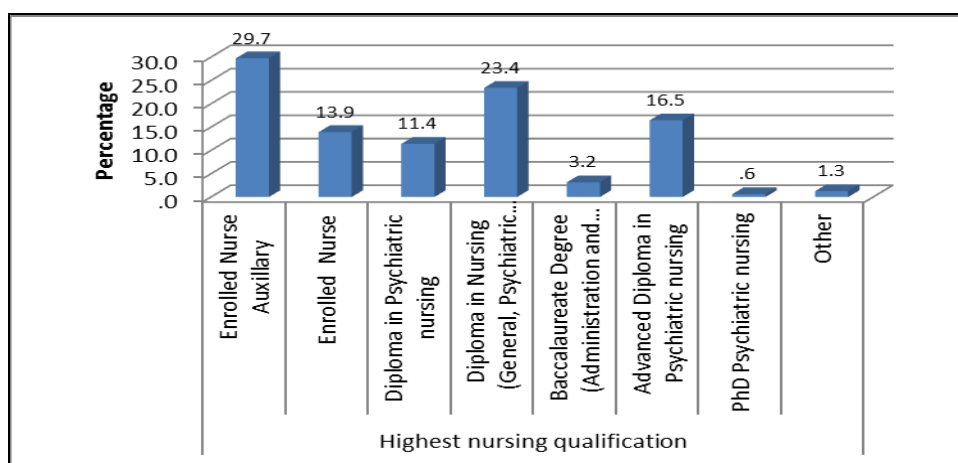


Figure 4: Highest Nursing Qualification

4.3.1.4 Job title

Sixty-seven (42.4%) participants were Registered Psychiatric Nurses; 40 (25.3%) were Auxiliary Nurses; 16 (10.1%) were Operational Nurse Managers; 16 (10.1%) were Staff Nurses; 7 (4.4%) were Senior Staff Nurses (Senior Enrolled Nurses); 6 (3.8%) were Assistant Nursing Service Managers and 6 (3.8%) were Senior Nurse Auxiliaries.

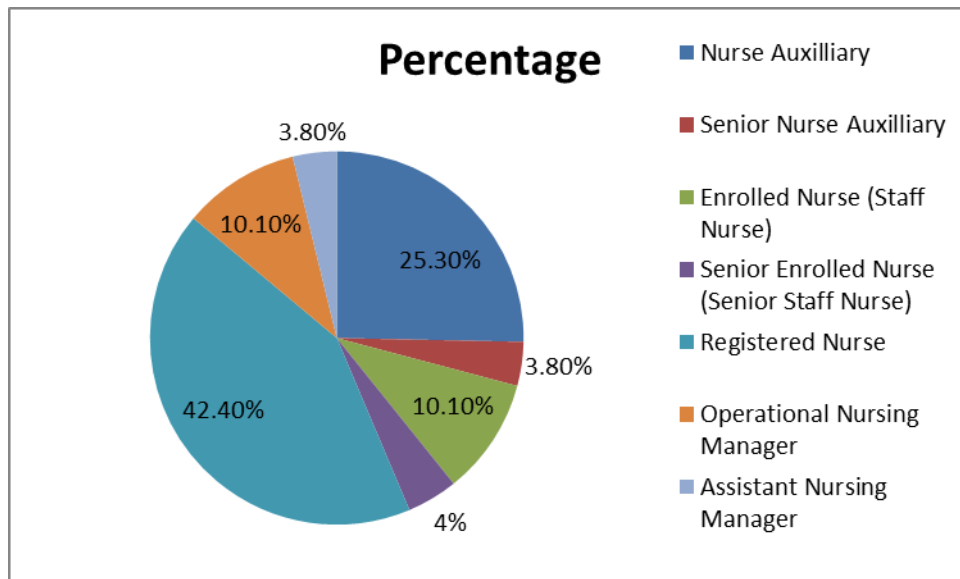


Figure 5: Job Title

4.3.1.5 Ward currently placed

Nearly one third (29.1% n = 46) of participants were placed in male acute in - patient wards, almost a quarter (24.7 % n =39) of participants in male chronic in - patient wards, just over a fifth (22.2% n =35) of participants in male sub - acute patient wards and 10.1% (n = 16) in forensic wards. Fewer participants reported working in other departments such as outpatients (3.8%, n = 6) the psychotherapy unit (3.2%, n = 5), Neuro-psychiatric unit (1.9%, n = 3) and unspecified departments (1.9 %, n = 3). Participants reported only one (0.6%, n = 1) working in each of the Female acute in - patient, Female chronic in - patient and Child and Adolescent units which is to be expected. Figure 6 reflects the ward/unit that respondents were working on at the time of data collection.

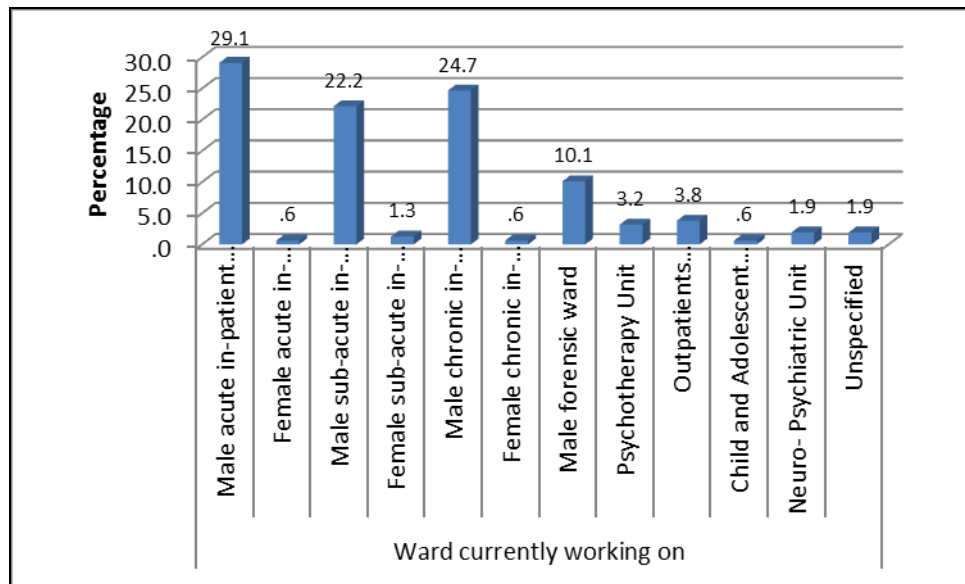


Figure 6: Ward Currently Placed

4.3.1.6 Choice of working in a mental health care setting

The majority of those sampled (93.7%, n=148), indicated to work in a mental health care setting. Only a small number (n=10; 3%) of respondents indicated that it was not their choice to work in mental health care settings. A significant 94% indicated that it was their choice to work in a mental health care setting, $p < .0005$. Refer to figure 7 in text.



Figure 7: Choice of Working in a Mental Health Care Setting

4.4 Objective 1: To describe male mental health care nursing practitioner's years of experience in psychiatric nursing

The participants were asked to specify the number of years that they had worked at in-patient psychiatric hospitals. As reflected in Figure 8, 25.3% (n = 40) of the participants had been working in an in-patient mental health care setting ranging from 11 to 15 years. 24.7% (n = 39) for a period of 1 - 5 years; 17.7% (n = 28) for more than 20 years and 17.1 % (n = 27) for a period of 6 to 10 years. Almost 9% (n = 14) reported having worked in psychiatric nursing for 16 - 20 years and only 6.3% (n = 10) had worked in psychiatric nursing for less than a year.

A binomial test was applied to years of experience and a significant 69% had more than five years' experience working in a mental health care setting, $p < .0005$.

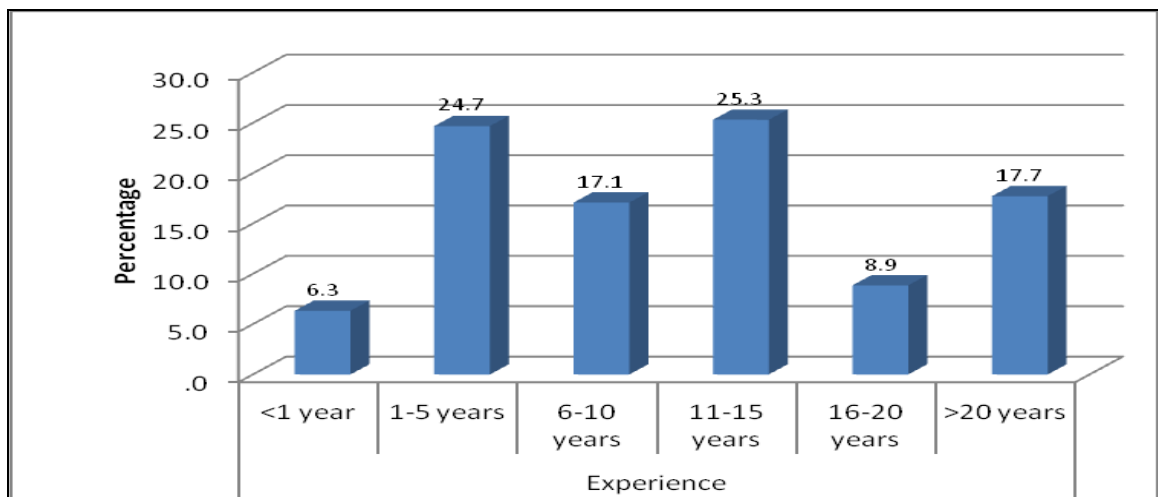


Figure 8: Work Experience

4.5 Reliability statistics

In this study a factor analysis (called principal axis factoring in SPSS) with varimax rotation was performed. This was essential to test the construct validity of the data and identify the underlying factors for this scale with reference to this sample/population. According to Polit and Beck (2012: 363), factor analysis comprises an objective, realistic method of clarifying the fundamental dimensionality of a large set of measures. Fundamental dimensions thus recognised are called factors, which are weighted combinations of items in the analysis.

An exploratory factor analysis, with varimax rotation, was performed on the 41 items set out in the 'sources of pressure' section (section B) of the questionnaire. Ten factors were found to have eigenvalues greater than 1 but only 8 of these were used as the last 2 did not produce any meaningful factors. These 8 factors account for 62.52% of the variance in the data. The Kaiser-Meyer-Olkin Measure of Sampling Adequacy Test (KMO) and Bartlett's Test of Sphericity measured and indicated that the sample was adequate and the factors found are reliable and valid. Reliability of the questionnaire was measured using the following tests:

4.5.1 Kaiser-Meyer-Olkin Measure of Sampling Adequacy test

The Kaiser-Meyer-Olkin Measure of Sampling Adequacy is a statistic that indicates the percentage of difference in the variables that might be caused by essential factors. High values (close to 1.0) generally indicate that a factor analysis may be valuable with the available information. If the value is less than 0.50, the results of the factor analysis are not very useful (Cerny and Kaiser, 1977: 43-47).

4.5.2 Bartlett's test of sphericity test

Bartlett's test of sphericity tests the statement that the correlation matrix is an identity matrix, which would indicate that the variables are isolated and therefore not appropriate for structure detection. Lower values (less than 0.05) of the significance level indicate that a factor analysis may be useful with the statistics (Cerny and Kaiser, 1977: 43-47)

Table 6: Kaiser-Meyer-Olkin Measure of Sampling Adequacy and the Bartlett's Test of Sphericity

KMO and Bartlett's Test	
Kaiser-Meyer Oklin Measure of Sampling Adequacy	0.808
Bartlett's Test of Sphericity	(Approx. Chi-Square) 2.981.865
	(Differential) 820
	(Significance) 0.000

4.5.3 Cronbach's Alpha score test

The coefficient alpha or Cronbach's Alpha is the commonly used method for evaluating internal consistency (Polit and Beck 2012: 333). Coefficient alpha can be understood to be like any other reliability coefficients: the usual range of values is between 0 and 1 and higher values reveal higher internal consistency. The reliability scores of all the sub-sections have values that are above the recommended value of 0.700, as reflected in Table 7. This indicates an overall high degree of satisfactory, reliable scoring for this study.

Table 7: Extracted Factors Summary

Factor	Items	Label	Cronbach's alpha	Label used for construct names
1	1.1 – 1.7	Workload	.829	WL
2	7.1 – 7.5	Home-work conflict	.835	HWC
3	3.1 – 3.4; 2.5	Lack of resources	.846	RES
4	5.1, 5.3 – 5.5	Relationships with other professionals	.848	REL
5	4.1 – 4.5; 6.5	Client/Patient difficulties	.798	PD
6	6.1 – 6.4; 4.6	Professional self-doubt	.762	SD
7	2.2; 2.6; 2.7; 5.6; 5.7	Organization	.711	O
8	2.1; 2.3; 2.4	Management	.799	M

4.6 Objective 2: To identify levels of stress in male mental health care nursing practitioners in tertiary psychiatric hospitals in the uMgungundlovu Health District

The following stressors, client/patient related difficulties, organizational structure and procedures, lack of resources, workload, home - work encounters, professional self-doubt and relationships & conflicts with other professionals have been established to

be sources of pressure at work in mental health care. Each respondent's overall score was calculated using the mean of their total score on the scale, with the means of each of their seven subscale totals also being calculated (Cushway *et al.* 1996).

4.6.1 MHPSS – Workload

In response to the question “too much work to do” less than 12% (n=18) of the respondents felt that too much work to do in the ward/unit did not apply to them and 31%(49) felt it applied to them.

In response to the question regarding the lack of adequate staffing 10.8 % (n=17) felt this did not apply to them with 44.3% responding that it applied to them.

Almost a third (32.9%, n= 52)) of participants felt that the question “ not enough time to complete all tasks satisfactorily” moderately applied to them.

Just more than two thirds (67.1%, n=106) of the participants reported that taking work home did not apply to them.

Just under two thirds (64.6%, n=102) of participants felt that working too long hours applied to them to some extent. In response to the question that they have too many different things to do in the unit, 30.4% (n= 48) suggested that this moderately applied to them. Refer to table 8 in text.

Table 8: Workload

Construct	Does not apply to me	Does apply to me mildly	Does apply to me moderately	Applies to me	Total N=158
Too much work to do	18 (11.4%)	42 (26.6%)	48 (30.4%)	49 (31.0%)	157 (99.4%)
Lack of adequate staffing	17 (10.8%)	27 (17.1%)	42 (26.6%)	70 (44.3%)	156 (98.7%)
Not enough time to complete tasks	57 (36.1%)	30 (19.0%)	52 (32.9%)	18 (11.4%)	157 (99.4%)
Taking work home	106 (67.1%)	21 (13.3%)	19 (12.0%)	10 (6.3%)	156 (98.7%)
Too many MHCUs	28 (17.7%)	32 (20.3%)	40 (25.3%)	57 (36.1%)	157 (99.4%)
Working too long hours	53 (33.5%)	27 (17.1%)	37 (23.4%)	38 (24.1%)	155 (98.1%)
Too many different things to do	30 (19.0%)	44 (27.8%)	48 (30.4%)	33 (20.9%)	155 (98.1%)

4.6.2 MHPSS - Organizational structure

With regard to organizational structure and policies, (n = 58, 36.7%) participants mentioned that this applied to them moderately and only (n = 27, 17.1%) felt that this did not apply to them at all.

The lack of flow in communication and information at work applied to most of the participants from mildly (n=45, 28.5%) through moderately ((n=43, 27.2%) applies to me (n=32, 20.3%).

Just over 40% (n=66, 41.8%) felt that the statement “poor management and supervision in the unit/ward” did not apply to them and just under 10% felt that it did apply to them.

Poor physical working conditions was reported by most participants as applying to them mildly (n=46, 29.1%), moderately (n=42, 26.6%) and applies to me (n=31, 19.6%). Only 22.8% felt this statement did not apply to them.

Just under 20% (n=29) felt that keeping professional/clinical skills up to date does not apply to them whereas (n=50, 31.6%) felt that this applied to them.

Over a quarter of the sample (n=42, 26.6%) reported that “The way conflicts are resolved in the unit/ward” did not apply to them. Under 20% felt that the way conflicts are resolved in the unit/ward applied to them mildly and (28.5%) felt that this applied to them in the unit/ward. Refer to table 9 in text.

Table 9: Organizational Structure

Construct	Does not apply to me	Does apply to me mildly	Does apply to me moderately	Applies to me	Total N=158
Lack of support from management	47 (29.7%)	32 (20.3%)	47 (29.7%)	32(20.3%)	158(100%)
Organizational structure and policies	27 (17.1%)	36 (22.8%)	58 (36.7%)	35 (22.2%)	156(98.7%)
Lack of flow in Communication and information at work	52 (32.9%)	45 (28.5%)	43 (27.2%)	17 (10.8%)	157(99.4%)
Poor management and supervision in the unit/ward	66 (41.8%)	32 (20.3%)	45 (28.5%)	15 (9.5%)	158(100%)
Poor physical working conditions	36 (22.8%)	46 (29.1%)	42 (26.6%)	31 (19.6%)	155(98.1%)
Keeping professional/clinical skills up to date	29 (18.4%)	39 (24.7%)	40 (25.3%)	50 (31.6%)	158(100.0%)
The way conflicts are resolved in the unit/ward	42 (26.6%)	30 (19.0%)	38 (24.1%)	45 (28.5%)	155 (98.1%)

4.6.3 MHPSS: Lack of resources

More than half of the participants (n=83, 52.5%) felt that the lack of financial resources for training workshops/courses applied to them and only 15.8% (n=25) responded that this statement did not apply to them.

The shortage of adequate equipment/supplies applied to 38.6% (n=61) of participants and 15.8% (n=25) felt that this did not apply to them. Nearly half of the participants

(45.5%) responded that this applied to them mildly (n=31, 19.6%) and moderately (n=41, 25.9%).

The lack of adequate cover in a potentially dangerous environment was felt to apply to 83.5% (n=132) of participants (mildly applicable n=24, 15.2%; moderately n=40, 25.3% and applies to me n=68, 43%). Twenty-seven participants (17.1%) felt that inadequate clerical/technical back-up did not apply to them and 54 participants (34.2%) felt that this applied to them in the unit/ward. Refer to table 10 in text.

Table 10: Lack of Resources

Construct	Does not apply to me	Does apply to me mildly	Does apply to me moderately	Applies to me	Total N=158
Lack of financial resources for training workshops/courses.	25(15.8%)	21(13.3%)	29 (18.4%)	83(52.5%)	158 (100%)
Shortage of adequate equipment/supplies	25(15.8%)	31(19.6%)	41 (25.9%)	61(38.6%)	158 (100%)
Lack of adequate cover in potentially dangerous environment	24(15.2%)	24(15.2%)	40 (25.3%)	68(43.0%)	156 (98.7%)
Inadequate clerical /technical back-up	27(17.1%)	32(20.3%)	44 (27.8%)	54(34.2%)	157 (99.4%)

4.6.4 MHPSS: Client/patient difficulties

To the question of feeling inadequately skilled in dealing with the emotional needs of mental health care users/clients 33.5% (n=53) of participants felt it did not apply to them. However just under 2/3 (65.9%) of the participants felt to some degree this

statement applied to them (applies mildly n=29, 18.4%; moderately applies n=46, 29.1% and applies to me n=29, 18.4%).

Just under 30% (28.5%, n=45) of participants felt the statement “feeling inadequately skilled for working with difficult clients/patients” did not apply to them and 71.6% (n=113) felt that this statement applied to them in some measure.

Participants reported that physically threatening clients/mental health care users (MHCU's) was a source of stress which applied to them at some level – mildly applies (n=35, 22.2%), moderately applies (n=33, 20.9%) and 34.2% (n=54) felt that this applied to them.

Just under half of the participants (n=75, 47.5%) felt that dealing with death and suffering did not contribute to their stress while just over half (51.2%) felt it did apply to them in some way. Refer to table 11 in text.

Table 11: Client/Patient Difficulties

Construct	Does not apply to me	Does apply to me mildly	Does apply to me moderately	Applies to me	Total N=158
Feeling inadequately skilled in dealing with emotional needs of mental health care users/clients	53 (33.5%)	29 (18.4%)	46 (29.1%)	29 (18.4%)	157(99.4%)
Feeling inadequately skilled for working with difficult clients/patients	45 (28.5%)	39 (24.7%)	39 (24.7%)	35 (22.2%)	158 (100%)
No change or slowness of change in clients/mental health care users(MHCU's)	35 (22.2%)	40 (25.3%)	49 (31.0%)	34 (21.5%)	158 (100%)
Difficult and/or demanding clients or mental health care users (MHCU's)	23 (14.6%)	30 (19.0%)	43 (27.2%)	62 (39.2%)	158 (100%)
Physically threatening clients/ mental health care users (MHCU's)	34 (21.5%)	35 (22.2%)	33(20.9%)	54 (34.2%)	156(98.7%)
Dealing with death and suffering.	75 (47.5%)	47 (29.7%)	18 (11.4%)	16 (10.1%)	156(98.7%)

4.6.5 MHPSS: Relationships with other professionals

Eighty - three participants (52.5%) reported that conflict with other professionals eg. professional nurses; unit doctors; psychiatric consultants; occupational therapists; psychologists and pharmacists did not apply to them and just over 10% (n=16, 10.1%) felt that this applied to them and so contributed to their stress.

Just over 36% (n=83) of participants reported that having a relationship with an operational manager did not apply to them whereas 33.5% (n=53) felt that this applied to them. Sixty-two (62) participants (39.2%) reported that having difficulty in working with certain colleague's does not apply to them whereas nearly 2/3 of those sampled (59.5% n=94) felt that this applied to them to some degree.

Seventy - seven participants (48.7%) felt that criticism by another professional for example a doctor or nurse did not apply to them and so was not a contributor to their stress whereas 81 (51.3%) participants felt to some extend this type of criticism applied to them. It was interesting to note that only 36 participants (22.8%) rated this as moderately applicable to them.

The way conflicts are resolved in the unit/ward as a contributor to stress was rated by 53 (33.5%) participants as not applying to them and 26 (16.5%) felt that this applied to them. Half of the participants (n=79, 50%) felt that the way conflict was resolved mildly or moderately applied to them.

Managing therapeutic relationships as a stressor contributed to 36 (22.8%) participants who reported it applied to them, 38 (24.1%) reported this as moderately applying to them and 41 respondents (25.9%) reported it mildly applied to them. Refer to table 12 in text.

Table 12: Relationships with other Professionals

Construct	Does not apply to me	Does apply to me mildly	Does apply to me moderately	Applies to me	Total N =158
Conflict with other professionals eg. Professional Nurses; Doctors etc	83 (52.5%)	37(23.4%)	22 (13.9%)	16 (10.1%)	158 (100%)
Relationship with Operational Manager	57 (36.1%)	16 (10.1%)	29 (18.4%)	53 (33.5%)	155(98.1%)
Conflicting roles with other professionals.	77 (48.7%)	34 (21.5%)	24 (15.2%)	19 (12.0%)	154(97.5%)
Difficulty of working with certain colleague's	62 (39.2%)	28 (17.7%)	42 (26.6%)	24 (15.2%)	156(98.7%)
Criticism by other professional e.g. doctor, nurse.	77 (48.7%)	45 (28.5%)	17 (10.8%)	19 (12.0%)	158 (100%)
The way conflicts are resolved in the unit/ward.	53 (33.5%)	40 (25.3%)	39 (24.7%)	26 (16.5%)	158 (100%)
Managing therapeutic relationships.	40 (25.3%)	41 (25.9%)	38 (24.1%)	36 (22.8%)	155(98.1%)

4.6.6 MHPSS: Professional self – doubt

Just under 60% of participants (n=94, 59.5%) felt that they did not experience any uncertainty about their own capabilities and this statement did not apply to them and just under 9 % (n=14, 8.9%) felt that this applied to them.

Lack of emotional support from colleagues as a stressor was identified as not applicable to them by 50% (n=79) of the participants.

Fear of making an error over a client/patient's treatment programme was identified as applying to them by 50.6% (n=80) of participants (apply to me mildly n=38, 24.1%; apply to me moderately n=18, 11.4% and applies to me n=24, 15.2%).

Just over half (n=86, 54.4%) of those sampled felt that work emphasizes feelings of emptiness and/or isolation did not apply to them whereas 8.9% (n=14) felt that this applied to them.

Half of the participants (n=79, 50%) felt that having doubts about the efficacy of therapeutic endeavours did not apply to them while 19% (n=30) felt the statement moderately applied to them and so contributed to their stress. Refer to table 13 in text.

Table 13: Professional self-doubt

Construct	Does not apply to me	Does apply to me mildly	Does apply to me moderately	Applies to me	Total
Uncertainty about own capabilities.	94 (59.5%)	30 (19.0%)	19 (12.0%)	14 (8.9%)	157(99.4%)
Lack of emotional support from colleagues	79 (50.0%)	40 (25.3%)	25 (15.8%)	13 (8.2%)	157(99.4%)
Fear of making an error over a client/patient's treatment program.	78 (49.4%)	38 (24.1%)	18 (11.4%)	24 (15.2%)	158 (100%)
Work emphasizes feelings of emptiness and/or isolation	86 (54.4%)	38 (24.1%)	19 (12.0%)	14 (8.9%)	157(99.4%)
Doubt about the efficacy of therapeutic endeavours.	79 (50.0%)	47 (29.7%)	17 (10.8%)	13 (8.2%)	156(98.7%)

4.6.7. MHPSS: Home- work conflict

Not spending enough time with family was identified by 67.8% (n=107) of those sampled as applying to them to some degree – does apply to me mildly, moderately or applies to me.

Just over $\frac{3}{4}$ (75.9%, n=120) of those sampled reported that their relationship with a spouse/partner affecting their work, did not apply to them or only applied mildly.

The inability to separate their personal life from their professional role was reported to not apply to them by 63.9% (n=101) of participants with 35.5% (n= 56) reported this as applying to some degree.

Almost a third of participants (n=51, 32.3%) reported they felt that not having enough time for recreation did not apply to them and almost $\frac{2}{3}$ (n=104, 65.9%) felt that this mildly applied to them, moderately applied or applied to them.

A small majority of participants (n=91, 57.7%) felt that having insufficient time for acquaintances/social relationships applied to them to some degree with 41.8% (n =66) reporting that the statement did not apply to them. Refer to table 14 in text.

Table 14: Home-Work Conflict

Construct	Does not apply to me	Does apply to me mildly	Does apply to me moderately	Applies to me	Total
Not spending enough time with family.	51(32.3%)	32(20.3%)	30(19.0%)	45(28.5%)	158(100%)
Relationship with spouse/partner affects work	89(56.3%)	31(19.6%)	18(11.4%)	19(12.0%)	157(99.4%)
Inability to separate personal from professional role.	101(63.9%)	26(16.5%)	18(11.4%)	12 (7.6%)	157(99.4%)
Not enough time for recreation.	51 (32.3%)	32(20.3%)	35(22.2%)	37(23.4%)	155(98.1%)
Inadequate time for friendships/social relationships	66 (41.8%)	30(19.0%)	35(22.2%)	26(16.5%)	157(99.4%)

4.6.8 Extent to which sources of pressure apply

It is generally accepted, that there are a variety of sources of pressure at work and those found to be sources in health care were tested using the MHPSS.

When the one sample T-test was applied, it was found that the constructs work load (WL), client/patient difficulties (PD) and organizational structure (O) were not significantly different from a score of 1.5 (between mildly and moderately). It was found that the sources of pressure are all less than 2.5. Therefore, lack of resources (RES) is the worst stressor ($X = 1.84$, $SD.864$), followed by organizational structure (O) ($X= 1.52$, $SD .745$), workload (WL) ($X =1.48$, $SD.744$). The least stressor (that was found to lie in the mild region) is professional self-doubt (SD) ($X = .81$. $SD.723$). It cannot be classified where workload (WL) ($X1.48$, $SD .744$), client/patient difficulties (PD) ($X = 1.44$, $SD .775$) and management (M) ($X = 1.20$, $SD .895$) lie but they are between mild and moderate. Refer to figure 9 in text.

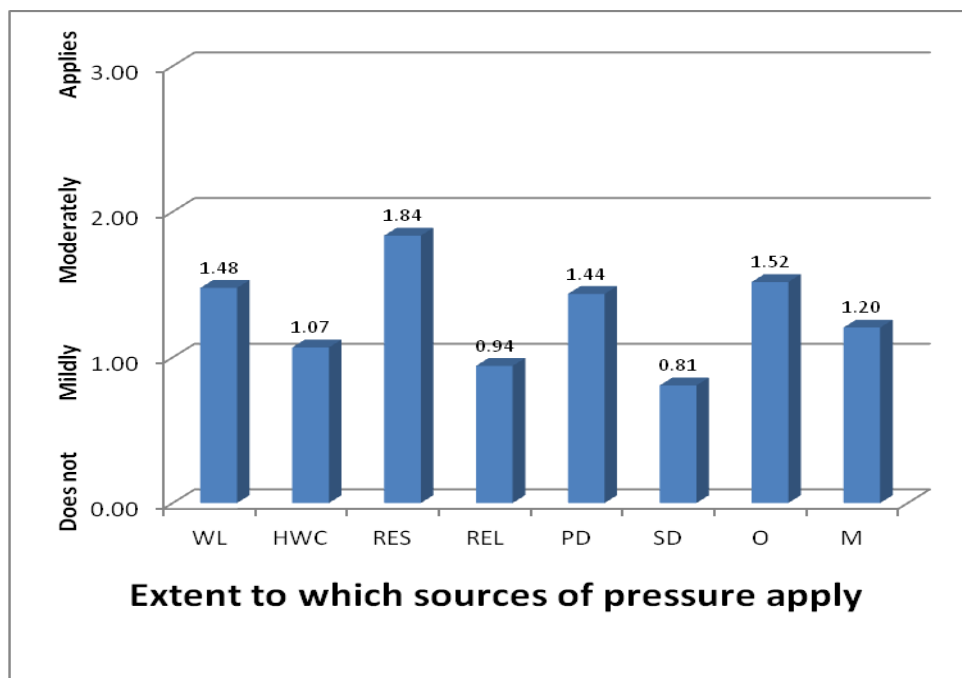


Figure 9: Extent to which sources of Pressure apply

4.7 Objective 3: To determine if there is any relationship between stress and years of experience in male mental health care nursing practitioners in tertiary psychiatric hospitals in the uMgungundlovu Health District

4.7.1 Correlation testing

Statistically significant relationships between variables are measured using correlation tests. This study used inferential statistics, viz. Pearson's and Spearman's correlations, at a significance level (p-value of 0.05). Pearson's r is a coefficient specifying the magnitude of the relationship between two variables measured on an interval scale (Polit and Beck 2012:737). Spearman's rank-order correlation (Spearman's rho) is a correlation coefficient which indicates the relationship between variables measured on an ordinal scale and further measures the bivariate relationships between variables (Polit and Beck 2012: 422;743). The study reflected positive values suggesting that there were statistically proportionate relationships between variables.

In this study, the relationship between overall stress and individual stress constructs and experience was computed using Spearman's rho correlation coefficient depicted in table 15 below.

Table 15: Spearman's Rho correlation coefficient

Sources of Pressure	Experience in psychiatric nursing	
	Correlation Coefficient	P - Values
Stress	-.189	.017
Workload	.002	.984
Home - work conflict	-.173	.030
Lack of resources	-.128	.110
Relationships with other Professionals	-.187	.019
Client/Patient difficulties	-.218	.006
Professional self – doubt	-.211	.008
Organizational Structure	-.038	.632
Management	-.126	.115
Total Number	158	

In this study that there was a significant but weak negative correlation between general stress and experience, $\rho = -.189$, $p=.017$. It was found that there are significant negative correlations between experience and levels of stress in general as well as for the constructs home- work conflict (HWC) ($\rho=-.173, p=.030$); lack of resources:(REL)($\rho=-.128, p=.110$); client/patient difficulties (PD) ($\rho=-.218, p=.006$); and professional self - doubt (SD) ($\rho=-.211, p=.008$). These results indicate more experience is correlated with less stress. In keeping with the stress vulnerability family coping skills model of adaption (Hazeldene foundation 2008:1; Mueser and Glynn 1990:129), male mental health care nursing practitioners with more years of experience are well capable to deal with stress.

4.8 Summary

Demographic data was introduced with all of the participants ranging in age from 19 years to 64 years. Descriptive statistics in the form of cross-tabulations, graphs and other figures for the data collected were presented, which were interpreted using the p-value of 0.05. Tests for reliability of the research instrument used were also presented and the statistical software program (SPSS version 22.0) used to analyse data. Tests performed were the Kaiser-Meyer-Olkin measure of sampling adequacy test (KMO); Bartlett's test of sphericity tests; Cronbach's Alpha test and an inferential statistics test (one sample t-test). Findings revealed that when the one sample T-Test was applied, the sources of pressure were all less than 2.5.

Lack of resources (RES) is the worst stressor, followed by organizational structure (O) and workload (WL). The least stressor (that was found to lie in the mild region) is professional self-doubt (SD). This study used inferential statistics to test for any correlations, Spearman's rho correlation coefficient indicated a significant but weak negative correlation between general stress and experience, $\rho = -.189$, $p=.017$. In keeping with the stress vulnerability family coping skills model of adaption (Hazeldene Foundation 2008:1; Mueser and Glynn 1990:129), male mental health care nursing practitioners with more years of experience are better able to deal with stress. Chapter 5 will present an interpretation, discussion and summary of findings and guidelines.

CHAPTER 5

DISCUSSION OF RESULTS

5.1 Introduction

This chapter presents an interpretation and discussion of the findings of this study and recommendations to be made. According to the Hazeldene Foundation (2008:1) and Mueser and Glynn (1990:129), all psychiatric illnesses have a genetic basis, but socio-environmental stressors and influences can affect their development over time. The stress vulnerability family coping skills model of adaption arguments that a progressive result of a psychiatric disorder is more likely if the environmental stress is reduced or managed well, if medication is taken as recommended and liquor and drug use is avoided. Professional work colleagues, the individual (male mental health care nursing practitioners) and their relatives all functioning together can restore the long term development of the psychiatric disorder resulting in a healthier value of life for all male mental health care nursing practitioners and their family members (Hazeldene Foundation 2008:1; Mueser and Glynn 1990:129). In keeping with the stress vulnerability family coping skills model of adaption (Hazeldene Foundation 2008:1; Mueser and Glynn 1990:129), male mental health care nursing practitioners with more years of experience are better able to deal with stress.

5.2 Demographic Findings

5.2.1 Age

The findings reflect a mature and skilled sample, between 30 to 39 years who chose to work in tertiary mental care health care which is a socio - environmental stressor that can influence their biological vulnerability over time (Hazeldene Foundation 2008:1; Mueser and Glynn 1990:129). These findings could also reflect that this age group are able to cope with the sources of pressure in these tertiary in-patient psychiatric settings. These findings are similar to Joubert (2015:92) where more than

30% of male and female participants were inside the age group 30 to 39 years which also mirrored a mature and skilled sample in psychiatric nursing care settings. Joubert found that this was not unusual, as with age and experience there is confidence and this acts as a protective factor which reduces an individual's biological vulnerability and stress (Dawood *et al*, 2017:43; Joubert 2015:92; Hazeldene Foundation 2008:1; Mueser and Glynn 1990:129).

In a similar study by Dawood *et al*. (2017:43), findings revealed that most psychiatric nurses who are younger tend to experience more stress in comparison to their work colleagues who have more experience and are thereby able to cope with stress better (Dawood *et al*. 2017:43). Based on the above findings, male mental health care nursing practitioners who are older have better coping skills such as communication and problem-solving skills, tend to be more mature and have more nursing experience; therefore, they are able to cope with stress more effectively (Hazeldene Foundation 2008:1; Mueser and Glynn 1990:129).

5.2.2 Nurse training program completed

A total of 57% of participants have completed a psychiatric module as part of their training. This was similar to a study by Joubert (2015:93) who found that nearly half (48.4%) of the sample of both male and female participants completed a module as part of their four-year diploma training (R425 SANC 1985) and this had increased their knowledge of mental health care. This suggests that nurses with psychiatric training would have more knowledge of mental health care.

Only 13.9% who were staff nurses studied a small component of mental health care in the R2175 programme (R2175 SANC 1985). This is provided in their second year of study which includes psychiatric nursing science as part of meeting the requirements of this course (Section (b);(ii) ;(ee) (section 45 (1) of the Nursing Act, 1978 (Act No. 50 of 1978). These participants would have a basic understanding of mental health care. Also, a little less than 30% of nurse auxiliaries who had a minimal

amount of training in mental health care such as in the R2176 program (R2176 SANC 1985) as part of section 6 (1). (Act No. 50 of 1978).

5.2.3 Highest nursing qualification and job title

The study also indicated that a small number of male professional nurses (16.5%) completed their Advanced Diploma in Psychiatric Nursing as part of post graduate studies resulting in advance knowledge in psychiatric care. This is in contrast to a South African study by Ramalisa (2014:63 – 64); who found that only 18.8% of the participants had a basic undergraduate diploma in psychiatric nursing, and 16.7% held a bachelor degree in nursing science; which indicated a basic education in mental health care as opposed to nurses with post graduate diploma in psychiatric nursing.

42.4% (n=67) of the male participants were registered psychiatric nurses which concurs with the study by Joubert (2015:70) who also found that about 85% of the sample, both male and female, were registered nurses and psychiatric nurses. This study also reflects a sample that has the qualifications and skills required to manage mental health care users (MHCU'S) (Joubert 2015:70). According to the stress vulnerability family coping skills model of adaption, protective factors reduce individuals and colleagues biological vulnerability and stress for example, like having proper training skills and requirements in psychiatric nursing science together with a supportive environment can prevent further stress (Hazeldene Foundation 2008:1; Mueser and Glynn 1990:129).

5.2.4 Ward/unit currently working in

Male participants who were placed in male acute in - patient and forensic wards found patients to be at a higher risk due to the unpredictable nature of their mental illness. This study concurred with Joubert (2015) who found that mental health care users in chronic and forensic wards are unpredictable; hence, the high percentage of male nurses in these units is warranted.

5.2.5 Work experience in mental health care setting

The participants were also asked to specify the amount of years that they had worked at in-patient psychiatric wards/units with 25.3% (n = 40) of the participants having worked in an in-patient mental health care setting ranging between 11 to 15 years. A binomial test to years of experience was applied and it was found that a significant 69% of the respondents have more than 5 years' experience working in a mental health care setting, $p < .0005$. This study seems to be congruent with a study of Joubert (2015:71) where about 43.7% of the sample both male and female worked for more than ten years in psychiatric units/wards.

This reflects a sample with extensive psychiatric nursing experience and skills, capable of handling with the trials and problems faced when caring for mental health care users (Joubert 2015:71). According to the stress vulnerability family coping skills model of adaption, protective factors reduce individuals and colleagues' biological vulnerability and stress. For example, having good handling skills like problem solving and communication and skills together with a supportive environment can prevent further stress (Hazeldene foundation 2008:1; Mueser and Glynn 1990:129).

5.2.6 Choice to work in a mental health care setting

A majority (94%; n=148) of participants specified that they chose to work in these mental health care settings. Only a minor percentage 0.6%; (n=10) of respondents indicated that it was not their choice to work at these units/wards. This was similar to a study by Joubert (2015:72) where it was also found that almost all (92.2%) of the male and female participants chose to work at psychiatric in-patient settings. It seems that being a male nurse, played an important role in terms of choice of work. In this study, 34.1% of male participants chose psychiatric settings as their workplaces (Joubert 2015:72). These findings were further aligned with a study in America, which revealed that 39% of participants were male.

It is encouraged that men who are not at ease with the old-fashioned caring and nurturing features of nursing incline to choose mental health nursing, because of its job-orientated purposes such as physical management of mental health care users (Torkelson and Seed 2011: 36). According to the stress vulnerability family coping skills model of adaption, protective factors provide meaningful but not an over-demanding structure such as allowing the individual (male nursing practitioner) to choose their own workplace setting can further protect him from further stress (Hazeldene foundation 2008:1; Mueser and Glynn 1990:129).

5.3 The Mental Health Professionals Stress Scale (MHPSS): Sources of pressure at work in male mental health care nursing practitioners

According to the Spearman's rank-order correlation coefficient, there are substantial negative correlations between experience and levels of stress in general which should also be expected for the constructs home-work conflict, lack of resources, difficulties with clients and professional self-doubt, and relationships with other professionals. The above are sources of pressure as stated by Cushway *et al.*'s. (1996) Mental Health Professionals Stress Scale (MHPSS) which contributes to stress as follows:

5.3.1 Workload

Using Spearman's rank-order correlation coefficient with regards to workload, there was a significant negative correlation between "workload" and "experience at 0.984. Workload is a significant stressor but it is not correlated with experience. This shows that respondents with experience are able to cope with the workload in the unit/ward and respondents with less experience are not able to cope with higher workloads. In a similar correlation study by Azizollah *et al.* (2014:186), stress is necessary for increasing performance of employees but up to a certain level. In this study the employees did their job regularly; however, due to workloads and time constraints their performance was reduced. The results of this study showed there was a

negative correlation between job stress and performance (Azizollah *et al.* 2014:186). In another study by White, (2006:54), the final research question examined the relationships among occupational stressors, coping strategies, and burnout among psychiatric nurses working in secured psychiatric units. It was found that the correlation between stress and coping revealed a statistically significant negative relationship ($r = -.62$, $p < .05$) and this negative correlation suggested that those nurses with greater coping strategies experienced less stress (White, 2006:54).

It was also recommended that nurses be trained on coping strategies to protect them against personal stress while preventing burnout and poor health outcomes in a study by Khamisa *et al.* (2016:257). This was found to be effective in some studies (Ford, Heinen, & Langkamer, 2007; Luthans, Avey, Avolio, Norman, & Combs, 2006). Work stress can be alleviated through addressing staffing issues for nurses (Jennings, 2008). This can be achieved through improved recruitment and retention policies (Buchan & Aiken, 2008). It was also recommended in this study that evaluation procedures will help ascertain the effectiveness of such strategies, while potentially informing policy and practice in developing contexts such as South Africa (Khamisa *et al.* 2016:257).

5.3.2 Organizational structure

Using Spearman's rank-order correlation coefficient with regards to organizational structure, there was a significant negative correlation between the variables "organisational structure" and "experience" at a p value = 0.632. This shows that participants with experience are able to cope without the support of management; understand their organizational structure and policies and handle the lack of flow in communication and information at work to the best of their abilities. Also, it seems like participants are able to cope with poor management and supervision; work in poor physical working conditions; are able to keep professional/clinical skills up to date and are able to resolve conflicts as best as they can in the organization. According to the stress vulnerability family coping skills model of adaption, experienced male mental health care nursing practitioners are able to manage their units with minimal managerial support (Hazeldene Foundation 2008:1; Mueser and

Glynn 1990:129). This is because their coping skills have been developed with multiple years of experience.

In a similar study by Hanrahan *et al.* (2010:1), they observed the extent to which organizational factors of inpatient psychiatric environments are associated with psychiatric nurse burnout. It was discovered that there were lesser levels of mental health nurse fatigue in inpatient settings due to the fact that they had better overall superior work environments, better nurse-physician relationships, more efficient nurse managers, and greater mental health nurse-to-patient enlistment ratios. The outcomes propose that changes in organizational management of inpatient psychiatric units could have an optimistic effect on mental health nurses' capability to tolerate safe and operative patient care settings.

It was also felt in the study that hospital managers should notice the relationship between organisational factors and psychiatric nurse burnout, whereby even minor adjustments in the value of the nursing clinical environment would expand mental health nurse job satisfaction, and investigation demonstrates that healthier patient outcomes are associated with the total value of the nurse clinical setting (Aiken *et al.*, 2008). Also, in future studies of inpatient mental health care environments including patient outcomes is vital in mental health establishments (Hanrahan *et al.* 2010:7).

5.3.3 Lack of resources

Using Spearman's rank-order correlation coefficient with regard to lack of resources there was negative correlation between the variables "Lack of resources" and "experience" at p value = .110 thereby concluding that male mental health care nursing practitioners with more experience are able to cope better with little resources such as deficiency of sufficient equipment/provisions; lack of sufficient staff coverage in an unsafe environment and with insufficient secretarial / procedural support. This is in keeping with the stress vulnerability family coping skills model that states that the more experienced male mental health care nursing practitioners are

able to cope during times of lack of resources (Hazeldene foundation 2008:1; Mueser and Glynn 1990:129).

This was in contrast to a study by Konstantinos, (2008:191-193) which concluded that the pressures related to mental health care user's treatment with great dangerous occurrences in the ward, were established to have a optimistic relationship with stress. Moreover, absence of nursing personnel was found to have a negative relationship with mental health nurses' stress. Furthermore, managerial issues and concerns were established to be related with stress. It was described in this study that nurses in the work environment perceive different sources of stress and that stress decreases nurses' job satisfaction (Konstantinos, 2008:191-193).

5.3.4 Client/patient difficulties

Using Spearman's rank-order correlation coefficient with regards to client/patient difficulties, it was found that there was weak negative correlation between the variables "Client/Patient difficulties" and "experience" at a p value =.006. This shows that with more experience it results in less client/patient difficulties in the unit/ward. This is in keeping with the stress vulnerability family coping skills model, which states that the more experienced mental health care nursing practitioners' are able to cope with difficult mental health care user's (MHCU) (Hazeldene Foundation 2008:1; Mueser and Glynn 1990:129). This was also similar to a study by Joubert (2015: 107) where the experience of participants working at psychiatric facilities is evident in the findings which show that more than 40% of the participants had more than 10 years' experience and felt that they were satisfactorily prepared to care for mentally ill patients (Joubert 2015:107).

In contrast to a study by En-Chi Shih *et al.* (2016:15); the outcomes of this study specified that a nurse's age, nurse title, mental health ward/unit placed, the psychiatric conditions faced with daily, overtime work and level of seniority were related with the nurse's level of job-related exhaustion and its three extents. There was a positive association between job stress and burnout. The study showed that complete job stress, overall no of years in nursing, specific age, professional

relations with mental health care users, individual growth performance assessment system, and facing medical differences are probing issues for mental health nurses' overall job-related burnout and its three extents of emotional exhaustion, depersonalization, and individual achievements (En-Chi Shih *et al.* 2016:15).

Whereas, Hagen *et al.* (2016:31-37) in study in Norway where one participant was male and seven female nurses in two different psychiatric hospitals, aged between 43 to 60 years in five different psychiatric wards, pointed to the lack of ability among inexperienced nursing staff, leading to higher strains on experienced nurses additionally leading to poor care for patients, which may contribute to increased self-destructive behaviour among patients. It was recommended that adequate staffing, adequate resources and sufficient training of all staff members is important to enable them to provide good care (Hagen *et al.* 2016:31-37).

5.3.5 Relationships with other professionals

With Spearman's rank-order correlation coefficient with regards to relationships with other professionals there was a weak negative correlation between the variables "relationships with other professionals" and "experience" at a p value = .019. It was then concluded that with more experience, the respondents showed they are able to resolve conflicts with other professionals e.g. Professional nurses; doctors, operational managers and respond to criticisms easily in the unit/ward which is to be expected. This is in keeping with the stress vulnerability family coping skills model which states that the more experienced mental health care nursing practitioners are able to cope with conflicting roles with other professionals and respond to criticisms easily in the unit/ward (Hazeldene foundation 2008:1; Mueser and Glynn 1990:129).

This was very similar to a study by Konstantinos, (2008:191-193) which determined that there is a negative relationship between stress and good professional relations between nurses and doctors, as well as between psychiatric nurses. It was established in the study that nurses who experience little intensities of stress would have caring relationships with doctors and other nurses, and those with greater

stress scores will have reduced relations with colleagues (Konstantinos, 2008:191-193).

5.3.6 Professional self – doubt

Using Spearman's rank-order correlation coefficient with regards to professional self-doubt there was a weak negative correlation between the variables "Professional self-doubt" and "experience" at a p value = .008. It was then concluded that the more experience the participants had, resulted in them possessing less professional self-doubt e.g. doubt about own capabilities; that they experienced lack of emotional support from co-workers and had concerns of making a error over a client/mental health care users treatment program.

It is also noted that more experience results in less stress as shown in a similar previous study by Humpel *et al.* (2001) amongst a sample of Australian mental health nurses. The study detected the relationship between the extent of time in mental health nursing and emotional capability and stress and emotional capability and work stress were measured using the Multifactor Emotional Intelligence Scale (Mayer *et al.*1999) and the Mental Health Professionals Stress Scale (MHPSS) (Cushway *et al.*1996). A noteworthy association was found between emotional competency and stress whereby nurses with six years and more work experience had greater levels of emotional capability and those with fewer than two years' experience were found to experience importantly more personal self-doubt (Humpel *et al.*2001).

5.3.7 Home- work conflict

Using Spearman's rank-order correlation coefficient with regards to home-work conflict there was a weak negative correlation between the variables "home-work conflict" and "experience" at a p value = .030. It was then concluded that the more experience the participants had shown, participants were able to spend enough time with family, work does not affect their relationship with their spouse/partner and they are able to separate their personal life from their professional role. Also, they had

enough time for recreation and have adequate time for friendships or social relationships. According to the stress vulnerability family coping skills model, family and home problems can make the male mental health care nursing practitioner more vulnerable to stress in the workplace (Hazeldene Foundation 2008:1; Mueser and Glynn 1990:129).

However, in a similar study by Al-Khasawneh *et al.* (2013:272), in the study were asked to express their opinions about the extent to which their families were understanding by encouraging them in their professions and also accepting the challenging nature of their work. It was obvious from the value of the overall mean of the family factor questions (2.95) with (0.62) standard deviation that the sample considered their family groups rather than stressors to their working life. Pearson's Correlation Coefficient with 0.05 sig. level was used to test the study hypothesis: It was found that there was no substantial association between family influences, stress and nurses' performance. There was no association between family influences and performance, so that this hypothesis was accepted at $R = 0.01$, which was reliable with the descriptive results; the participants considered their families' supporters and that no stress could transfer from home to their work (Al-khasawneh *et al.* 2013:272; Abdalrahim, 2013:34).

5.4 Limitations experienced during the study

The current study was restricted to the three specialist psychiatric hospitals only. Another restriction was that male nursing staff employed in psychiatric wards of another three district hospitals in the Pietermaritzburg region did not have the opportunity to participate.

There were challenges with the data collection process due to fact that data collection commenced in February 2018 and was completed in the latter part of May 2018. The researcher expected to complete this process by the end of April 2018. This was due to the telephone lines being down for about 2 weeks at Umgeni Hospital, the date for the research presentation and handing out of questionnaires

was postponed several times as well as permission to do the presentation due to hospitalisation of the nursing manager.

Other reasons included were that in 2016 the initial population was 268. However, when the researcher undertook his research presentations with the nursing managers of the three hospitals, the number of participants changed due to male staff retiring; being medically boarded; some were on vocational leave; some were transferred to other hospitals and clinics and others eventually retired. A further challenge was that nursing posts are currently frozen in the KZN Dept of Health; hence the numbers have dropped drastically. No vacant posts have been open as yet because of the moratorium placed by Minister of Health, Dr Aaron Motsolaedi, and the KZN Dept of Health MEC, Dr S Dlomo (7 August 2017).

With the current changes in nursing education, this has also affected the sample size of the population due to the fact that on the 20th of December 2016; the South African Nursing Council (SANC), as a statutory body, established in terms of the Nursing Act, 2005 (Act No. 33 of 2005), circular 7/2016 implemented the phasing out of legacy nursing qualifications which has led to the reduction of nursing auxiliaries (R2176) and staff nurses (R2175). Furthermore, the closing down of sub-campusess which previously offered these training courses in preparation for the new nursing diploma and degree programs that will be incorporated into Higher Education and will commence in the year 2019 (SANC Circular 7 of 2017).

Due to the above-mentioned reasons, the final total population was 227 and out of the 227 questionnaires and consent forms handed out; only 158 were returned as some participants did not return completed questionnaires and consent forms and others refused to participate in the research study.

A few questionnaires and consent forms were however retrieved after data analysis and were not included in the final data analysis report.

5.5 Recommendations

Established on the above conclusions, the researcher makes the following commendations for clinical practice and preparation; nursing research and nursing education.

5.5.1 Clinical practice and preparation

As discussed in the study, a lack of resources which increases pressure for clinical practice in the psychiatric ward/unit, it is recommended that recruitment concerns are imperative issues in defining stress levels of male mental health care nurse practitioners working in mental health facilities. Therefore, it is important for nurse managers to focus on nurse-to-patient ratios and additional categories of staff related complications in the place of work to develop the value of work-life for male mental health nurse practitioners (White, 2006:58).

Another source of pressure discussed was home-work conflict and that male mental health nurses should include participating in other interests outside of work like hobbies and sport activities and knowing that natural life separate of work is healthy and can be pleasurable and meaningful (Abdalrahim, 2013:34, White 2006:58). Furthermore, it was said in this study that these nurses should look forward to going home to their families at the end of a working day, ensuring a stable home life that is kept unconnected from their work life and having confidence in one's capabilities to do the job well (Abdalrahim, 2013:34, White 2006:58).

In agreement with Yusi, (2015:49-50) related to organisational structure and policies, nurses need to work in a non-violent and protected environment; for that reason, a risk assessment of influences that could provoke violence should be done on an ongoing basis. Precise guidelines concerning to the procedures of incident reporting should be articulated and applied, so that staff can be certain that their welfare is significant. Around patient care, nurses should be intricate in independent decision-making, which would lead to self-empowerment. Staff should also be invigorated to report instances of ferocity in a caring setting. Managers should also consider remunerating a special danger payment to staff employed in mental health facilities

and consider compensation of indemnity against the lengthy term risks of physical ferocity. Frequent update training on self-awareness should be piloted to make sure that nursing staff are capable to read mental health care user indications, and in reply, apply tactics such as de-escalation to avert occurrences of viciousness against employees. Employee upkeep structures should be acknowledged inside the mental health hospital for employee referrals. Analysis meetings must be official to intensify nurses' alertness of interactive skills, thereby supporting staff in the alertness of signals that may be suggestive of possible patient ferocity. Skills improvement training workshops to cope with violent mental health care users is also recommended (Yusi, 2015:49-50; Ramalisa 2014:105).

With regards to increased workload in the unit, the researcher in line with Ramalisa (2014:105-106), agrees that there should be sufficient staff in the unit which will effect in greater productivity and solidarity amongst all staff. Also, with adequately skilled nursing staff in the unit, the amount of work is shared likewise and decreases exhaustion among these nurses. Furthermore, MHCUs will receive the utmost care and treatment while threats such as suicide and physical violence will be decreased.

It is also recommended that nurses be sent to assertiveness skills training workshops that will promote self-assurance in the nurses as it contributes to their confidence in due course (Ramalisa 2014:106). When nurses are self-assured, they have a tendency to be capable to cope with insecure feelings such as uncertainty about their own capabilities and concern of making an error with a patient's management program because of believing in their work. Nurse managers and operational nurse managers should also concentrate on this feature of decisiveness as it could decrease exhaustion and unhappiness in the place of work as this study assessed professional self-doubt as another source of pressure (Ramalisa 2014:106).

It is also suggested in another study by En-Chi Shih *et.al.* (2016: 22), that male nurse practitioners regularly attend courses to help manage stress, self-control, relaxation methods, time management, and form peer support groups and social support systems to increase support networks as these have been well established to be effective in reducing burnout in nurses (En- Chi Shih *et.al.* 2016: 22).

5.5.2 Nursing education

Lack of resources is another source of pressure where the advanced psychiatric nurse practitioner should assemble resources to encourage an environment of teaching and education. The advanced psychiatric nurse practitioner should encourage, inspire, make learning materials accessible, and encourage mental health nurses to partake in short courses, work-related training and educational platforms related to working with MHCUs displaying with severe indications (Ngako *et al.* 2012:8). The course content, programmes and structure should include working with MHCUs displaying with hallucinations and delusions, and treatment of MHCUs with these acute symptoms that show fierce and unwanted sexual behaviour (Ngako *et al.* 2012:8).

In agreement with Khamisa, Peltzer, Ilic and Oldenburg (2016), another source of pressure with regards to keeping professional/clinical skills up to date under organizational structure, psychiatric nursing educators often forget that male students have unique needs for learning and may contribute to creating an unsupportive and unwelcoming environment for male learners. It is apparent that factors affecting male students in nursing courses and clinical placements require more research. Connecting this idea with mental health education and clinical experience might provide an opportunity for valuable findings in this area of nursing. It is important to mention that the representation of male students' experiences may be different when the population of male students is more mature, not just physiologically but also emotionally, socially, intellectually, and maybe even spiritually. In terms of preparedness for clinical placements in psychiatric facilities, there is a notion that older male students could succeed more than their younger male colleagues simply because they might be more experienced in dealing with psychologically challenged mental health care users.

Muller, Preston and Dyjak (2010) stated that psychiatric nursing has traditionally attracted more males, whereas females have always dominated general nursing. In fact, men have been able to contribute a lot to mental health by bringing some masculine traits, which sometimes prove to be useful when dealing with psychotic

patients. However, there are some barriers for men entering the area of mental health, and in fact, they exist in the nursing profession in general. Many male nurses are reconsidering their career options for various reasons, causing the retention rates in the profession to fall. It is therefore recommended that even before marketing mental health nursing to men, we need to think about what nursing education can do to attract more male students into university studies in the first place and, furthermore, steer their interests towards the area of psychiatric nursing. To address current shortages, nurse educators have adopted strategies for drawing male students' attention to psychiatric nursing programs. This will assist with the stress related to the lack of adequate staffing, which is another source of pressure in the psychiatric unit or ward under the concept workload (Muller, Preston and Dyjak 2010).

Also under organisational structure, it is also recommended that adult critical psychiatric wards should make available planned activities and specific relaxation care for mental health care users according to a study on the learning needs of mental health nursing staff in acute wards in Greece (Moschovopoulou, Valkanos, Papastamatis and Giavrimis (2011:372)). This empiric study indicated that mental health nurse's at work in critical inpatient wards/units are extremely inspired to be more knowledgeable and improve their daily clinical duties. The researcher also with this particular study agrees that learning structure should be of significance to critical inpatient nursing, flexible in provision and technique. A clinical practice-based program-incorporating knowledge into daily clinical practice e.g. specific areas of training need to be recognised such as risk assessment, management of violent and aggressive behaviour, effective management of acutely ill and patients who harm themselves, accurate assessment and counselling skills. This uninterrupted process of teaching needs assessment is necessary for the mental health nurse to be of value for mental health care user's and begin to apply beneficial methods through teaching and clinical practice improvement (Moschovopoulou, Valkanos, Papastamatis and Giavrimis, 2011:372).

The researcher in agreement with Ramalisa (2014:106), recommends that nurse educators should encourage male nursing students to decide on mental health nursing as a profession of choice. With accurate mentoring, assistance and direction, these male students would be prepared to go into the nursing clinical area with self-confidence and enthusiasm. The nursing student curriculum in South Africa focuses generally on general nursing and the majority of nursing students in their final year of study of the R425 program are introduced only to mental health nursing when they undertake their psychiatric nursing science module. By educating and teaching the essentials and fundamentals of psychiatric nursing at first or second year, this will encourage student nurses to have a diversity of fields to choose from like midwifery, psychiatric nursing or emergency care nursing. This should be from an initial period of their professional growth and this should get the nursing students ready for the clinical practice and deliberation of speciality and progression in mental health nursing (Ramalisa 2014:106).

The stress vulnerability family coping skills model of adaption points out that a mental illness is managed effectively if environmental stress is reduced or managed well; for example, specialist psychiatric nurses with an advanced diploma in psychiatric nursing science have scarce skills and that more specialist training is needed to advance competence in mental health nursing to avoid issues of stress experienced by nurses leading to the assault of patients. There will be better patient outcomes if they are nursed by advanced specialist nurse psychiatric nurses (Hazeldene Foundation 2008:1; Mueser and Glynn 1990:129).

5.5.3 Nursing research

The Mental Health Professionals Stress Scale (MHPSS) by Cushway *et al.* (1996); pertaining broadly to mental health professionals was applied specifically to measure stress in the population of male mental health care nursing practitioners and was used to guide this study. This topic has the potential to promote further nursing research as was agreed upon in a previous study by Ngako *et al.* (2012) where nurse

managers and advanced psychiatric nurse practitioners provided the resources to promote evidence-based practice and encouraged registered male psychiatric nurse practitioners to participate and be involved in research. The advanced psychiatric nurse practitioners should promote registered male psychiatric nurse practitioners with access to research information associated to working with MHCUs displaying acute mentally ill symptoms, centred on clinical experience supported by research (Ngako *et al.* 2012).

Moreover, with regards to increased workload as a source of pressure for male nursing mental health nursing practitioners, it is acknowledged that the shortage of nursing staff is a world-wide subject that has a severe influence on the health of MCHUs and nursing staff that take care of them. It was also recognised that the lack of nursing staff in critical admission units of the hospital continually occurs which requires instant intervention. Furthermore, this study and other research has discovered that critical admission units and psychiatric wards in psychiatric hospitals are perplexing settings and actions should be taken to guarantee that they are well staffed and to intensify the quantity of nurses with advanced training in psychiatric and mental health nursing (Sobekwa *et al.* 2015:81).

It was discussed that inadequate organisational structure is a source pressure that affects psychiatric nurses in the units/wards that they are placed. It is highly recommended that nursing management include patient results in forthcoming research of inpatient psychiatric care settings. Hospital administrators should notice the strong point of the association between organizational issues and psychiatric nurse exhaustion. Even slight adaptations in the value of nursing clinical practice would increase psychiatric nurse work happiness and research demonstrates that improved patient results are related with the total improved excellence of nursing clinical practice environment (Aiken *et al.* 2008; Hanrahan., 2011:7).

For future research, a qualitative study to describe the experiences of male mental health care nursing practitioners work stressors in mental health and in general health facilities should be investigated to obtain more in-depth data.

5.6 Conclusion

Many studies both locally, nationally and internationally investigated both male and female psychiatric nurses and were not specific to male nurse's in psychiatric nursing science clinical areas in particular. This study was salient as it applied specifically to male mental health nurse practitioners in the three tertiary psychiatric hospitals in the uMgungundlovu Health District in Kwazulu-Natal.

The findings reflected a mature and skilled sample between 30 to 39 years who chose to work in tertiary mental health care. These findings could also reflect that this age group are able to cope with the pressure in these tertiary psychiatric in-patient settings. The experience of participants working at these three psychiatric tertiary hospitals is evident in the findings. It was then concluded that male mental health care nursing practitioners with more years of experience are better able to deal with stress in the workplace.

Additionally, male mental health care nursing practitioners with more experience are able to cope better with limited resources and could resolve conflicts with other professionals. The study showed that participants with experience are able to cope with the workload whereas the unit/ward and respondents with less experience are not able to cope with a higher workload. Furthermore, with more experience, the participants had less professional self-doubt in their capabilities in the unit or ward.

Finally, with more experience, the participants showed that they were able to spend enough time with family, which does not affect their relationship with their spouse/partner, and they are able to separate their personal lives from their professional roles.

More significantly, as one of the initial research studies on describing the relationship between work stress and years of experience amongst male mental health care nursing practitioners, this study not only occupied a much-needed opening in the South African context, but also highlighted the important areas for future research.

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APPENDICES

Appendix: 1a



LETTER OF INFORMATION

Warmest greetings to you. Thank you for showing an interest in my study.

Title of the research study: The relationship between work stress; years of experience and emotional competency in male mental health care nursing practitioners in Pietermaritzburg Tertiary Psychiatric Hospitals

Principal Investigator/researcher: Mr M.A.Smith B Cur (Ed et Admin) (Health Science Education and Management)

Supervisor/s: Dr Penny Orton PhD Nursing and Mrs C Adams Masters of Nursing

Brief introduction: Moylan & Cullinan (2011) found that the attitudes and ability of psychiatric nurses providing psychiatric care is often poor due to them working under extremely high-risk conditions and being exposed to violence such as strangulation and assaults that could lead to potentially fatal outcomes. These incidents of violence could have a negative impact on the emotional and physical well-being of nurses and the type of nursing care that they render. In addition, Bilgin (2009) asserts that nurses have to contend with occupational stressors, such as low income and status, long working hours, as well as poor administrative and emotional support. In mental health settings, such variables are made worse by the prevalence and more dangerous stressors with a high level of violence directed at nurses by mental health care users (MHCU's) (Bilgin, 2009; Yusi; 2015).

Internationally there is evidence of studies related to the challenges faced in psychiatric and mental health nursing the and relationship between their years of experience, work stress and emotional

competency. In contrast, there is minimal research concerning the relationship between work stress; years of experience and emotional competency of psychiatric nurses locally.

Purpose of the study: The aim of this study is to describe the relationship between work stress; years of experience and emotional competency in a sample of male mental health care nursing practitioners in Pietermaritzburg's Tertiary Psychiatric Hospitals.

Outline of the procedures: You the participant will complete an informed consent form supplied by the researcher and research assistant. Questions and concerns raised by you will be answered by the researcher. The questionnaires will be delivered to the Nursing Service Managers and or the Operational Managers personally by the researcher together with a sealed box. The latter will be stored in a locked venue where you the participants can at any time, drop off completed questionnaires. The researcher will oversee the data collection procedure. The researcher will collect the sealed box a month later or on an agreed date. The researcher will send follow-up letters to you the participants, two or three weeks from the delivery date of the original questionnaire.

Risks or discomforts to the participant: There will be no risks to you for participating in the study.

Benefits: The intended benefits are to enhance the quality of nursing care in psychiatric facilities, address the challenges which male mental health care nursing practitioners encounter and propose recommendations for mental health nursing education. The value of this study may provide hospital and nurse managers with the necessary information to assist with the adequate preparation of male nurses both in general and psychiatric nursing departments with regards to overcoming stressors; developing coping strategies and enhancing their emotional competency.

Reason/s why the participant may be withdrawn from the study: You may withdraw from the study at any time with no adverse consequences to yourself.

Remuneration: There will be no remuneration for you, the participant or the researcher during or on conclusion of the study.

Costs of the Study: There are no costs for the participant in the study.

Confidentiality: Confidentiality and anonymity of your information will be maintained at all times. Please do not put your name on the questionnaire. All information will be stored under lock and key, with researcher access only. Any electronic data will be stored on a password protected computer which only the researcher will have access to.

Research-related Injury: The researcher does not foresee you being exposed to any risks or research related injuries during the data collection process. There will be no risk or injury compensation to participants in the study.

Persons to contact in the event of any problems or queries:

Mr Mark Albert Smith; Student No: 21644767; Contact details: 033 8973541(work), 033 3428601 (home), 0722209740 (Cell) or mark.smith@kznhealth.gov.za or mark49sm@gmail.com (email).

Supervisor: Dr. Penny Orton; Contact details: 031 3732537 or penny@dut.ac.za (email).

Co – Supervisor: Mrs C Adams; Contact details: 033 8459027 or carolinea@dut.ac.za (email).

Complaints can be reported to the Institutional Research Ethics Administrator on 031 373 2900 or reported to the Acting DVC Research, Innovation and Engagement, Prof S Moyo on 031 373 2577 or moyos@dut.ac.za

Appendix: 1b



Questionnaire No:

Section A: Demographics of Participants:

This section includes questions related to demographic and other personal and professional background information. **Instruction:** Indicate the most appropriate response with an X in the block provided:

1. Gender:

Male	
------	--

2. Indicate your age in years:.....

3. Indicate which nurse training programme you have completed:

Advanced Psychiatric nurse training programme	
1year Diploma in Psychiatric Nursing Science(R880)	
4 year Comprehensive Programme (R425)	
Enrolled Nurse (R2175)	
Enrolled Nurse Auxiliary (R2176)	

4. Indicate your highest nursing qualification:

Enrolled Nurse Auxiliary	
Enrolled Nurse	
Diploma in Psychiatric nursing	
Diploma in Nursing (General, Psychiatric and Community) and Midwife	
Baccalaureate Degree (Administration and Education)	
Advanced Diploma in Psychiatric nursing	
Master's Degree in Psychiatric nursing	
PhD Psychiatric nursing	
Other	

5. Which job title in the nursing profession best describes you?

Nursing Manager	
Assistant Nursing Manager	
Operational Nursing Manager	
Registered psychiatric nurse	
Senior Enrolled Nurse	
Enrolled Nurse	
Senior Enrolled Nurse Auxiliary	
Enrolled Nurse Auxiliary	

6. Where do you work currently?

Male acute in-patient ward	
Female acute in-patient ward	
Male sub-acute in-patient ward	
Female sub-acute in-patient ward	
Male chronic in-patient ward	
Female chronic in-patient ward	
Male forensic ward	
Female forensic ward	
Psychotherapy Unit	
Outpatients Department	
Child and Adolescent Unit	

7. How long have you been working in an in-patient mental health care setting? (Indicate in this block the number of years working in the health care setting).

< 1 year	
1 - 5 years	
6 - 10 years	
11 - 15 years	
16 - 20 years	
> 20 years	

8. Was it your choice to work in a mental health care setting?

Yes	
No	

If not, specify reasons:

.....

Section B: (Modified Mental Health Professional Stress Scale (MHPSS) (Adapted from Cushway, 1996).

The following have been found to be sources of pressure at work in mental health care. Please respond by circling the numbers which represent the extent to which item applies to you. (ie. Represents a source of pressure at work for you).

	Does not apply to me	Does apply to me mildly	Does apply to me moderately	Applies to me
1. MHPSS: Workload:				
1.1. Too much to do at work	0	1	2	3
1.2. Lack of adequate staffing.	0	1	2	3
1.3. Not enough time to complete all tasks satisfactorily.	0	1	2	3
1.4. Taking work home.	0	1	2	3
1.5. Too many clients/Mental Health Care Users.	0	1	2	3
1.6. Working too long hours.	0	1	2	3
1.7. To many different things to do.	0	1	2	3

2. MHPSS: Organizational Structure:				
2.1. Lack of support from management	0	1	2	3
2.2. Organizational structure and policies.	0	1	2	3
2.3. Lack of flow in Communication and information at work.	0	1	2	3
2.4. Poor management and supervision.	0	1	2	3
2.5. Poor physical working conditions.	0	1	2	3
2.6. Keeping professional/clinical skills up to date.	0	1	2	3
2.7. The way conflicts are resolved in the organization.	0	1	2	3
3. MHPSS: Lack of resources:				
3.1. Lack of financial resources for training workshops/courses.	0	1	2	3
3.2. Shortage of adequate equipment/supplies.	0	1	2	3
3.3. Lack of adequate cover in potentially dangerous Environment.	0	1	2	3
3.4. Inadequate clerical /technical back-up	0	1	2	3
4. MHPSS: Client/Patient difficulties:				
4.1. Feeling inadequately skilled in dealing with emotional needs of Mental health care users/clients	0	1	2	3
4.2. Feeling inadequately skilled for working with difficult clients/patients	0	1	2	3
4.3. No change or slowness of change in clients/mental health care users(MHCU's).	0	1	2	3
4.4. Difficult and/or demanding clients or Mental Health Care Users (MHCU's).	0	1	2	3
4.5. Physically threatening clients/ Mental Health Care Users (MHCU's).	0	1	2	3
4.6. Dealing with death and suffering.	0	1	2	3
5. MHPSS: Relationships with other Professionals:				
5.1. Conflict with other professionals eg. Professional Nurses; Doctors etc	0	1	2	3
5.2. . Relationship with Operational Manager	0	1	2	3
5.3. Conflicting Roles with other Professionals.	0	1	2	3
5.4. Difficulty of working with certain colleagues.	0	1	2	3
5.5. Criticism by other professional e.g. doctor, nurse.	0	1	2	3
5.6. The way conflicts are resolved in the unit/ward.	0	1	2	3
5.7. Managing therapeutic relationships.	0	1	2	3
6. MHPSS: Professional self – doubt:				
6.1. Uncertainty about own capabilities.	0	1	2	3
6.2. Lack of emotional support from colleagues.	0	1	2	3
6.3. Fear of making a mistake over a client/patient's	0	1	2	3

treatment program.				
6.4. Work emphasizes feelings of emptiness and/or isolation	0	1	2	3
6.5. Doubt about the efficacy of therapeutic endeavors.	0	1	2	3
7. MHPSS: Home- Work conflict:				
7.1. Not spending enough time with Family.	0	1	2	3
7.2. Relationship with spouse/partner affects work.	0	1	2	3
7.3. Inability to separate personal from Professional Role.	0	1	2	3
7.4. Not enough time for recreation.	0	1	2	3
7.5. Inadequate time for friendships/social relationships.	0	1	2	3

Thank you for your participation!

Appendix: 1 c

Email to Prof D Cushway:

From: Smith Mark <Mark.Smith@kznhealth.gov.za>
08:18 AM

Sent: Tue 2017/02/21

To: 'd.cushway@coventry.ac.uk'

Cc: mark49sm@gmail.com

Dear Dr/Prof D Cushway

Subject: FW: Request permission to use the MHPSS (Mental Health Professionals Stress Scale)

I am Mr Mark Albert Smith; a senior Lecturer at Greys Nursing Campus in Pietermaritzburg; Kwazulu- Natal, South Africa.

I am presently studying towards a Masters degree at DUT. My topic is: The relationship between work stress; years of experience and emotional competency using a sample of male mental health nurses in Pietermaritzburg Tertiary Psychiatric Hospitals.

I am kindly requesting permission to use the Mental Health Professionals Stress Scale (MHPSS): Your self-report method of identifying sources of stress for mental health professionals which will guide my study as a theoretical framework.

This study will hopefully assist the male mental health nurse's at Fort Napier Hospital; Townhill and Umgeni Hospitals in Pietermaritzburg; Kwazulu- Natal, South Africa with some insight and awareness of the challenges that they experience as male mental health nurse's as well as coping mechanisms that they can use to assist them in their clinical working environment.

Kindly send me your latest version of the stress scale if permission is granted.

Thank You

Mr M.A.Smith

Lecturer Nursing: Grade 2

Greys Nursing Campus

Private Bag X9001

Pietermaritzburg

Work: 033 8973541

Cell: 0722209740

Email: mark.smith@ kznhealth.gov.za and/or mark49sm@gmail.com

Appendix: 1 d

Email from Prof D Cushway:

From: Delia Cushway d.cushway@gmail.com

Wed 2017/03/08 05:18 PM

To: Smith Mark Mark.Smith@kznhealth.gov.za

Cc: mark49sm@gmail.com

Dear Mark Smith

Subject: Fwd: MHPSS (Mental Health Professional Stress Scale)

Message:

Thank you for your email. I'm sorry for the delay but coincidentally I have just returned from a holiday in South Africa.

I am happy for you to use the scale providing that you acknowledge the authors in any subsequent publication.

I am attaching a copy for your use. It has the sub scales and the scoring. If you need to contact me please use the Gmail address above.

Good luck with your research.

Kind regards

Delia Cushway

Professor of Clinical Psychology

Sent from my iPad

Appendix: 2



CONSENT

Statement of Agreement to Participate in the Research Study:

- ☐ I hereby confirm that I have been informed by the researcher, _____ (name of researcher), about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: 092/17,
- ☐ I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- ☐ I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- ☐ In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- ☐ I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- ☐ I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- ☐ I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant:

Date: _____ Time: _____

Signature / Right Thumbprint:

I, Mr Mark Albert Smith herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Full Name of Researcher: _____

Date: _____ Signature: _____

Full Name of Witness (If applicable): _____

Date: _____ Signature: _____

Appendix: 3

Invitation to all categories of Male nurses employed in Psychiatric Nursing in Townhill; Fort Napier Hospital and Umgeni Hospital to participate in a study.

Title of study: The relationship between work stress; years of experience and emotional competency in male mental health nurses in Pietermaritzburg Tertiary Psychiatric Hospitals

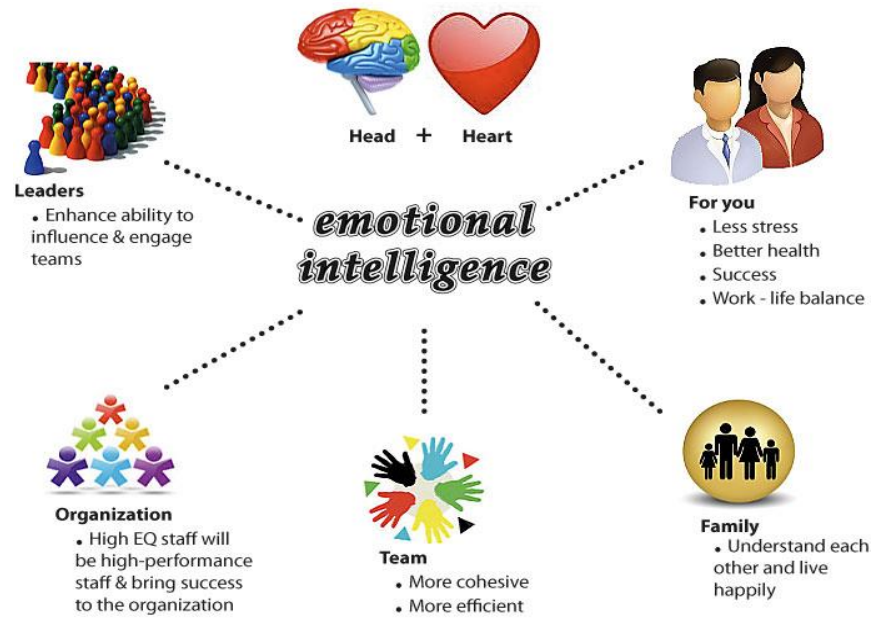
The objectives of the study are:

- To describe male mental health nurse' years of experience in psychiatric nursing.
- To identify levels of stress in male mental health nurses' in tertiary psychiatric hospitals in Pietermaritzburg.
- To describe the emotional competency of male mental health nurses in tertiary psychiatric hospitals in Pietermaritzburg.
- To determine if there is any relationship between stress, years of experience and emotional competency in male mental health nurses in tertiary psychiatric hospitals in Pietermaritzburg.

Date:

Venue:

Time:



Contact Person: Mr Mark Smith (Researcher)
0722209740/0783590029

Contact details: Cell:

Supervisor: Dr. Penny Orton

Co – Supervisor: Mrs C Adams

Contact details: 031 373 2537

Contact details: 033 8459027

Appendix: 4 a



49 Langenhoven Road

Napierville

Pietermaritzburg

3201

20 October 2017

Hospital Manager: Ms Z.G.Mfeka

Nursing Manager: Mr M Ntombela

Townhill Hospital

Private Bag

Pietermaritzburg, 3201

Re: Request to survey male professional nurses; male enrolled nurses; male enrolled nursing auxiliary at the following provincial hospitals in KwaZulu-Natal: Townhill Hospital.

Dear Madam / Sir

I am a lecturer in Nursing Education at Greys Nursing Campus, Pietermaritzburg, pursuing the following Post Graduate degree: Master of Health Sciences: Nursing at the Durban University of Technology. The purpose of this current study is to describe the relationship between work stress; years of experience and emotional competency in a sample of male mental health nurses in Pietermaritzburg Tertiary Psychiatric Hospitals. To this end a quantitative research design, will be utilized to survey the views of these categories of male nurses at select public hospitals in KwaZulu-Natal through a process of non-probability purposive sampling.

My intention is to survey 94 male nurses at your hospital using questionnaires. All categories of male nurse's will be invited to take part in my survey. There will be no physical or emotional risks involved. Information will be confidential. No benefits will be given for their participation. They may withdraw from the survey whenever they want to, with no penalties. I kindly request permission to use your hospital in order to access the views of these categories of male nurses. I require a letter of support from you in accordance to our Provincial Department of Health.

Permission has been obtained from Durban University of Technology Departmental Research Committee, Faculty Research Committee and the Institutional Ethics and Research Committee: Ethical Clearance Number: IREC 092/17.

Kindly find attached a copy of my proposal, questionnaire, letter of information and consent for your information. If you have any questions or concerns, kindly contact either me, my supervisor or the Institutional Ethics administrator on the telephone numbers below.

Thank you for your consideration of this matter and I look forward to hearing from you at your earliest convenience.

Yours sincerely

Mr Mark Albert Smith

Student No: 21644767

Contact details: 033 8973541(work), 033 3428601 (home), 0722209740 (Cell) or 0783590029(Cell)

mark.smith@kznhealth.gov.za or mark49sm@gmail.com (email).

Supervisor: Dr. Penny Orton

Contact details: 031 373 2537 or penny@dut.ac.za (email).

Co – Supervisor: Mrs C Adams

Contact details: 033 8459027 or carolinea@dut.ac.za (email).

Appendix: 4 b



health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Hyslop Road, Pietermaritzburg, 3201
PO Box 400, Pietermaritzburg, 3200
Tel: 033 341 5500, Fax 033 345 5720
www.kznhealth.gov.za

TOWN HILL HOSPITAL
ETHICS AND RESEARCH
COMMITTEE

28/11/2017

The CEO
Town Hill Hospital

**RE: The relationship between work stress, years of experience and emotional competency
amongst male mental health care nursing practitioners within Tertiary Psychiatric Hospitals in
the uMgungundlovu Health District**

Dear Ms. Mfeka

Please note that the Ethics and Research Committee Town Hill Hospital, has considered the application from Mr. MA Smith, a lecturer at Grey's Nursing Campus, regarding the above research to be conducted at Town Hill Hospital. He has obtained provisional approval and ethical clearance from the Biomedical Research Ethics Committee of UZKN.

Mr Smith has assured us that no staff member will be coerced to participate and the research will not impact negatively on staff duties. He will follow the correct channels of communication to inform all relevant managers prior to commencement of study and has offered that he will be eager to share his findings on completion of his study.

The Ethics and Research committee has no objection to Mr Smith conducting his research at Town Hill Hospital and believe that his research will impact positively on the future mental health of health care workers.

Yours Sincerely

DR. J. NAIDOO
MBBCh(Wits), DMH, FCPsych
SPECIALIST PSYCHIATRIST
MP 0496200

Dr J. Naidoo

Acting Head Clinical Unit

Acting Chairperson- Townhill Hospital Research and Ethics Committee

~~Approved/ Not Approved~~

Ms. Z G Mfeka

CEO Town Hill Hospital

Fighting Disease, Fighting Poverty, Giving Hope

Appendix: 5 a



49 Langenhoven Road

Napierville

Pietermaritzburg

3201

20 October 2017

Hospital Manager: Mrs N.T.Xaba

Nursing Manager: Mrs T.N.Ngcobo

Fort Napier Hospital

P. O. Box 370

Pietermaritzburg, 3201

Re: Request to survey male professional nurses; male enrolled nurses; male enrolled nursing auxiliary at the following provincial hospitals in KwaZulu-Natal: Fort Napier Hospital.

Dear Madam

I am a lecturer in Nursing Education at Greys Nursing Campus, Pietermaritzburg, pursuing the following Post Graduate degree: Master of Health Sciences: Nursing at the Durban University of Technology. The purpose of this current study is to describe the relationship between work stress; years of experience and emotional competency in a sample of male mental health nurses in Pietermaritzburg Tertiary Psychiatric Hospitals. To this end a quantitative research design, will be utilized to survey the views of these categories of male nurses at select public hospitals in KwaZulu-Natal through a process of non-probability purposive sampling.

My intention is to survey 94 male nurses at your hospital using questionnaires. All categories of male nurse's will be invited to take part in my survey. There will be no physical or emotional risks involved. Information will be confidential. No benefits will be given for their participation. They may withdraw from the survey whenever they want to, with no penalties. I kindly request permission to use your hospitals in order to access the views of these categories of male nurses. I require a letter of support from you in accordance to our Provincial Department of Health.

Permission has been obtained from Durban University of Technology Departmental Research Committee, Faculty Research Committee and the Institutional Ethics and Research Committee: Ethical Clearance Number: IREC 092/17.

Kindly find attached a copy of my proposal, questionnaire, letter of information and consent for your information. If you have any questions or concerns, kindly contact either me, my supervisor or the co-supervisor on the telephone numbers below.

Thank you for your consideration of this matter and I look forward to hearing from you at your earliest convenience.

Yours sincerely

Mr Mark Albert Smith

Student No: 21644767

Contact details: 033 8973541(work), 033 3428601 (home), 0722209740 (Cell) or 0783590029(Cell)

mark.smith@kznhealth.gov.za or mark49sm@gmail.com (email).

Supervisor: Dr. Penny Orton

Contact details: 031 373 2537 or penny@dut.ac.za (email).

Co – Supervisor: Mrs C Adams

Contact details: 033 8459027 or carolinea@dut.ac.za (email).

\

Appendix 5 b



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:

Postal Address : P.O. Box 370 Pietermaritzburg 3200
Physical Address:
1 Devonshire Road
Pietermaritzburg 3200
Tel: 033 260 4319/18 Fax: 033 345 5730 / Email: nelisile.nxaba@kznhealth.gov.za
www.kznhealth.gov.za

03 November 2017

Mr M.A.Smith
Lecturer
Greys Nursing Campus
Contact: 033 8973541/3505/3503
Cell: 0783590029

Dear Sir

RE: RESEARCH ETHICS APPLICATION

The relationship between work stress; years of experience and emotional competency amongst Male mental health care nursing practitioners' within Tertiary Psychiatric Hospitals in the uMgungundlovu Health District

At a meeting today, the Fort Napier Hospital Research Ethics Committee considered the application from Mr M A Smith to conduct the abovementioned research with male nursing staff at Fort Napier Hospital.

From the application documents and the research protocol provided we see no significant problem with this research being conducted at the hospital. Permission is given to conduct the research

Subject to the following:

- (1) Members of staff who do not wish to participate should not be coerced to do so.
- (2) The research can only be conducted at times that are convenient to the staff and the units in which they are employed.
- (3) Advance notice should be provided to the Head of the Nursing Department before the fieldwork begins.
- (4) The researcher should provide a report of the findings to the Fort Napier Hospital management and present a brief summary at one of the Fort Napier Hospital Academic Seminars.

Mrs. N.T Nxaba
Chief Executive Officer

Fighting Disease, Fighting Poverty, Giving Hope

Appendix: 6 a



49 Langenhoven Road

Napierville

Pietermaritzburg

3201

20 October 2017

Hospital Manager: Ms N.E.Ndlovu

Nursing Manager: Mrs N.C. Zondi

Umgeni Hospital

Private Bag X23

Umgeni 3290

Re: Request to survey male professional nurses; male enrolled nurses; male enrolled nursing auxiliary at the following provincial hospitals in KwaZulu-Natal: Umgeni Hospital.

Dear Madam

I am a lecturer in Nursing Education at Greys Nursing Campus, Pietermaritzburg, pursuing the following Post Graduate degree: Master of Health Sciences: Nursing at the Durban University of Technology. The purpose of this current study is to describe the relationship between work stress; years of experience and emotional competency in a sample of male mental health nurses in Pietermaritzburg Tertiary Psychiatric Hospitals. To this end a quantitative research design, will be utilized to survey the views of these categories of male nurses at select public hospitals in KwaZulu-Natal through a process of non-probability purposive sampling.

My intention is to survey 94 male nurses at your hospital using questionnaires. All categories of male nurse's will be invited to take part in my survey. There will be no physical or emotional risks involved. Information will be confidential. No benefits will be given for their participation. They may withdraw from the survey whenever they want to, with no penalties. I kindly request permission to use your hospitals in order to access the views of these categories of male nurses. I require a letter of support from you in accordance to our Provincial Department of Health.

Permission has been obtained from Durban University of Technology Departmental Research Committee, Faculty Research Committee and the Institutional Ethics and Research Committee: Ethical Clearance Number: IREC 092/17.

Kindly find attached a copy of my proposal, questionnaire, letter of information and consent for your information. If you have any questions or concerns, kindly contact either me, my supervisor or the Institutional Ethics administrator on the telephone numbers below.

Thank you for your consideration of this matter and I look forward to hearing from you at your earliest convenience.

Yours sincerely

Mr Mark Albert Smith

Student No: 21644767

Contact details: 033 8973541(work), 033 3428601 (home), 0722209740 (Cell) or 0783590029(Cell)

mark.smith@kznhealth.gov.za or mark49sm@gmail.com (email).

Supervisor: Dr. Penny Orton

Contact details: 031 373 2537 or penny@dut.ac.za (email).

Co – Supervisor: Mrs C Adams

Contact details: 033 8459027 or carolinea@dut.ac.za (email).

Appendix: 6 b



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: Old Main Road, HOWICK, 3290
Postal Address: P/Bag X23, HOWICK, 3290
Tel: 033 3306146 Fax: 033 3305564 Email: mpume.ndlovu@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:

UMGENI HOSPITAL
OFFICE OF THE CEO

05 December 2017

Mr. M.A Smith
Lecturer
Greys Nursing Campus
Contact: 033 8973541/3505/3503
Cell: 078590029

Dear Sir

RE: RESEARCH ETHICS APPLICATION

The relationship between work stress; years of experience and emotional competency amongst Male Mental Health Care Nursing Practitioner's within Tertiary Psychiatric Hospitals in the uMgungundlovu Health District.

Umgeni Hospital Management considered the application of Mr. M.A Smith to conduct the above mentioned research with male nursing staff at Umgeni Hospital.

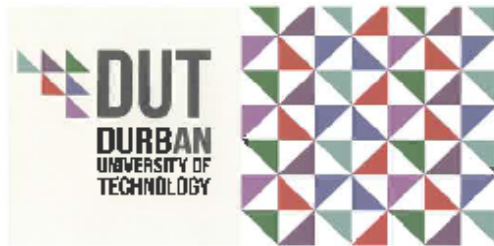
From application documents and the research protocol provided we see no significant problem with this research being conducted at the hospital. Permission is given to conduct the research subject to the following:

1. Member of staff who do not wish to participate should not be coerced to do so.
2. The research can only be conducted at times that are convenient to the staff and the units in which they are employed.
3. Advance notice should be provided to the Head of the Nursing Department before the fieldwork begins.
4. The researcher should provide a report of the findings to the Umgeni Hospital management and present a brief summary at one of the Umgeni Hospital Academic Seminars

Regards

 Miss N.E Ndlovu
Chief Executive Officer

Appendix 7 a



Institutional Research Ethics Committee
Research and Postgraduate Support Directorate
2nd Floor, Kesteven Court
Gate 1, Simon Dikho Campus
Durban University of Technology

P.O. Box 1334, Durban, South Africa, 4001

Tel: 031 379 1175
Email: research@dut.ac.za
http://www.dut.ac.za/research_institutional_research_ethics
www.dut.ac.za

14 December 2017

IREC Reference Number: **REC 80/17**

Mr M. A. Smith
49 Langenhoven Road
Napierville
Plettenmaritzburg
3201

Dear Mr Smith

The relationship between work stress; years of experience and emotional competency amongst Male mental health care nursing practitioners' within Tertiary Psychiatric Hospitals in the uMgungundlovu Health District

The Institutional Research Ethics Committee acknowledges receipt of your notification regarding the plotting of your data collection tool.

Kindly ensure that participants used for the pilot study are not part of the main study.

In addition, the IREC acknowledges receipt of your gatekeeper permission letters.

Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC SOP's.

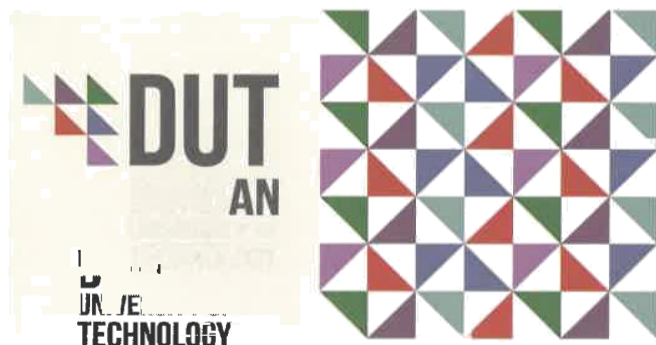
Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely,

Professor J. K. Adam
Chairperson: IREC



Appendix 7 b



Institutional Research Ethics Committee
Research and Postgraduate Support Directorate
2nd Floor, Berwyn Court
Gate 1, Steve Biko Campus
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2375

Email: lavishad@dut.ac.za

http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

21 August 2018

Mr M A Smith
49 Langenhoven Road
Napierville
Pietermaritzburg
3201

Dear Mr Smith

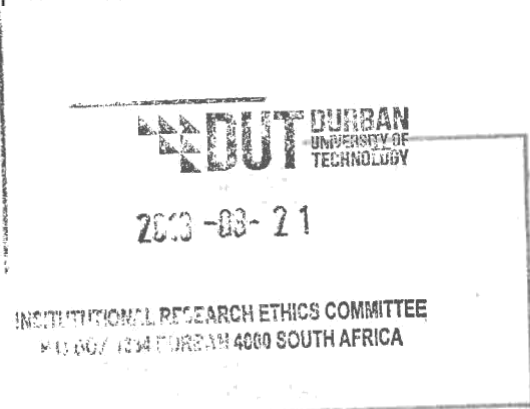
Application for Amendment of Approved Research Proposal

The relationship between work stress and years of experience amongst Male mental health care nursing practitioners' within Tertiary Psychiatric Hospitals in the uMgungundlovu Health District

I am pleased to inform you that your application to remove objective 3 and to change the title of your study have been approved.

Yours Sincerely

Professor JUK Adam
Chairperson: IREC



Appendix: 8



49 Langenhoven Road

Napierville

Pietermaritzburg

3201

1 March 2017

The Interim Chairperson

The Provincial Health Research and Knowledge Management Committee

Department of Health, KwaZulu-Natal

Private Bag X9051

Natalia

Pietermaritzburg

3201

Re: Request to survey male mental health nurses at the following provincial nurse training hospitals in KwaZulu-Natal: Fort Napier hospital, Townhill hospital and Umgeni hospital,

Dear Sir/Madam

I am a lecturer at Greys Nursing Campus, Pietermaritzburg pursuing the following post graduate nursing degree: Master of Health Sciences in Nursing at the Durban University of Technology. My topic is: The relationship between work stress; years of experience and emotional competency in male mental health care practitioners in Pietermaritzburg Tertiary Psychiatric Hospitals.

The purpose of this current study is to describe the relationship between work stress; years of experience and emotional competency in a sample of Male mental health care practitioners in Pietermaritzburg Tertiary Psychiatric Hospitals. The value of this study may provide Hospital and Nurse Managers the necessary information to assist with the adequate preparation of male nurses both in General and Psychiatric Nursing Departments with regard to overcoming stressors; developing coping strategies and enhancing their emotional competency

I request permission to use the above-mentioned provincial nurse training hospitals in order to access the views of 268 male mental health nurses. The hospital management of these hospitals has provisionally agreed (see letters of support- Appendices 2;3;4) pending your approval. I have obtained ethical clearance from Durban University of Technology No 092/17. Please find attached a copy of my proposal, research questionnaire, letter of information, consent form and the ethical approval letter for your information.

Male mental health nurses from the above-mentioned hospitals will be invited to volunteer to take part in the survey. There will be no physical or emotional risks involved. Information will be confidential. The nursing Service Managers will be asked to assist with the distribution and collection of questionnaires. No benefits will be given for their participation. They may withdraw from the study whenever they want to, with no penalties.

If you have any questions or concerns, kindly contact either me or my supervisor on the telephone numbers below.

Thank you for your consideration of this matter and I look forward to hearing from you at your earliest convenience.

Yours sincerely

Mr Mark Albert Smith

Student No: 21644767

Contact details: 033 8973541(work), 033 3428601 (home), 0722209740 (Cell) or mark.smith@kznhealth.gov.za or mark49sm@gmail.com (email).

Supervisor: Dr. Penny Orton

Contact details: 031 373 2537 or penny@dut.ac.za (email).

Co – Supervisor: Mrs C Adams

Contact details: 033 8459027 or carolinea@dut.ac.za (email).

Complaints can be reported to the Institutional Research Ethics Administrator on 031 373 2900 or reported to the Acting DVC Research, Innovation and Engagement, Prof S Moyo on 031 373 2577 or moyos@dut.ac.za

Appendix: 9



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: 330 Langakubele Street, Pietermaritzburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/3183/3123 Fax: 033 394 3760
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:

Health Research & Knowledge
Management

HRKM Ref: 511/17
NHRD Ref: KZ_201712_016

Date: 17 January 2018
Dear Mr M.A. Smith

Approval of research

1. The research proposal titled '**The relationship between work stress; years of experience and emotional competency amongst male mental health care nursing practitioners' within tertiary psychiatric hospitals in the uMgungundlovu district**' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby approved for research to be undertaken at Fort Napier, Townhill and Umgeni Hospital.

2. You are requested to take note of the following:
 - a. Make the necessary arrangement with the identified facility before commencing with your research project.
 - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lutge

Chairperson, Health Research Committee

Date: 18/01/18

Fighting Disease, Fighting Poverty, Giving Hope

Appendix: 10

Gill Hendry B.Sc. (Hons), M.Sc. (Wits), PhD (UKZN)

Mathematical and Statistical Services

Cell: 083 300 9896

email : hendryfam@telkomsa.net

7 January 2019

Re: Assistance with statistical analysis

Please be advised that I have assisted Mark Smith (Student number 21644767), who is presently studying for a Masters in Health Sciences (Nursing) at DUT, with the data analysis for his study.

Yours sincerely

A solid black rectangular box used to redact the signature of Gill Hendry.

Gill Hendry (Dr)

Appendix: 11



22nd of January 2020

To whom it may concern

EDITING OF DISSERTATION FOR MR MARK ALBERT SMITH

I have a master's degree in Social Science, Research Psychology and a TEFL qualification from UKZN. I also have an undergraduate and honour's degree Bachelor of Arts in Health Sciences and Social Services from UNISA. I have 15 years of teaching experience and have been editing academic theses for students from UKZN, UNISA, the University of Fort Hare, and DUT for the past eight years. I have further done editing, transcribing and other research work for private individuals and businesses. I hereby confirm that I have edited Mark Albert Smith's dissertation titled **"THE RELATIONSHIP BETWEEN WORK STRESS AND YEARS OF EXPERIENCE AMONGST MALE MENTAL HEALTH CARE NURSING PRACTITIONERS WITHIN TERTIARY PSYCHIATRIC HOSPITALS IN THE UMGUNGUNDLOVU HEALTH DISTRICT"** for submission of his master's dissertation in Nursing at Durban University of Technology. Corrections were made in respect of grammar, tenses, spelling and language usage using track changes in MS Word 2016. Once corrections have been attended to, the dissertation should be correct.

Yours sincerely

Terry Shuttleworth (TEFL, UKZN, MSocSc, Res Psych, UKZN).

PLEASE NOTE Should the student not attend to the changes suggested by the editor and make additions to the dissertation after editing has been completed, the editor cannot guarantee the language, grammar and tenses are correct.